

Review & Commentary on Health Policy Issues from a Rural Perspective - October 1<sup>st</sup>, 2000

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The Health Care Dilemma For Politicians

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From "Swallow Hard, What if There Is No Cure for Health Care's Ills?" by David E. Rosenbaum in *The New York Times*, 9/10/00:

"In an era of unrivaled prosperity, when Americans express complete confidence in their ability to handle most economic concerns, the authorities and the public have begun to doubt whether costs for the best medical care can ever be contained, or whether a practical way exists to provide insurance for all citizens."

"In the last year, health costs have risen much faster than the overall rate of inflation or workers' wages. And the only main economic indicator that has actually worsened during the Clinton years is the number of Americans without medical insurance. A study last spring by the Henry J. Kaiser Family Foundation shows that 44 million people, or 18.4 percent of the population, had no insurance in 1998, the last year for which figures were available, up from 38 million people, or 17.5 percent, in 1992."

"The case seems to be that what is economically rational is politically unacceptable. And what is politically possible does not fit with economic realities. People demand the finest doctors, state-of-the-art technology and expensive drugs, no strings attached. But neither they nor their political representatives are willing to pay the price this would entail."

"For a time it was thought that health maintenance organizations were the silver bullet. But the public re-

belled against the restrictions they imposed. And once premiums began to rise, companies began dropping them."

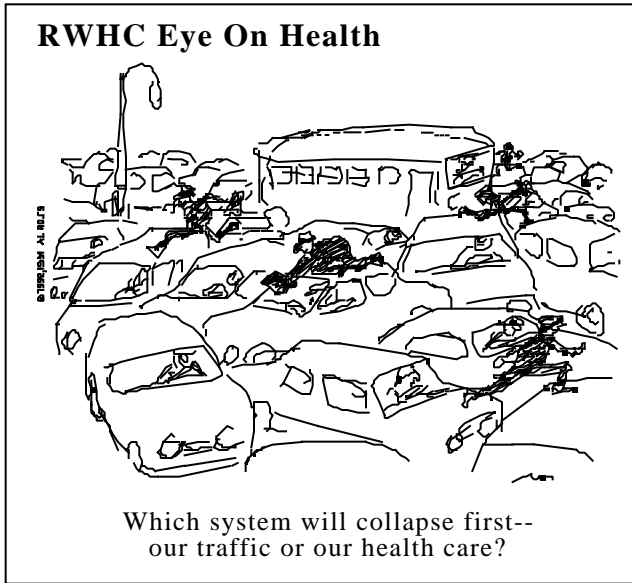
"The political turning point, of course, was the collapse of the mammoth health plan President Clinton offered in 1994. The plan, grounded in large part on H.M.O.'s, was too complicated and ambitious, and fell victim to opposition from the insurance industry and Republicans. It was the worst legislative defeat of the Clinton presidency, and it contributed to the Democrats' loss of Congress in the 1994 elections."

"Mr. Gore is obviously gun-shy from that defeat. The book-length manifesto he put out with his policy speech in Cleveland addresses his health proposals in passing on Page 118--including an ambitious and expensive promise to guarantee all children health insurance by 2005. But this was not one of the vice president's top 10 goals -- like encouraging home-ownership or expanding access to college."

"Gov. George W. Bush of Texas would just as soon skip the issue of health care and avoid further scrutiny of the record in Texas. Thirty-seven percent of low-income

children there are uninsured (only Arizona does worse), and a federal judge ruled last month that the state had failed to abide by a 1996 court order to provide appropriate health care for more than 1.5 million children eligible for Medicaid."

"Public opinion on health policy has clearly changed, as well. 'In the last eight years,' said Robert J. Blendon, an authority at Harvard on health and public opinion, 'people got scared away from big solutions.' "



"A decade ago health maintenance organizations (H.M.O.'s) seemed to offer a solution to the health care dilemma. Companies would pay a flat fee per employee; workers could see only the doctors in their particular plan; and primary-care physicians decided what treatment was permitted. In turn, they were rewarded for holding down costs."

