DOCUMENT RESUME

ED 455 057 RC 023 053

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TITLE Rural Health Issues. Keynote Address.
PUB DATE 2000-05-00
NOTE 7p.; In: Issues Affecting Rural Communities (II). Proceedings of the International Conference [on] Rural Communities & Identities in the Global Millennium (Nanaimo, British Columbia, Canada, May 1-5, 2000); see RC 023 040. Edited transcript of a speech.
PUB TYPE Opinion Papers (120) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Allied Health Personnel; *Educational Needs; Federal Aid; *Health Services; Medical Education; *Physicians; *Public Policy; *Rural Areas; Rural Education; Rural Urban Differences
IDENTIFIERS *Health Personnel Shortage; Rural Health Clinics

ABSTRACT

Medical students that come from rural areas are more likely to return to rural areas to practice, but rural students apply for medical school at half the rate of urban students. Factors that contribute to this problem are the lack of rural representation on medical school selection committees; centralization of medical education facilities in urban areas; the perspective payment system, which contributed to rural hospital closures; the reduction of services brought about through managed care; reductions in federal funding; the "one size fits all" approach to legislation; and the urban perspective of most policymakers. Addressing the rural health care provider shortage will require: educational programs that give rural students the science they need to apply to medical school; role models for rural students; rural physicians on medical school selection committees; more residency programs with a rural training track; community empowerment to determine and meet local health care needs; development of students' sense of place by reemphasizing courses such as geography and history; policies that encourage the recruitment and retention of rural physicians; increased federal funding of programs for the rural poor; insurance for the uninsured; an environment for rural providers that is satisfactory socially, financially, and professionally and gives opportunities for growth; and local leaders that take responsibility for efficient use of available resources. (TD)

KEYNOTE ADDRESS
Rural Health Issues

Gary Hart, USA

W. C. Fields said something about following children's acts and they were wonderful. I am really happy to be here. In fact I guess as I've gotten older, I'm just happy to be anywhere. This is an interesting presentation, I originally thought that I had made a vow that my last presentation that I was going to do them on my lap top. I was keeping that vow, couldn't get everything transferred, then got caught in between them, so I have overheads which I'm mostly going to use.

Yesterday, listening to some of the presentations I was struck by some of the things that were said and last night made some changes in what I'm going to talk about. So things may seem a little more disjointed than they would have otherwise but I am trying to make things more relevant than they would have been some other way.

I am from a program called WWAMI. That's a strange name;it stands for Washington, Wyoming, Alaska, Montana and Idaho. The northwest part of the United States. Back in the 1970's just for a couple of minutes there was reason prevailed and they were building medical schools all over the country and this group of States decided to build to just build one medical school and that the States would all use it and that is the University of Washington. We have a regionalized medical education program and so each of the States Legislatures appropriate money to the medical school and in exchange for that medical students are brought in from each of the various states. We have a motto around the program which is "to try to keep people out of Seattle as much as we can". One of the priorities with the program is to train rural physicians and the more we get them in to Seattle, the more they have opportunities to marry spouses that are urban. There is a whole series of kinds of things that happen to them. So we try not to have them be there very much except for where we need it for accreditation. Even the first year of medical school none of them come in, they stay in Boise, and they stay in Anchorage, and they stay out in these other states. Then they come in for us but while they are in with us being trained we send them out for the summers to be with role model family physicians in towns. We make requirement research projects for them and try to make it a rural research project. There is a whole series of sorts of things including even visiting the junior high's and high schools of local physicians and getting people interested in rural health and see that as something they can become.

Probably the single most impediment to us right now is how many rural kids apply for medical school at the university. They just don't apply in the numbers. In fact we have looked at that carefully and the rate of applying to medical school from the rural areas of our region. It's half that of the urban kids. It's half. We accept them at the same rate, they get the same grades, they graduate the same, we can't tell them apart ever, in terms of how good a physicians they land up being. Their clearly, if they come from rural areas, much more likely to return to rural areas to practise, but it is at applying. We have looked at not just us but what if they applied to other medical schools and other places they still apply to those at half the rate. So one of the real challenges for us is to create educational programs out there for the students so they get the science they need so that they can apply and be competitive. Secondly, to help create role models for them and help them to understand and see that as a path way in their lives and we are not still doing well at that. We are trying to do better but that is a significant problem for us. We originally had a problem with getting them accepted into the school.

