weapons technology to Pakistan, a militaristic nation that spreads terrorism throughout South Asia by supporting the Taliban and other repressive forces. China has also sold billions of dollars of arms to the narco dictatorship in Burma that borders on India.

We need to lift the remaining sanctions that were imposed on India for testing nuclear weapons. As long as the State Department permits China to go unchecked and it continues to stoke the fires in South Asia, India will need to be able to defend itself.

The Prime Minister's address to Congress this week will afford all of our Members of the House and Senate the opportunity to hear about issues of importance in the U.S.-India bilateral relationship, including trade, energy, investment, science, information technology, as well as cooperative efforts to combat terrorism and to achieve regional peace and security in South Asia—a region of prime importance to our national interests.

As the current Indian government works to ensure that India remains secure, we should be marching shoulder-to-shoulder with her during this new century.

I look forward to meeting with the Prime Minister and working closely with him and his government on initiatives that bring peace and prosperity to India and Asia, and even stronger bonds of friendship between our two nations.

I submit the full text of H. Res. 572 for the RECORD and I urge my colleagues to support the resolution.

H. RES. 572

Whereas the United States and the Republic of India are two of the world's largest democracies that together represent one-fifth of the world's population and more than one-fourth of the world's economy;

Whereas the United States and India share common ideals and a vision for the 21st century, where freedom and democracy are the strongest foundations for peace and prosperity;

Whereas in keeping with this vision India has given refuge to His Holiness the Dalai Lama, Burmese refugees fleeing repression in Burma, and is a refuge for people in the region struggling for their basic human rights;

Whereas the United States and India are partners in peace with common interests in and complementary responsibility for ensuring international security and regional peace and stability;

Whereas the United States and India are allies in the cause of democracy, sharing our experience in nurturing and strengthening democratic institutions throughout the world and fighting the challenge to democratic order from forces such as terrorism;

Whereas the growing partnership between the United States and India is reinforced by the ties of scholarship, commerce, and increasingly of kinship among our people;

Whereas the industry, enterprise, and cultural contributions of Americans of Indian heritage have enriched and enlivened the societies of both the United States and India; and

Whereas the bonds of friendship between the United States and India can be deepened and strengthened through cooperative programs in areas such as education, science and technology, information technology, finance and investment, trade, agriculture, energy, the fight against poverty, improving the environment, infrastructure development, and the eradication of human suffering, disease, and poverty: Now, therefore, be it

Resolved, That it is the sense of the House of Representatives that—

(1) the United States and the Republic of India should continue to expand and strengthen bilateral security, economic, and political ties for the mutual benefit of both countries, and for the maintenance of peace, stability, and prosperity in South Asia;

(2) the United States should consider removing existing unilateral legislative and administrative measures imposed against India, which prevent the normalization of United States-India bilateral economic and trade relations;

(3) established institutional and collaborative mechanisms between the United States and India should be maintained and enhanced to further a robust partnership between the two countries;

(4) it is vitally important that the United State and India continue to share information and intensify their cooperation in combating terrorism; and

(5) the upcoming visit of the Prime Minister of India, Atal Bihari Vajpayee, to the United States is a significant step toward broadening and deepening the friendship and cooperation between United States and India.

WHAT'S SO GREAT ABOUT CANADA'S MEDICAL SYSTEM?

HON. PHILIP M. CRANE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, September 12, 2000

Mr. CRANE. Mr. Speaker, Dr. Bill McArthur is a practicing physician, research scientist and writer in Vancouver, B.C. In a recent issue of the Las Vegas Review-Journal, he criticizes some U.S. politicians for promising they can offer Americans much cheaper drugs simply by copying the Canadian pharmaceutical system. For one thing, he argues, the reason some drugs are 23 percent cheaper in Canada is that individual incomes there are 24 percent lower than in the United States, and therefore manufacturers there are able to make and sell drugs at a lower price.

The doctor stresses, however, that up to 50 percent of any Canada-United States price-differential is due to the cost of legal liability in the United States. Americans, he says, ''sue more often, win their cases more often, and get much larger settlements than Canadians''—and those extra costs must be added to the price of United States drugs. In addition, he argues, much of the cost-differential is the result of the expensive continuous research and development effort in U.S. companies, where most of the world's new drugs and new cures are created.

In contrast to the significant progress of American medical technology, Dr. McArthur observes that Canada ranks ''right in there with Poland, Mexico, and Turkey near the bottom of the 29 OECD countries.'' He concludes that any suggestion by politicians that pharmaceuticals are much cheaper in Canada ''is just plain wrong.''

Mr. Speaker, I submit Dr. McArthur's article, ''What's So Great about Canada's Medical System?'' as printed in the Las Vegas Review-Journal on September 1, 2000, in the CONGRESSIONAL RECORD to enable all Americans to compare the real status of medical costs and services between our two countries.

[Las Vegas Review-Journal, Sept. 1, 2000]

WHAT'S SO GREAT ABOUT CANADA'S MEDICAL SYSTEM?