"H.M.O.'s seemed to work for a time. The rise in health costs slowed. But the public began to complain about all the rules limiting the services they could receive -- about the rationing. Eventually, those complaints grew so widespread that politicians began debating what they called a patients' bill of rights."

"Then the costs began to rise again. The Kaiser Foundation reported that between the spring of 1999 and the spring of 2000, monthly premiums for employer-sponsored health insurance rose by 8.3 percent, a full 5 percentage points more than the overall national inflation rate and 4 points more than the rise in workers' earnings."

"Now, in increasing numbers, companies are abandoning H.M.O.'s for preferred provider organizations -- doctor networks that agree to reduced rates for their services. They don't have the expensive approval-referral bureaucracy of H.M.O.'s, and they offer a wider range of doctors and relaxed rules about the availability of treatments."

"A major problem with controlling health care costs is that conventional economic principles do not fully apply. Employers want to keep the cost of insurance down. Doctors and hospitals will not perform services at a loss. Drug and insurance companies want the largest profits possible for their shareholders. The less money people pay out of pocket, the more expensive treatments they demand."

"But market forces do not apply to other aspects. Because most bills are picked up by insurance, people pay little attention to the cost of treatment, and they have no way to assess the quality of medical services they receive. Beyond that, for most people, good health is priceless; they are willing to pay whatever it takes for themselves and their families."

**"So this is the conundrum for politicians. Their constituents will not accept the rationing of their medical treatment. People do not want to be told that good health has a price. On the other hand, neither the politicians nor their constituents want to pay the higher taxes or higher insurance premiums required for unlimited health care."**

"Some day this may be sorted out. But not in this election. The best guess is that matters will get worse sooner rather than later. With the tight job market, many employers are simply swallowing the cost of higher insurance premiums because they cannot risk losing workers. But when the economy turns the slightest bit sour, employers will surely force workers to pay more or even cancel insurance altogether."

"What this means politically is uncertain. But for now, the policy experts and politicians agree, if changes are made, they will be incremental. 'We are definitely in a transition period,' said Dr. David A. Kessler, dean of the Yale Medical School. 'But no one knows where we are headed.'"

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## The Political Dilemma for Providers

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From "Two Visions of Government" in *The New York Times*, 8/20/00:

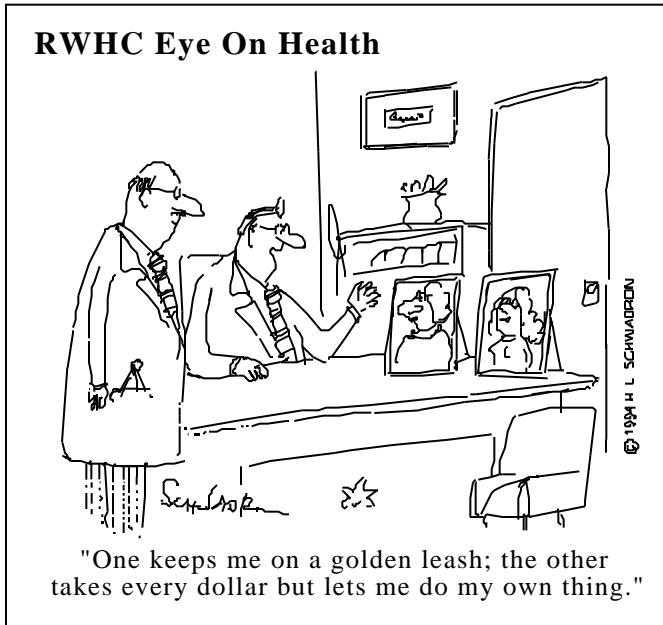
"The biggest difference, perhaps the defining difference, (*between George Bush & Al Gore*) lies in how the two men would distribute the lion's share of a projected budget surplus of \$4.6 trillion over the next 10 years. Mr. Bush, warning that this money should not be hijacked by federal programs, would use about \$1.3 trillion to cut taxes, mainly for affluent families. Mr. Gore would cut taxes by \$500 billion, mostly subsidies of one sort or another for middle-income families."