The University of Washington is a real high tech, bench research kind of medical school in the nation. And what happens was historically the selection committees became very much oriented toward neurosurgeon type characters coming in to apply to medical school and over the last decade we have managed to really change that too. There used to be a selection committee of eight people who were mostly bench researchers, now it's fifty and a bunch of those are rural physicians. So we are really trying to change the mix of the students. We still want those bench research types because there is obviously a role for them but we are trying to get a better mix so that we get an opportunity to get more of the rural kids in and now it's the application process that's the hard part for us.

We have a residency network program. Family medicine department has eighteen residencies scattered across the five states. Those residencies are for when you are finished medical school and you are specializing in family medicine. There are eighteen of them spread around and this is a very unique program in the states. Only a few schools have these kinds of programs. One of the programs out of Spokane has a rural training track. Now we try to keep them out of Spokane because that's a smaller city and we don't want them there either. So they spend some of their time there because they have to have some surgical experience and various kinds of things there but we put them out literally for a year in to smaller places of the ten thousand and five thousand, and as small as we can get them and get them accredited and

we put those students out in those kinds of areas in these residencies.

So we have a large residency program trying to get rural physicians experience in rural places with rural physicians, so that they can do a better job. A lot of folks when they talk about that kind of work, talk about it being the reason that you are doing it is so you get more rural physicians and that is certainly a part of it but one thing I keep reminding folks about because they are always evaluating - do you get more, don't you get more, their selection, it's not randomized, how do you know you wouldn't get all of them being rural physicians anyway? All those are valid points but the come back to all that is if we didn't get one extra rural physician and those rural physicians practiced better and fit in better in rural towns and became better rural physicians. That would make the programs worth just doing that.

I testified at Medpack a while back, which is the Medicare Policy Advisory Commission for the Congress, and one of the last questions asked of me was "why should we waste money training people in rural places?" which wasn't even the topic that I was talking about but never the less somebody threw it in at the end and one of the things I tried to explain to him was, I said," well let's reverse things, just go with me for a minute and think of the world as being different from what it is. Let's just for a minutes play like history was a little different and all the rural doc's and all the doc's in the world in U.S., which is not the world clearly, I can differentiate that, everybody there can't but I can. Let's just say they all were trained in rural places and let's say all those doc's that were going to practise in inner cities to various groups the indigent and others were being trained in rural sites, would it make you uncomfortable at all to send them to inner-city emergency rooms to practise and if it does just don't ask me the question. And it better make you uncomfortable because that wouldn't be the training they were getting. So in any event we are a large educational program, we are actually working in the Pacific right now doing continuing medical education in places like Pilow and Casari and Ponipa, which are all rural places although we don't think of islands out in the Pacific that way.

The other thing that we do a lot of the centres that I am connected with. I'm the Director of a Rural Health Research Centre at the University of Washington and the Director of a Health Work Force Centre. The Rural Centre has been around since the twelfth year as an official Federal, National Work Force Centre and one of the things that goes along with our Work Force Centre is another program called programs for Healthy Communities which has been around since 1980, about twenty years ago where we have been doing Rural Community Health Development. Which is a little different than what a lot of you folks have been talking about but there are a lot of similarities. We basically go into small towns, at their invitation, I've done well over a hundred of them in the last decade. In those towns we do several things, we do an inventory of the health care that is there, we look at and interview - two of us would interview people for a day and a half at an hour a piece, talk about health care, we would survey the community related to where they go for care and how they rated care and how they felt about care and various things. We would do a fiscal analysis of the local hospital if it has one or the local clinic. We usually produce some kind of document that sort of notes all these things and talks about the strengths and weaknesses in the town. What the document doesn't talk about is what they should do about it.