PATIENTS PAY MORE FOR DRUGS; MANY COME TO U.S. FOR TREATMENT

(By Bill McArthur)

VANCOUVER, B.C.—Some politicians are promising they can deliver cheap drugs for Americans by copying the Canadian system. Beware—the silly season lasts until Nov. 7.

The claim that pharmaceuticals are hugely cheaper in Canada is just plain wrong. Many drugs are much more expensive in Canada and generic prices are consistently higher. The Organization for Economic Cooperation and Development reports that prices for brand name drugs are overall 23 percent lower in Canada. However, individual incomes of Canadians are 24 percent lower and the standard of living is lower.

That is what happens when an economy is badly managed—wages and standard of living decline and manufacturers are able to make and sell drugs and other products at a lower price.

The politicians promoting Canadian drug pricing should quit loading the buses bound for Canada and consider loading up 747's heading to Southeast Asia. Drugs and other products are really cheap there. However, per capita income, standard of living and prices are inseparable and I doubt Americans want a Southeast Asian standard of living.

Dr. Richard Manning, when at Brigham Young University in 1997, demonstrated that up to 50 percent of any Canada-U.S. price differential was due to the cost of legal liability in the United States.

Americans sue more often, win their cases more often and get much larger settlements than Canadians. These costs have to be added to the price of drugs and artificially jack up the cost to consumers.

I'll bet the folks clambering on the buses to Canada haven't been told they have very little hope of collecting anything if they suffer serious complications from drugs prescribed and purchased in Canada.

The bulk of the world's new drugs are developed in the United States. Canada and many other countries do not do their share of pharmaceutical R&D. So if all the really cheap drugs for Americans are bought from Third World countries, who will do the R&D?

The drug companies will be fine because they will have switched to making largely unregulated veterinary drugs or more likely, nonpharmaceutical products.

But who is going to do the R&D to develop the cures for diabetes, osteoporosis, coronary artery disease, Alzheimer's, Parkinson's and all the other diseases that affect the elderly?

No one—that's who! And with those over 65 doubling to 25 percent of the population by 2025, what lies ahead for those now under 40, when they reach their golden years—ill health and poverty—that's what.

I am a practicing physician in the pharmaceutical nirvana lauded by some U.S. politicians. Every day I see my patients suffering in the collapsing health-care system that we have in Canada. In terms of medical technology we rank right in there with Poland, Mexico and Turkey near the bottom of the 29 OECD countries.

Patients wait months for a simple CT scan or an MRI. Recently I had to tell a lady she had cancer and also that she had to wait 10 weeks for the appointment to be assessed for treatment.

In Ontario in one year, 121 people were permanently removed from the coronary artery bypass graft list because they had waited so long, they were now too ill to withstand the surgery.

One hundred twenty-one, souls condemned to a slow, unpleasant and very expensive death because of the lack of timely care.

Every day I see patients suffering because government regulations prevent me from prescribing frontline drugs, or because our system of price controls and delays in approval mean that they are not available at any cost.

Just three years ago, I personally needed to drive periodically to Washington state to get medication that was not available in Canada. This is the system that some politicians say they would impose on the United States.

Provision of pharmaceuticals for the elderly, the poor and the chronically ill is an important objective in all civilized societies, but Canada does not provide an example to emulate.

Americans deserve something far better than Canada's ramshackle health-care system. Come to think of it, so do Canadians.

UNITED STATES HOLOCAUST MEMORIAL MUSEUM

SPEECH OF

HON. NITA M. LOWEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 7, 2000

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 4115) to authorize appropriations for the United States Holocaust Memorial Museum, and for other purposes:

Mrs. LOWEY. Mr. Chairman, I rise in strong support of H.R. 4415.

The United States Holocaust Memorial Museum stands in our nation's capital in solemn testimony to the terrible power of senseless hatred and the ultimate triumph of faith and the human spirit. It guards the memory of the six million Jews and millions more who fell victim to Nazi Germany's genocidal persecution during World War II. And it stands as a symbol for those who survived this tragedy, assuring them that we are committed to keeping their stories alive.

An investment in the Holocaust Memorial Museum is an investment that strengthens the very fabric of our society. The nearly 15 million people who have visited the museum since its establishment have seen the pictures of murdered families, loyal and productive members of society, who were sent to their deaths for the crime of being Jewish. They have seen the gaunt bodies of survivors, liberated by allied troops from the death camps, facing the reality of families destroyed and lives shattered. They have seen the examples of the righteous, like Raoul Wallenberg, who risked their lives to defy Nazi hatred and save their Jewish brethren. Because of this museum, 15 million people know the price society pays when contempt triumphs over compassion, when people blinded by hatred are allowed to reign free.

In light of the events of the past decade, of the strife we have seen in Bosnia, Rwanda, Kosovo, and other places, it it more important than ever that we offer our full and unwavering support to the educational and cultural mission of the Holocaust Memorial Museum. It is a powerful rebuke to those who would divide us, both at home and abroad. It is a clear statement, a tangible symbol, of our active, ceaseless resistance to the darker impulses of humanity. It is a manifestation of our commitment to end hatred and bigotry in all their forms, to liberate those who face misfortunate and oppression, and to cherish the differences among the world's inhabitants. The museum is at once a monument to the past and a challenge for the future.