**The Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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## RWHC Eye On Health



## Grass Roots Medicare Suits Continue

From a Press Release by the Minnesota Senior Federation, 7/27/00 (*the Wisconsin suit is still pending*):

“The Minnesota Senior Federation, Metro Region is appealing the recent US District court decision to dismiss the lawsuit against the United States of America and Secretary of Health and Human Services Donna E. Shalala, alleging discriminatory Medicare rates. The Board acted on the unanimous recommendations of the Medicare Justice Campaign’s Consumer Steering Committee and its Provider/Professional Advisory Board. The lawsuit, which was originally filed jointly by the Senior Federation and Minnesota Attorney General Mike Hatch, will be appealed solely by the Federation.”

“In Alsop’s order, the judge said the court’s decision ‘is not to be considered a judicial endorsement of a reimbursement system which even the defendants concede results in gross unequal treatment of senior citizens.’ Furthermore, he said, ‘it is to be hoped that those with ultimate authority to remedy this wrong -- indeed those who created it -- will promptly recognize the injustice they have created and enact legislation to correct it.’”

“ ‘Judge Alsop in dismissing the case said in his opinion, that though the Medicare reimbursement is unjust, it is not unconstitutional. With this appeal, our job is now to more forcefully and more effectively argue the constitutional issues advanced by the Senior Federation,’ said Barb Kaufman spokesperson for the Minnesota Senior Federation and its Medicare Justice Campaign. ‘Judge Alsop was obviously supportive of the Federation’s work towards changing the law now. Therefore, we are not only encouraged, we are energized, by his strong words to challenge Congress to promptly correct the injustices of Medicare.’ ”

*A Medicare Primer on Medicare Funding and Managed Care Issues* is now available. “The video is designed to provide background especially for consumer groups that want to become activists on Medicare Equity issues. The MJC also has a videotape from the Jim Lehrer PBS *News Hour* on the ‘Sun City Choice’ which examines the Medicare Equity issue as it impacts seniors in Sun City, Arizona.” For further information call the Medicare Justice Coalition hotline at 651-645-0261 or check Federation’s web site at [www.mnseniors.org](http://www.mnseniors.org).

“He would also use every penny of the surplus generated by Social Security, about \$2.5 trillion, to reduce the national debt. Mr. Bush would use the same money partly to reduce the debt and partly to finance a new system of personal retirement accounts. When all is said and done, Mr. Gore would have about \$1 trillion for new spending, Mr. Bush about \$300 billion.”

“These numbers imply important differences in philosophy. Perhaps oddly, they cast Mr. Gore as the conservative custodian of President Clinton’s policies of securing growth by chipping away at the burdensome national debt, and Mr. Bush as the risk-taker who would reverse course on tax policy and divert part of the Social Security payroll tax to private retirement accounts at a time when Social Security’s long-term solvency is still very much in doubt. They also reflect Mr. Gore’s stronger faith in the remedial powers of the federal government.”

“There are also important differences in emphasis when it comes to new spending. **Both would use about the same amount, \$100 billion, for education, Mr. Bush’s signature issue. Mr. Gore, however, would spend \$400 billion on health care, mainly to expand insurance coverage and underwrite a prescription drug program under Medicare, while Mr. Bush would spend only \$100 billion on health.**”

“And Mr. Gore would put as much into environmental programs -- at least \$125 billion -- as Mr. Bush would into all other programs combined, defense included. These figures must be treated with caution, since the projected surpluses are iffy. But they do give some indication of priorities.”

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## Sound Bites Mislead On Drug Coverage

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From "No Simple Answers to Rising Cost of Drugs for the Elderly" by Sheryl Gay Stolberg in *The New York Times*, 9/3/00:

"On the campaign stump, Vice President Al Gore pushes his plan for a Medicare prescription drug benefit as a humane effort to help older Americans who are being gouged by profit-hungry pharmaceutical manufacturers. In television commercials, Gov. George W. Bush's campaign characterizes the Gore plan as another example of bureaucracy run amok."