What we do is in the end we meet with and have as partners in all this the hospital administrator, the hospital board, the local health care providers, and community members. In the end this sort of culminates all this, it's the beginning not the end, all this culminates in a community meeting where the documents have been available, we sit down and talk about what they mean at this community meeting, folks start prioritizing as a community which things they are most interested in which things they want to work on, it doesn't have to be what you can affect may not be the thing on top of the list, so part of it is what you can change and then we go through this process and people vote and we refine things and make committees. It is not us, it's the town, we are acting as a catalyst, not as the goers and doers. What doesn't happen at the end of those meetings, we then facilitate, you decide that you want to do this and you need somebody to help you by doing that we will go help try broker that person for you or broker the resource for you but it's about the town doing it and it has really been a wonderful process and it puts ownership and it empowers the town that they can change things. It is something that we have been working at for a long time. It has worked well in the State of Washington where we are. The Hospital Association basically after seeing how well it worked has taken over doing a lot of that and we are not doing as much in Washington anymore because they are doing a very good job and we don't need to have competition. It's not about competition.

The other thing I want to comment on, it was talked about the other day, was a sense of place. I'm a medical geographer by background, like Jim indicated and that's always been part of the way that I was educated. Is in the geography. A lot of the discipline of geography besides doing spatial analysis and statistics and research and things is more the geography that you think of which is what takes place in school. As you know, as we have increased emphasis on science and math and other things, the history of things like geography and history and requirements and how much students have to take has changed dramatically. I think that really goes along with what Paul and Tony were talking about yesterday that as those things have dropped away people lose it. That's how you put things in to perspective and that's how you get the sense of place. Geographers do things like mental math. Where they have people draw things and then you put these maps together and you can see how groups of people are perceiving where they are and a whole list of other things along those lines. But the geography and history allow people to put things in

perspective where they are. Invariable, geographers when they are teaching courses wherever they are teach courses that relate to the place where they are. We may talk about the world and this and that but it is always brought back to relating it to the environment. The definition of geography most people use is that it is it's relationship between man and his environment/persons and their environment is now a days I suspect more appropriate. In any event it is that relationship and we are very happy, unhappy to see this kind of emphasis on place. Again these programs that we have been working on for years have been ones that have been around kind of empowering people.

Let me just speak about a little bit of background of what has happened to work force the last bunch of years. What I really have is a presentation that takes over an hour and we are going to only do a little bit of that, probably here at the end and I'll cut it off at some point so I can hit some issues with you. I want to give a little bit of background and talk about the political side of things that have to do with rural. I'll speak for the United States because that is what I know best. I think Canada actually has paralleled a lot of the things that I am going to speak about in terms of developmentative providers, as have some of the other countries such as Australia.

Roger Rosenblatt and Ira Moskovice, two friends of mine and Rodger has been my partner for twenty years came up with a way of talking about the history, the development of medicine. One of those areas is from 1625 to 1850, just bear with me a little history here. It is called the Aquarian era and it was the era when physicians were apprentices. They were very much like tailors and other things. They were apprenticed and at some point they took over there was no licensing. From 1850 to 1910 there was this big industrial growth period and rural places even during this period are still healthier. Cities are dirty places, cities are places where people die when plaques come you go to the country to get away from them. It is very different, think of that change. There are still shortages but physicians in country areas are as likely as they are in urban environments. 1910 was an interesting year, a guy named Abraham Flexner, wrote a report and it acted as a catalyst. It really changed medical education where instead of being trained in apprentice mode, it became very much more centralized, licensing kinds of things, certifications, medical schools had to be accepted, they had to have special curriculum to be accredited, that sort of thing took place. There are parallels in all disciplines. Public health grew especially in rural areas as things were cleaned up in urban places and then basically toward the end of that period in 1940 the depression hit in 1929 and 1930 and with that depression, seven hundred rural hospitals closed in the United States. 700 and there was dramatic shortages, centralization was taking place. So in 1940 to 1970 is another period, it's called the Hilberton and the War on Poverty - Hilberton was a Congressional Bill that was passed that put in a lot of money in to rural building of hospitals and health care facilities. So a lot of those 700 hospitals that were destroyed, new ones were built, specialization continued, a lot of specialization became as generalists started to become the exception. The centralization of the medical schools and large universities continued dramatically. This again, the shortage of physicians and other providers in small rural places became acute. Toward the end of that period because of these shortages in the States, Medicare, which is insurance for the elderly, Medicaid, insurance for the poor, the National Health Service Core, that's when you send physicians to places where there aren't physicians in return for having paid for their education and community health clinics which are again for clinics that are built in places where physicians basically won't go and where there are lots of folks that are indigent. These were created all those programs, they came about within three years in the late sixties. The next period, Ira and Rodger called it the technology era from then to the present. The present was 1983 when they finished that book. There was still basically a crisis. Technology as you know has gone just crazy, especially in health care. The specialization we were talking about continues and in 1970 there was a real reaction against the specialization and family medicine was created as a discipline in which you got boarded. General internal medicine developed, general pediatrics developed, there was a move to add added status to people who were generalists. This is all going somewhere, trust me!

