

station could not cope with an emergency when it is crowded with the 42,000 souls who pass through every workday between 8 and 9 a.m. In addition, structural steel in the station has shown its age and needs immediate repair. And these are just the most pressing needs.

There is also a need to add capacity as ridership grows. The station, designed in 1963, will not be able to accommodate the growing volume of people. It is projected that by the year 2005, New Jersey Transit ridership will increase 44 percent, Amtrak, 26 percent, and the Long Island Railroad, 9 percent. If we do not act now, pedestrian gridlock will shut us down in 10 years.

Happily, there is a redevelopment plan to change things for the better, a \$315 million project to renovate the existing station in the only way possible: across the street into a portion of the neighboring historic James A. Farley Post Office. The plan will nearly double the access to the station's platforms, which lie far below street level beneath both buildings. Moreover, there is a financing plan in place that will accomplish this with \$100 million from the Federal Government—\$31.5 million has already been appropriated—\$100 million from the State and city, and \$115 million from a combination of historic tax credits, bonds supported by revenue from the project's retail component, and building shell improvements by the Postal Service, owner of the James A. Farley Building. Governor Pataki of New York and Mayor Giuliani of New York City strongly support the project and have made available funding in their budgets in accordance with a memorandum of agreement signed in August 1994.

Now, \$26½ million can be used immediately for pressing safety repairs at the existing station, in the first step of the overall redevelopment effort. These are the first Federal funds into the project that will actually go toward construction, and they will count towards the Federal share of the \$315 million project to transform the station into a complex capable of safely handling the crowds that have made Pennsylvania Station the Nation's busiest intermodal facility. The authorization approved in this bill for the remaining Federal share of the project will assure the viability of the Pennsylvania Station into the 21st century.●

A TRIBUTE TO GEORGE E. NORCROSS, SR.

● Mr. LAUTENBERG. Mr. President, I rise today to pay tribute to a man who never failed to rise to the challenge of serving his fellow human beings; George E. Norcross, Sr.

George started as a union organizer in the 1940's. He got involved in the labor movement because he understood that working people needed to come together to protect their common interests and promote their common goals.

He translated that theory into practice when he founded and served as president of RCA Local 106 in Morrestown, NJ. His responsibilities to the local kept him busy, but they did not prevent him from becoming involved in other activities. His commitment to the labor movement ultimately resulted in his serving as president of the AFL-CIO Central Labor Council of South Jersey. In that capacity, he made sure that the union movement contributed to the community as a whole as well as its members.

George took steps to get the 80,000 members of the central labor council's 73 locals involved in community events. He became active in the United Way and served as chairman of the campaign in 1982 as well as holding other post of responsibility in that organization.

While George recognized the need for larger organizations like the United Way, he never lost sight of the obligation that labor unions themselves had to assist those in needs. He served as president of the union organization for social service which provided services to the community ranging from food banks to job training and clothing drives.

George is the kind of man who believed that Americans ought to care about their neighbors and accept a responsibility to help them. His life has been devoted to basic values: seeing all men and women as brothers and sisters, realizing that we share common dreams and face a common destiny, accepting the obligation and opportunity to give those in need a helping hand.

Mr. President, because of George, literally tens of thousands of lives have been improved and enriched. I join with those tens of thousands in wishing him a rewarding retirement and expressing our appreciation for all he has done, and all that he will continue to do.●

RURAL HEALTH IMPROVEMENT ACT OF 1995

● Mr. ROCKEFELLER. Mr. President, I am very pleased to be here with my colleagues from Montana and Iowa, Senators BAUCUS and GRASSLEY, to introduce a bill for rural America. The point of our bill is to help make sure that the people living in rural areas—who are disproportionately elderly—will be assured access to vital health care services, especially primary care and emergency care services. Our legislation is an effort to make sure that senior citizens are not forced to travel long distances in emergency situations or for simple, but life-saving reasons like getting certain tests.

Getting reliable access to health care services has always been a struggle for the people of rural West Virginia and the rest of the country. Now, as major changes are unfolding in the delivery of health care and throughout the health care system, many rural hospitals are being forced to re-examine and re-focus their mission and their capabilities.