"With profits that rank consistently higher than other Fortune 500 companies and products that can cost tens of thousands of dollars a year, the drug industry has long been an easy target for politicians. Another has to do with economics: while prescription drugs account for only 9 percent of all health care spending, they are now the fastest-growing segment of the national health bill."

"The elderly bear a disproportionate burden: they account for 13 percent of the population but more than a third of all drug spending, and nearly one-third of them lack insurance coverage."

"Mr. Gore's plan to ease that burden is nearly identical to President Clinton's. Except for the poorest of the poor, the elderly would not have insurance covering the full cost of all their prescription drugs. Older Americans whose incomes are 135 percent of the poverty level or lower, about \$12,000 a year for an individual and \$14,000 for couples, would have all of their drug costs covered. Others would pay premiums on a sliding scale, and would be reimbursed for half the cost of their prescriptions up to \$5,000 a year. Once the \$5,000 cap has been met, beneficiaries would pay out of pocket, up to an additional \$1,500. After that, a catastrophic insurance provision would kick in, and the government would pay all additional drug bills."

"A central feature of the Gore plan is that it offers a uniform benefit; in each region, all Medicare beneficiaries would be covered by the same plan, administered by a single pharmacy benefits manager under contract with Medicare. That kind of government control worries the pharmaceutical industry. Mr. Gore's plan would effectively give Medicare vast purchasing power, enabling the government to extract deep discounts from drug makers. Medicare drug prices would then become public -- in the private sector, negotiated discounts are kept secret -- and private insurers would inevitably demand similar breaks."

"Like most Republicans, Mr. Bush favors letting the private sector handle prescription drug coverage, an approach that has drawn criticism because many private insurers say they will not offer drug benefits. The Bush campaign has characterized the Gore proposal as a 'one-size-fits-all plan' that would interfere with the authority of doctors, presumably by restricting the list of drugs covered by insurance."

"During his campaign, the vice president has relentlessly attacked the companies as price gougers. But the forces that are driving prescription drug spending are complicated. The increase, experts say, is not so much because manufacturers are raising prices on existing medicines but because patients are switching to newer medications that cost more. At the same time, more prescriptions are being written, because the population is aging and older people take more drugs."

"And there is another possible explanation: advertising. Steven Findlay of the National Institute for Healthcare Management Foundation, a nonprofit research group is studying television advertising of prescription medicines, which has flourished since the regulations were relaxed three years ago. 'The drugs that are the most heavily advertised to consumers are the ones that are driving the increase in spending.'"

"Are some people taking costly prescription drugs when cheaper, over-the-counter ones will do? If so, who? And how can they and their doctors be persuaded to use medicines more cost-effectively? 'The question of what is appropriate from a medical perspective is more acute than it ever was and that question is not addressed by either party's plan,' said John Golenski, executive director of RxHealth Value, a coalition of consumer, labor, business and insurance groups."

### RWHC Eye On Health



"Yea, you still don't have enough for the daily special with Gore or Bush's drug plan, but they feel better."

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## Capital Short For Electronic Med. Orders

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The momentum behind the diffusion of computerized drug order entry technology as a major patient safety issue is clearly accelerating. For rural hospitals the capital cost of acquisition and implementation are staggering, particularly during an era of declining financial margins. **Federal and state assistance will be necessary if this technology is to become commonly adopted in all hospitals** as recommended by the Institute for Safe Medication Practices. *Mark your calendar on November 16th for a statewide "Patient Safety Forum" in Madison, sponsored by the Wisconsin Patient Safety Work Group, of which RWHC is a member. The following item is from A Call to Action: Eliminate Handwritten Prescriptions Within 3 Years! Electronic Prescribing Can Reduce Medication Errors* from the Institute for Safe Medication Practices (ISMP), 4/00:

"Research demonstrates that injuries resulting from medication errors are not the fault of any individual healthcare professional, but rather represent the failure of a complex healthcare system. System failures can be analyzed and prevented, many through emerging information technology (I.T.) solutions."

"In the medication management system, errors can be introduced at multiple points. Numerous problems are related to the naming, labeling, and/or packaging of drugs or to inefficient distribution practices. Patients often contribute to errors by failing to comply with instructions. Many errors occur as prescriptions are written; these tend to be failures of communication and, in far too many cases, the underlying problem is clinicians' handwriting."