I actually have called the seventies a little different - it was the access era in the States, where all those programs that I named before really started - access was the issue. Everybody was very interested in access. With 1982 just about the time when they wrote the book another era came in, it came in with Ronald Regan and has continued since then in the States for the last eighteen years and that's a cost control era where cost has been clearly the number one issue that has faced folks. In 1983 perspective payment came in. Perspective payment system was one where hospitals were paid set amounts for when people came to those hospitals and somebody came and they had an appendectomy you got "x-amount" of money, period, and there were some adjusters but not very many. 250 rural hospital closed, "do you notice some pattern here, we keep closing them, then we build them, and then we closed them." Well 250 rural hospitals, ten percent of all the rural hospitals in the United States closed in about five years because that method of paying hurt those hospitals very much. Manage Care came in, regardless of what you hear from folks about Manage Care and Prevention which is not happening much related to Manage Care. Manage Care when it is said by somebody in the U.S. Congress should be interpreted in another way. It is like a foreign language. Manage Care means equals less care and the reason you save money is not because of the economies, although there are little bits of economies, the reason you save money is because you give less. You notice when they went to Manage Care they cut billions of dollars out of the budget. With the billions of dollars that they cut out wasn't because it

was so efficient, everybody got the same care, they just said Manage Care and cut a bunch of money out and they gave less service. There were some budgetary reasons for that and it is not about the politics of this but the net effect has been for the safety net folks - the indigent, the poor, the racial and ethnic minorities have suffered dramatically over the last eighteen years related to that. Then the newest, interesting move was in 1997, it is the Balanced Budget Act of 1997 which was the biggest reform that there has been in fifty years in health care financing. We did a lot of work on the Balanced Budget Act of 1997. It cuts out one hundred and twenty-eight billion dollars out of health care and that isn't because of efficiency, it is just cutting it. That one hundred and twenty-eight billion dollars came out of everybody's hide but specifically for rural hospitals. It made a perspective payment system for Nursing Homes, Out Patient Care and Home Health. There were others but those three are the big ones, especially Out Patient Hospital Care. This was effected dramatically. We did a study where we did site visits at six hospitals across the country for the policy debate after the fact and we analyzed those hospitals. We found these small rural hospitals that we picked in states all over the country, they were ones that the Hospital Association or the Office of Rural Health told us that they were the best managed small remote hospitals in the States. This is everywhere from Pennsylvania to Montana to Mississippi. Everyone of them lost in the period of putting those things in, would have lost and gone in to the red by hundreds of thousands and we predicted two of them could not have survived and most of them would have had to cut their services dramatically.