As a first step toward meeting this challenge, I urge my colleagues to support this bill.

INTRODUCTION OF HOUSE JOINT RESOLUTION REGARDING QUALITY OF CARE IN ASSISTED LIVING FACILITIES

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, September 12, 2000

Mr. STARK. Mr. Speaker, I join today with my colleague Representative COYNE to introduce a House Joint Resolution relating to the quality of care in assisted living facilities.

As long-term care has emerged as a vital issue for the health and well-being of our nation's elderly, assisted living is emerging as a popular model. More and more consumers are drawn to the ideals of privacy and independence that are promoted by the assisted living industry. States have followed the trend by increasingly providing public funding via Medicaid's Home & Community-Based Services waiver for assisted living services.

Despite assisted living's popularity; however, there remain many questions regarding the direction of this industry. Assisted living facilities are defined and arranged in a variety of ways. Some view assisted living as housing residences while others view them as medical service providers. Many facilities often do not allow ''aging in place'' despite pictures painted by their marketing brochures. States have responded with varying definitions, regulations, and oversight, resulting in unequal consumer protections throughout the country.

Quality of care in assisted living facilities has been an issue of concern. A GAO study found that 25 percent of surveyed facilities were cited for five or more quality of care or consumer protection violations during 1996 and 1997, and 11 percent were cited for 10 or more problems. I understand that steps have been taken to address these concerns, but news reports of lawsuits filed on behalf of assisted living residents continue to illustrate the impact of poor quality on the health of elderly residents.

Just a few weeks ago in my district, an elderly woman passed away in an assisted living facility due to hemorrhaging from her dialysis shunt. Two times, she pressed her call pendant for help, but both of these calls were cleared and reset 10 minutes later. The facility did not place a 911 call for assistance until 1 hour and 34 minutes later. There was no nurse on duty, and all four resident aides in the facility at the time have denied responding to the calls or clearing/resetting the call system. This situation is still under investigation, but it highlights the seriousness of inadequate quality of care in these facilities.

A new Milbank Memorial Fund publication entitled, ''Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century,'' by Robyn I. Stone is an excellent review of issues facing assisted living. As the article indicates there are many questions concerning the current and future state of the assisted living movement. Because of these questions, I am proposing a White House Conference to help advance our knowledge and awareness of these issues, and if appropriate, recommend public policy steps that are necessary to ensure the optimal development of this industry.

Mr. Speaker, I urge my colleagues to join me in increasing our understanding of the assisted living industry. By focusing on consumer protections and quality of care, we will work to ensure the health and well-being for our country's elderly.

I submit an excerpt from the Robyn Stone paper along with a May 8, 1999 New York Times editorial calling attention to problems in this sector:

ASSISTED LIVING

Another trend that is attracting attention from policymakers, private developers, and consumers is assisted living. One significant problem with this trend is the lack of a consistent definition used by providers, regulators, and policymakers. Some argue that ''assisted living'' is just a '90s label for a long-term care setting that has been around for centuries—another example of ''old wine in new bottles.'' Homes for the aged, frequently associated with nonprofit fraternal and religious organizations, proliferated in the nineteenth and early twentieth centuries to supply room and board for poor, infirm elderly people. Over the past three decades, sporadic attention has focused on scandalous mistreatment of residents in board and care homes, a version of homes for the aged that also became a refuge for the people with chronic mental illness in response to the deinstitutionalization frenzy of the 1960s.

In the 1980s the term ''residential care facility'' became fashionable as a catch-all label for places providing room, board, and some level of protective oversight. Hawes et al. (1993) have estimated that about a half million people live in residential care facilities or board and care homes in the United States. Perhaps twice that number are living in unlicensed facilities (November et al., 1997).

It is somewhat ironic that homes for the aged, board and care homes, and other types of residential care were replaced in the late 1960s and 1970s by nursing homes modeled after hospitals. ''Nursing homes'' have delivered far less nursing care than the name suggests. Today residential care is again in fashion. It is viewed as a desirable alternative to nursing homes because of its ostensibly less institutional character and its emphasis on a social, rather than a medical, model. A number of states, including Oregon, Washington, Florida, and Colorado, have aggressively tried to use residential care as a less costly substitute for institutions. One recent study estimates that anywhere between 15 and 70 percent of the nursing home population, nationwide, could live in residential care instead (Spector et al., 1996). Kane (1997) has questioned the judgment of hospital discharge planners who refer elders with disabilities to nursing homes, rather than alternative arrangements, because 24-hour care is supposedly available. She notes that remarkably little nursing care is provided in nursing homes. For example, a survey of nursing home residents in six states found that 39 percent of the residents received no care from a registered nurse in 24 hours; residents who did receive such care received an average of only 7.9 minutes; care by a nursing assistant averaged 76.9 minutes daily (Friedlob, 1993). Despite these arguments, empirical research has been equivocal on the