"Prescription writing is perhaps the most important paper transaction remaining in our increasingly digital society; it seems simplistic to note that electronic prescribing tools could minimize medication errors related to handwriting. Yet even though such devices are available for use in hospitals, ISMP estimates that less than 5% of U.S. physicians currently 'write'

### **New Federal WWW Source For County Health Profiles**

**[www.communityhealth.hrsa.gov](http://www.communityhealth.hrsa.gov)**

From the federal Health Resources and Services Administration (HRSA): "All 3,082 U.S. counties can now be accessed as a Web-based snapshot of each county's health status. Causes of deaths, infectious diseases, teen mothers, and a host of other indicators from existing national data sets can be found at this new Web site. The data covers the period from 1988 to 1998." (*Editors note: take seriously the caveat noted on the web site: "Please be advised that the estimates presented here rely on various data sources and methodologies which may not be appropriate for particular counties and/or purposes."*)

prescriptions electronically."

**"Cost Considerations** -- While it is beyond the scope of this document to consider cost in great depth, it is probably safe to say that clinicians can obtain electronic prescribing capability at what may be a surprisingly low cost of entry. Moreover, in ISMP's view, the cost of such technology is far outweighed by the benefits hand-held devices offer in preventing the tragic human toll and devastating financial costs associated with medication errors. Creative strategies are in development for helping providers and healthcare institutions deal with the cost issue."

"One successful model involves a relatively low monthly subscription fee for access to a broad range of electronic prescribing capabilities. This fee may well be offset entirely by other savings realized through use of the technology, such as reducing the number of callbacks from pharmacists and streamlining the dispensing process. Another model might be to have the use of electronic prescribing tools underwritten by a third-party stakeholder, such as a pharmacy or pharmaceutical manufacturer. These strategies are worth exploring if they lead to more prescribers embracing the technology without lessening their control of the prescribing process."

**"Technology: Promise, Not Panacea** -- Easy-to-use point-of-care systems, some that offer comprehensive applications in real time, are becoming available from a number of manufacturers-and at perhaps a surprisingly low cost of entry. Such integrated programs may provide benefits for cost and risk management as well as for clinical care, and they may enhance the prescribing process beyond addressing penmanship alone. For example, hand-held devices can alert practitioners to potential drug or allergy interactions via up-to-date databases of medications that are connected with patient records. That kind of functionality should help to rapidly expand adoption of electronic prescribing among practitioners."

"Of course, computerized medication management systems certainly are not a panacea. Moreover, clinicians' use of hand-held technology will not solve the broad spec-

trum of medication errors, for technology is but one part of a larger solution that includes such simple and low-tech strategies as separating look-alike medications in a dispensing cabinet.”

**“A Call to Action** -- Still, while technology does not offer a perfect solution, ISMP does believe that technology, if appropriately and aggressively used, holds great promise for researching, identifying, reporting, and reducing medication errors. In particular, ISMP believes that electronic prescribing -- with proper systems design, implementation, and maintenance -- can contribute significantly to the prevention of medication errors today. There is no reason to wait for legislative activity or task forces to insist that this capability be utilized as fully as possible.”

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## Targeted Relief – The Health Services Corp

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From an Editorial, “Fund The Health Services Corp” in the *Washington Post*, 8/9/00:

“Medical students can apply for scholarships in exchange for service after graduation. Or medical school graduates can get grants to help pay off student loans in return for a promise of two years’ service. The program now supports nearly 2,500 doctors and other care givers in communities around the country.”

“A small but clearly effective and relatively inexpensive health care program has been allowed by the Clinton administration and Congress to languish, and the neglect in the form of insufficient funding has begun to take a toll. The National Health Service Corps subsidizes doctors and other health professionals who agree to practice in urban and rural areas that lack sufficient health care providers.”

“That’s good as far as it goes, but many communities remain inadequately served. Yet for years both the scholarship and loan repayment programs have had to turn away applicants for lack of funds. Last year the loan repayment program could fund only half its requests. This year administrators decided to take applicants from the neediest areas first, including some left over from last year. The effect was to shut out some communities and clinics that had been accustomed to using the program to recruit doctors in the past.”