As part of that and what a lot of other people did the Balanced Budget Refinement Act of 1999 was past this last year which basically delayed things. It didn't fix much but it delayed most of these things from being implemented. Although some of them have already hurt a lot of the hospitals and a few hospitals have even closed. The bottom line is without getting too much in to the long term politics of this is there is a crisis in the United States right now, if there is still a shortage it's never changed the providers in rural places but there is a dramatic shortage of services related to this Balanced Budget Act of '97 that is dramatic. There are people who are speaking of 5-6-700 hospitals closing. That is twenty percent of all the hospitals in the country. Be aware of what is going on. I guess the question I wanted to present again and it is away from what I had originally prepared and I do have seventy overheads here, but I'm not talking about those right now, "Is why does that happen and what allows it to happen in a country like the United States?" Sixty million people live in rural United States, that is as many people who live in the United Kingdom, as many that live in France. "Why is it that these policies are so hard on them?" I think there are a couple of reasons. One is how urban centric this society has become that in effect by saying twenty percent of the population is rural, we are saying eighty percent of it is urban. The legislators for the most part are elected from urban majorities. That changes the way they look at things. More important I have come to believe over the last few years of doing a lot of policy work has been the bureaucrats are urban. That is the Health Care Financing Administration in the United States, that is the group that pays for the things like Medicare and Medicaid. They do the reimbursement and is a huge and relatively efficient bureaucracy that deals with the finance. Those folks who do that for the most part live in Baltimore and work in a suburb of Baltimore and I have gone there and taught a class on "what is rural" and most of those folks have never seen a silo, don't know what a cow is. It sounds like an overstatement but they are just lost. They don't have a clue. It isn't that they hate rural places and they write policies that are nasty, they just don't understand. So one of the things we try to do a lot is we try to get folks to let us take them on site visits and we fly them out to wherever, to Wyoming was the last site visit. We took a couple of the senior folks, we flew out not long ago to Cheyenne Wyoming and we drove them to Thermopolis Wyoming, which is about two hundred and ten miles through absolutely nothing. You don't see anything between the two points and they had never seen empty space, they had never been west of the Mississippi. "Oh gee whiz, ambulance service is really important out here." It's amazing because you think in this day and age that we live in that people know. Medicine is urban for the most part, medical schools call the shots. There are one hundred and twenty-five of them in the United States and there isn't any of them in a rural place - none! Most of them are in very big cities. Like New York City, I think has eight. The committees that make many of the decisions, like Medpack, that I talk to. The Medpack committee and it's predecessor for the last twenty years has had nobody on it who has had a rural interest, nobody. Somebody was appointed this last year, it was a big deal to get somebody. About six months ago we gave a presentation in front of Medpack and we were the first people who had the topic of rural health, who ever presented to them in the twenty years of their existence. Fifty-five million people. The other thing that goes on in this process and we don't have time to talk about the legislative process, nor would it be interesting to many of you because each country is a little bit different is that there is a process by which we called it in a recent article, "the one size fits all mentality." When congress passes anything they want to make it simple. Health Care Financing Administration wants to keep it simple. Everybody wants to keep it really simple and so what they do is they make a set of rules and the idea historically has been just a band-aid kind of thing and we will make the policies and we will see how things follow and then we will make little band-aids to fix it after the fact. That is the federal policy about the policy and it is the way things have gone for a very long time. Well what has happened is the thing that they don't understand that many of you understand is how vulnerable small rural places are. These are not places like big cities where you can close two hospitals, you still have three, things just sort of rebound, it's fluid, there is lots of money, there is opportunities to do things, there is safety net facilities, like the public hospital that can take care of folks. In most rural communities there

is one small hospital. It is usually the biggest employer in the town by the way and it is interesting money when you start thinking about insurance and things. There are different kinds of things if you go to economic analysis there are different kinds of places, sort of the multiplier factors or sometimes when you are just exchanging money in town but when insurance companies are paying money through a hospital in to town that is money coming in from outside just like you were selling gold and bringing the money in. That money multiplies in the town. So in any event there is this "one size fits all" kind of a mentality that just pervades everything but this vulnerability we really manage to as these hospitals close. That two hundred and fifty hospitals that closed, not one re-opened, even when things got better. So there is a real mission to be accomplished related to these places. Over the last twenty years, rural has emerged, we have just finished an article that talks about that re-emergence and how it has taken place. The National Rural Health Association, lots of places, a bunch of research centres that were able to put real data in peoples hands about what was going on and I would love to talk about some of that with you as time goes on.