Our bill steps in by giving rural hospitals across the country an important option that rural hospitals in West Virginia and 7 other States already have to be more responsive to the people in their areas. Under this bill, rural hospitals will be relieved of burdensome regulations that may interfere with their ability to meet the most critical health needs of their local community.

Currently, most rural hospitals have only one choice when faced with declining occupancy rates, declining Medicare and Medicaid reimbursement rates, and intense market pressures to lower their costs: closing their doors. Small, rural hospitals are simply not able to take advantage of the "law of large numbers" and economize like larger hospitals can. Under our legislation, when a full-service hospital is no longer sustainable, critical access hospitals will assure rural residents basic access to essential primary care and emergency health care services.

This legislation is modeled on two separate, ongoing rural hospital demonstration projects. It is modeled after a demonstration project in Montana, called the Medical Assistance Facilities or MAF Program which has been in existence since 1990 and the Essential Access Community Hospital and Rural Primary Care Hospital Program, more commonly referred to as the EACH/RPCH Program which exists in seven States.

Under these demonstration programs, limits are placed on the number of licensed beds and patient length of stays in the participating rural hospitals. In exchange, hospitals receive slightly higher Medicare payments to cover the important services they do provide—along with relief from Federal regulations that are intended for full-scale, acute care hospitals.

We believe, based on new cost information collected by the General Accounting Office, that our legislation will actually save the Medicare Program money. By giving hospitals some flexibility on staffing and other Federal regulations, hospitals can staff-up based on their patients' need, not just to meet regulations meant for completely different situations. We want to encourage the development of rural health networks, to help small, rural hospitals save money and improve quality by tapping into the resources of larger, full-service hospitals. The labors of health care should be divided according to who can do what best, but there absolutely is a role for rural hospitals and a reason for Congress to help them survive.

Mr. President, this legislation will make sure that rural residents will have immediate access to emergency care, and that they and their families won't be forced to travel long distances for routine medical care. Rural residents who need just a short stay in the hospital can stay and receive their care at the local hospital rather than traveling to a usually more expensive medical center.

The magnitude of Medicare cuts that are included in this year's budget resolution make this legislation especially critical. We must make sure that rural hospitals have the ability to react to huge Medicare cuts by becoming more efficient and closing down unused beds rather than by simply closing their doors.

I am very proud to note that West Virginia has been a leader in helping small, rural hospitals figure out how to adapt and cope with rapidly changing economic circumstances. Webster County Memorial Hospital and Broaddus Hospital in Philippi were two of the first few hospitals to be designated rural primary care hospitals nationwide. Seven other West Virginia hospitals are currently considering making the transition.

According to Steve Gavalchik, the administrator of the Webster County Memorial Hospital, if they had not been able to take advantage of the EACH/RPCH Program, the hospital might have been able to hang on for only about 16 to 18 months more before being forced to shut its doors. Now, Webster County hospital can focus on doing a few things well. Networking with an essential access community hospital has been invaluable as Webster County has made the transition to a rural primary care hospital. United Hospital Center, their hospital partner, has provided technical assistance, financial advice, quality assurance and quality improvement support.

For the people of Webster County, access to basic and emergency health care services would have been severely curtailed if Webster County Hospital had been forced to close. The nearest hospital is 43 minutes away—in the summer. In the winter, the drive is much more treacherous and takes up to 1½ hours or more. Patients with chronic obstructive pulmonary disease [COPD], diabetes, pneumonia, and congestive heart failure are the most common diagnoses of patients admitted for short term stays. Just imagine if these patients, most of them elderly were forced to travel an hour or so to get routine hospital care, not to mention the extra costs that would be involved for them and their families.

Family practice services are now available on site at the hospital because the doctors in the town moved into unused space. The doctors' practice have benefited from sharing resources, and the local health department has moved its headquarters to the hospital complex. As a result, the hospital and the local health department are now working together in ways they would have never thought of before. More important, patients benefit from the ease of having a central place to go to take care of their routine health care needs.

According to the hospital administrator at Broaddus Hospital, Susannah Higgins, Broaddus Hospital was also faced with possible closure prior to being designated an RPCH hospital.