“But the rules’ changes were poorly communicated and caught some doctors and clinics by surprise. *The New York Times* reported that some doctors had taken

jobs counting on the repayment grants, then been left stranded.”

“Funding for the programs has been flat, meaning that in real terms it has declined. Administration officials haven’t asked for an increase, nor has Congress provided one. Department of Health and Human Services officials note that the budget has been tight, and that this is only one of a number of worthy health care programs competing for available funds.”

“But if the president wanted the funding increased, the money would be found. If the vice president or HHS Secretary Donna Shalala or any number of leading figures in Congress were to make an issue of it, the money would likely be quickly found as well.”

“There’s time enough remaining to come up with the money; it’s not a complicated thing to do. Associations of rural and urban health care centers, which employ doctors under this program, are lobbying for a doubling of the loan repayment budget as part of a reauthorization pending in the Senate. That would help reduce the waiting list of doctors and others who have applied to the program and been denied, though it won’t be a patch on the real need.”

“Charlotte Hardt, president of the National Rural Health Association, said she has watched over the years as the dollars have stretched thinner and competition for the doctors has increased. In seeking support for an expansion of the program, ‘we haven’t found a champion,’ she said. ‘Where are the people, in both parties, who are always making those flowery speeches about the need to increase access to care?’ ”

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## Cooperatives -- A Proud Wisconsin Tradition

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October is Cooperative Month; a current update and a bit of history from the Wisconsin Federation of Cooperatives:

“In Wisconsin, 2.9 million citizens depend on approximately 1,000 co-ops to market and supply agricultural products, as well as to provide credit, electricity, telephone service, health care, housing, insurance, and many other products and services. Cooperative businesses employ approximately 20,000 Wisconsin residents and pay millions of dollars in taxes each year.

- Wisconsin was one of the first states to enact a law authorizing cooperatives in 1887.

- Anne Pickett started the first dairy cooperative in the state in 1841, pooling milk from neighborhood farms, processing it into cheese and shipping it to Milwaukee for sale.
- The first Wisconsin rural electric cooperatives were formed in 1936 in Richland Center and Columbus. (Both longstanding RWHC members.)
- Wisconsin's earliest town mutual associations were organized in February 1860—one in Manitowoc County and one in Kenosha County.
- The Cochrane Cooperative Telephone Company, incorporated in 1905, was among the first telephone companies in the state.
- Cooperative livestock marketing had its beginnings in Wisconsin during the 1920s, when local livestock shipping associations organized at rail points to ship livestock to a terminal market. With transportation and livestock processing improvements, cooperative auction markets were organized in 1957.
- The first grain farmer cooperative and elevator was started in Madison in 1857. It was called the Dane County Farmers' Protective Union."

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## Rural Immunizations In The Tropics

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A periodic *Eye On Health* feature are excerpts of letters from Dr. Linnea Smith from the Yanamono Medical Clinic in the remote Amazon basin of northeastern Peru. The clinic operates with grass roots support from family and friends and many others. AMP is a non-profit, tax-exempt organization. Donations are welcomed c/o: Amazon Medical Project, Inc., 7600 Terrace Avenue, Suite 203, Middleton, Wisconsin 53562.

"End of July, 2000--I had told you last time around that the clinic was busy. July, however, has made June look quiet. How come? -- well, it's been quite a variety. A man in his late 20's, who had been bitten through the heavy rubber boot he was wearing. He had so much swelling in his leg that I hauled out the mercury tube blood pressure thing and connected tubing to needles in order to push a long needle into the depths of his leg to try to measure the pressure there."

"Sometimes when there is major swelling in the leg, the pressure inside becomes so severe that the nerve which lifts the foot is squished, and if the pressure is not relieved (by slicing the entire leg open), the patient

remains with a limp for life. I had seen that happen with a boy a few years ago. This time, though, the pressure looked ok, and the patient was still wiggling all his toes when he left a day or two after the bite and receiving antivenin."