Let me just mention a couple of things, for those who are interested from the States or any of the other places, this is not the book that I have been advertising that is coming out in August. This is another book that came out about six months ago, Tom Rickets is the editor and it is called the Rural Health in the United States. It is a very good book, it is the newest thing this decade, that gives good numbers and things about what is going on in rural places. A couple of policies, that are really important, that I need to mention. Recruitment, retention, the shortage of providers in rural areas is tremendous. That is at the macro level of policies and training. Training being the first big step. At the micro level is teaching people how to recruit and how to recruit spouses, which is incredible important. How to keep folks and retain them in a rural community. There are whole books written on the subject on recruitment and retention. The big issue right now for us in the States and it is going to be an issue for Canada and Australia too is that every year - good news - every year more and more women graduate from medical school. It was two percent, five percent, and right now it is 35 percent across the U.S. Medical Schools. Our school it is fifty-eight percent right now. In some disciplines like pediatrics it is seventy percent. In some things like OBGYN it is eighty percent female. That's good. The bad news, female physicians are eighty percent less likely to go to small towns to practise - eighty percent less likely and forty percent less likely to go to big rural towns. That's a problem. What we have little research on and know little about and very few people are working on, we are trying to do a bunch of studies related to that, is "how do you retain, recruit, make happy, women to work in small rural places." It is a real challenge and it is going to get harder and harder and put more and more pressure on places. Again, it is tremendous. I have a map that shows some states like Arkansas. Arkansas has eighteen male rural physicians to every female physician - eighteen to one and the ratio and like I say there are more and more females and you can see what affect that can have.

Finally, one of the things that I talk about and there are all kinds of policies going on related to license insurer and safety net issues, rural docs, in general rural providers give away, we have been doing some surveys and visiting and doing site visits, fifteen to twenty percent of all their effort is given away - is charity. Twenty percent! Most federal governments do all kinds of programs for the poor in urban places, they sort of let the rural docs just make it or not make it and they don't subsidize and don't help them in particularly but because it is the different kind of person that is and the different culture there is in these rural towns, they are giving away fifteen to twenty percent of their town. We can't make it too hard on them so that they have to leave in order to send their kids to college. One last thing about rural health. Three things that will never be solved until these - rural health problems will never be on even footing until we deal with several things. One is the uninsured, especially in the states. As long as there large numbers of uninsured that physicians and other providers see there, they are going to get less income and they are going to do it anyway and those folks need to be seen and need the insurance. Secondly, the only way we will have lots of rural providers in the long run is if we can create an environment that isn't incredibly hampered and strained and tight where the hospitals are closing and you don't know where the next money is going to come from and where there is not enough resources at all. That there is such a nasty health care reimbursement environment that nobody wants to be there, that is the other thing. Thirdly we have to make an environment for rural practitioners and rural people in general that creates a rewarding socially, a rewarding life that is financial remunerative. There is an often a lot of people in towns that see the doc and he is one of the riches guys in town. So there is a tendency to not want to give him a break whenever they get a chance to but the bottom line is this is a comparative world and it needs to be remunerative to them at least to the level that they are not drawn away to other places. We have to create an environment that is satisfactory socially and professionally and gives opportunities for growth for the rural providers or they are never going to stay there. And finally, and I have to say this is the last thing I always say in one of these lectures, none of this and I have talked about it at the federal level and the physician level, and the other providers kinds of levels, none of that relieves what we do in our community help development work with rural towns which is saying you can't do much about what the feds do but you can do a lot about is how efficient you can do. Rural towns and the folks who live in them have to take responsibility for using the resources they have as efficiently as they can to get the most out of them. There are some really efficient towns that really do that and have great leadership. There are other towns that we visited where that is not true and a responsibility has to be that the local folks take responsibility for themselves and do as

best they can with what they have and we all work for other kinds of changes.

Well I'm sorry for being foreshortened and I got off on some tangents but I felt that that was more relevant than what I more formally prepared. I would be glad to talk to any body here and try to catch me today as I will be leaving early tomorrow morning. I am very much enjoying being here.

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Title: Issues Affecting Rural Communities (II)

Author: J.C. Montgomery & A.D. ~~Kitchenham~~ Kitchenham (eds.)

Corporate Source: Malaspina University - College

Publication Date: JUNE, 2001

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Malaspina University College

Address: 900 Fifth St
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Quantity price: $37.00 / 100 copies.

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