Now, Broaddus can function as a mini-hospital. Through its relationships with partner hospitals, Broaddus offers oncology, general surgery, ob-gyn clinic services on-site on a weekly basis. Family practice and internal medicine services are available on a daily basis. Lifesaving emergency services are on-site. Just recently a local resident severed his leg in a logging accident. He was transported to Broaddus Hospital in a private car. By the time he arrived at the emergency room he was in extremely, extremely critical condition. Fortunately, he was able to be stabilized and was later transported to a medical center. If emergency services had not been available in the area, there is a very good chance that man would not be alive today. When minutes and seconds literally count, a helicopter landing pad cannot take the place of having highly trained and qualified emergency doctors and nurses available immediately to stabilize and begin emergency care.

Webster County Memorial Hospital and Broaddus Hospital are examples of how rural communities can adapt to a changing health care marketplace. This legislation builds on the strengths of the current EACH/RPCH program and the Montana MAF program; improves them; and expands them to all 50 States so that rural hospitals all across America will have the same opportunities.

Mr. President, under our bill, newly designated critical access hospitals would be limited to 15 inpatient days and patient stays would have to be the kind involving limited duration—up to 96 hours, although exceptions are allowed in special circumstances, such as inclement weather or a patient's medical condition.

In this bill, we ease up on hospital regulations so that critical access hospitals can meet the needs of their community and not the needs of a Federal bureaucracy. We are not easing up on quality standards but have rather allowed hospitals to use common sense when it comes to staffing and certain other Federal standards. For instance, if there are no inpatient beds occupied, hospitals do not have to have a full complement of hospital staff on duty. Medicare reimbursement would take into account a small, rural hospital's fixed costs and the inability of small, rural hospitals to take advantage of some of the cost-saving measures that larger hospitals can implement.

Our legislation is targeted at the 1,186 rural hospitals nationwide with fewer than 50 beds. While these hospitals are essential to assuring access to health care services in their local communities, these hospitals account for only 2 percent of total Medicare payments to hospitals. Our country's small rural hospitals needs special attention. This legislation gives them that attention and the ability to adapt to a rapidly changing health care world.

Finally, this legislation would require the Secretary of HHS to submit a report by next January on a methodology for Medicare reimbursement of telemedicine services. I recently, along with my colleague from Maine, Senator SNOWE, included an amendment in the telecommunications bill—that was passed by the Senate just last week—that will guarantee rural health care providers affordable transmission costs when it comes to telemedicine and other telecommunications technology. The provision in the bill we are introducing today is another important step to improving access to specialty and state-of-the-art medical care for rural residents.

Mr. President, I believe this legislation is critically important and, if enacted, will have an important difference on the health of rural residents across America. I am honored to be part of this effort, and intent on continuing to respond to the health care needs of the people in my State and rural America.●

DECLINE OF DEMOCRACY IN NIGERIA

● Mr. SIMON. Mr. President, today I remind my colleagues that June 12, 1995, was the second anniversary of the annulled election of Mashood Abiola as President of Nigeria. The people of Nigeria commemorated this anniversary with a general strike that brought business in Lagos and other cities to a standstill. The military regime of Gen. Sani Abacha marked the anniversary by rounding up and arresting dozens of Nigeria's prodemocratic leaders. As I speak today, General Abacha continues to hold in prison the legitimately elected leader of Nigeria; the general also continues to deny President Abiola badly needed medical attention.

Nigeria is a nation rich in natural and human resources. Besides producing 2 million barrels of oil a day, Nigeria mines significant amounts of coal, lead, zinc, and other minerals. Nigeria is also the most populous nation in Africa. In the 1960's and 1970's, the people of Nigeria set the standard for improving educational standards and promoting economic development in Africa. By the early 1980's, 100,000 men and women were graduating each year from Nigerian postsecondary institutions and one-third of the population belonged to the middle class. Observers of postcolonial Africa predicted that Nigeria would lead the way in building democracy and prosperity in sub-Saharan Africa.

Since that time, however, this optimistic outlook has been shattered. The military leaders of Nigeria have systematically looted their country's wealth and brought Nigeria to the edge of economic and political ruin. Today the Nigerian Government cannot even make interest payments on its foreign debt and is losing control over many of its territories. Fifteen years ago, Nigeria had a per capita income of \$1,000,