"I also have had the opportunity, for the first time in my life, to see whooping cough. Around here, parents frequently say their child has whooping cough, whenever the kid is coughing too much or for too long -- whatever too much or too long is. For years, I have assured parents that no, it was not whooping cough. It was bronchitis or pneumonia, but it was not whooping cough. That has changed."

"One day when the waiting room was full, I heard a small child coughing so strenuously that it seemed she would burst, and when she finally finished she ended up with a wailing, sucking-in whoop that sounded as though she had a golf ball lodged in her throat and was trying to breathe past it. I rushed out to the waiting room and dragged her in to be examined, and got the history from her parents that she and her sister were both that way, and had been so for several weeks. She looked ill but not terribly so, and I finally concluded that this must be the real article."

"Later, in Iquitos, I spoke with the epidemiologists and they said that yes, they had confirmed several cases of genuine whooping cough. The nine-month-old that I first saw, and her three-year-old sister, both recovered (though for a few weeks I thought the younger one was a goner). The illness lasts for weeks or even months, however, and it does sometimes kill children, and once you have it there is not much that can be done as far as treatment. The only thing to do is avoid it in the first place."

"Thus, the vaccine program has decided to re-vaccinate all children up to the age of five. Vaccines are very sensitive to heat, and must be maintained at strictly cold temperatures, ALWAYS. The problem is that, for instance, the vaccines may have sat in a railroad car on a siding in India for three days after leaving the factory; or they may have languished in the air-conditioned (but not refrigerated)."

"Customs office in Lima or Iquitos before being relinquished to the health authorities here; or perhaps, in the course of a long day in an open boat, being kept in a simple cooler with a little ice, the vaccines have warmed up before being administered to the last patients of the day. There is no way, in the field, to test them for potency. One discovers that there was a break in the 'cold chain' at the point when there is an outbreak of whooping cough among children who have supposedly been vaccinated."

“But the really exciting day was Vaccine Day. Since the vials of vaccines contain, usually, ten doses, and since all the doses must be used within hours to a couple of days, it makes no sense to open a vial for one person. Thus, we try to get everyone to show up for vaccines at the same time. Given the whooping cough outbreak, and the program’s desire to re-vaccinate all children up to age five with the DPT vaccine (the P is for Pertussis, which is whooping cough), and also the additional decision to re-vaccinate all children up to age fifteen for polio and measles, we had told many, many mothers to bring their children.”

“Since we were short-handed, I expected a busy day. When it dawned cold and overcast, due to the arrival of one of our periodic San Juan winds, I wondered whether this would affect the turnout. If it reduced the turnout, it was a blessing. The previous maximum number of patients we have treated in one day was 30-something. On Thursday, we ended up tending to 53. Of course, vaccines are a fairly simple thing to do, and after a while we quit trying to weigh the children or do any other evaluation. If they didn’t obviously have a fever, we stuck them and sent them off.”

“The clinic, naturally, was filled with shrieks and screams and the sounds of children crying, which made it all even more fun. Most of the kids screamed more loudly before the shots than after, however, which

made me a real believer in the medical value of candy. We happened to have some on hand, and it was amazing how a shrieking, just-vaccinated child would almost immediately cease crying, and his/her face would take on this look of dazed wonder, as a little sugar started melting in their mouths. I’ll worry about the tooth decay later; I’m going to be sure we always have candy around on vaccine days.”

“For the benefit of the several new names on the mailing list, let me explain how these letters came about ... when I first came here in 1990, it seemed important to maintain contact with friends and family at home. At first, I wrote to everybody individually. Then I realized that I was telling the same story over and over, so I got smart and wrote it once (by hand, then), and Mother copied the letters and mailed them. Then, people began making donations to help the clinic, so they got put onto the list, too, and the list grew.”

“Eventually, I got a typewriter, to the relief of those who found my handwriting too small to read easily. Finally, we got me a laptop computer, despite a few clashes with the rigors of living in the jungle (computers are not as a rule fond of rainforest-style humidity and warmth), so now they are even more legible and some of you even get them by e-mail.”

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