

Review & Commentary on Health Policy Issues from a Rural Perspective - April 1st, 1999

Medicare Reform Is About More Than Bucks

From "Geriatrics, Prevention, and the Remodeling of Medicare" by John W. Rowe, M.D., Sinai NYU Medical Center and Health System New York, NY in *The New England Journal of Medicine*, 3/4/99:

"Geriatric medicine has focused primarily on the management of acute and chronic diseases in frail older persons, with much less emphasis on the promotion of health and the prevention of disease than there is in health care for children or middle-aged adults. A growing body of knowledge about disease prevention in later life provides a valid basis for strengthening efforts in preventive geriatrics. Given its mission and responsibility, the Medicare program is well positioned to lead such an effort on a national level."

"Neglect of health promotion late in life seems based on two myths. The first myth is that the increased risk of disease in older persons reflects 'normal' aging, which is seen as an inevitable, intrinsic process that is largely genetically determined. The second myth is that the aged body has little plasticity and cannot respond to lifestyle changes. Both myths have been disproved."

"We now know that risk factors for coronary heart disease and stroke are neither immutable nor largely determined by genetic makeup. Substantial and growing evidence indicates that such established risk factors represent usual rather than 'normal' aging and can be modified through lifestyle interventions, including diet and exercise. A healthier lifestyle adopted late in life can increase active life expectancy, decrease disability, and reduce health care costs."

"Combining exercise and dietary is an important risk factor for coronary heart disease, and smoking-cessation programs might further increase the benefit. Although many questions remain regarding the details of implementation, the time has come for greater emphasis on comprehensive behavioral and medical programs aimed at promoting health and preventing disease among older Americans."

"In its new strategic plan, the Health Care Financing Administration (HCFA), which oversees the Medicare program, lists as the first of its goals 'to protect and improve beneficiary health and satisfaction.' Despite this, Medicare is currently not a health program but rather a health care insurance program. Medicare's primary-prevention initiatives are limited to vaccination against influenza, hepatitis B, and pneumococcal infection. Other preventive services focus on early detection and include screening mammography, screening for colorectal cancer, Pap smears, and measurement of bone density. HCFA recognizes that even these minimal preventive measures are underused and is studying ways to enhance their prevention initiatives."

"Current congressional efforts to 'reform' Medicare focus primarily on ensuring its continued fiscal stability. The chief new health care service being considered is coverage for outpatient prescription drugs. True reform would balance Medicare benefits by combining prudent purchase of health care services with robust, comprehensive initiatives to promote health and prevent disease. Such an effort, launched in conjunction with a re-

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"If you ask me, this illness prevention stuff can be taken too far."

view of the current benefits package, would improve Medicare's finances, since health care expenses are related to health status and since reductions in risk factors are associated with reduced expenses."

"A broad Medicare-supported prevention program might include payment for exercise, nutrition, and smoking-cessation programs, perhaps offered in senior centers, when these interventions are ordered by a physician for Medicare beneficiaries at documented high risk for disease. As a direct financial incentive, Medicare Part B premiums could be reduced for persons enrolled in health-promotion and disease-prevention programs and for those with low risk profiles, such as nonsmokers. Medicare might also establish requirements for preventive health services in its own managed-care programs. Evaluation of the feasibility and cost effectiveness of such efforts should be a high priority for Congress and HCFA, which must work closely with other federal agencies such as the Agency for Health Care Policy and Research and the National Institute on Aging and with professional organizations and foundations committed to improving the health status of older persons."

"Although HCFA's current Healthy Aging Project is a first step in this direction, the initiative must be enhanced and its implementation made a central component of HCFA's strategic plan. Reorientation of the Medicare program toward the promotion of health and the prevention of disease would encourage healthier aging, would be true to Medicare's mission and goals, and could in the long run enhance Medicare's financial stability."

If You Missed It, Medicare Commission Failed

From "Panel on Medicare Disbands After Clinton Denunciation" by Robert Pair in *The New York Times*, 3/17/99:

"A federal advisory commission searching for ways to preserve Medicare disbanded Tuesday night in disagreement, just three hours after President Clinton denounced its work and said he would devise a proposal of his own as an alternative. The commission ended its work without endorsing any recommendations to avert a financial crisis in the program, which provides health insurance for 39 million Americans who are elderly or disabled."

"Congress created the commission in 1997, expecting that it would propose the difficult and perhaps politically unpopular choices needed to insure the program's solvency. Medicare will almost certainly become an issue in the next presidential campaign. Democrats can portray themselves as defenders of Medicare, offering new coverage for prescription drugs, while Republicans will criticize Clinton and other Democrats as thwarting

efforts to stave off the insolvency of the Medicare trust fund."

Clinton's Proposed Medicare Cuts Still Loom

As things heat up in WDC around Medicare and additional cuts are proposed, it is critical that rural communities and providers communicate with Congress and emphasize the rural perspective. The National Rural Health Association (NRHA) has written an excellent letter to the House Budget Committee that makes the argument against cuts *using a rural spin* that I believe bears repeatedly more than once:

1. "NRHA strongly opposes the following reductions and reforms contained in the President's proposed fiscal year 2000 budget: an across-the-board freeze to the Medicare hospital inpatient PPS update, reduction of Medicare bad debt payments to all hospitals by 10 percent and the establishment of new taxes or 'user fees' on rural health care providers."
2. "Any change or extension of payment reductions must, at a minimum, include a rural differential that accounts for different impacts on providers as a function of size and geographic location."
3. "According to the Medicare Payment Advisory Commission, for rural hospitals fewer than 50 beds the average 1997 Medicare hospital inpatient PPS margin was nearly 8 percent below that of the average urban hospitals."
4. "In fiscal year 1995, 15.9 percent of rural hospitals experienced negative total margins, as compared to 9.8 percent for urban hospitals."

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 furthers the development of a coordinated system of rural health care which provides both quality and efficient care in that best meet the needs of rural residents in a manner consistent with their community values.

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Hospitals: NRHA Has Earned Your Support

I strongly believe in rural hospitals and so does the National Rural Health Association.

The challenges that rural hospitals face to provide cost effective, high-quality health care can at times seem overwhelming, or at least they seem so to me. Inequitable Medicare reimbursements, physician and staff recruitment and the growing presence of managed care are just a few of the challenges that we manage daily.

As immediate past president of the National Rural Health Association (NRHA) and a long time board member, I have repeatedly seen first hand NRHA's absolutely critical accomplishments on our behalf as rural hospitals. NRHA can't do our job for us but they can go a long way to leveling the playing field.

What has National Rural Health Association done for me lately? Through its strong advocacy the NRHA makes a real difference for rural hospitals; recent examples:

- **Securing \$25 million to implement the critical access hospital program;**
- **Changing the hospital wage index to better reflect the unique variables in rural hospital services;**
- **Working with Congress and HCFA to reform Medicare payments for home health agencies; and**
- **Making the reinstated Medicare dependent hospital program even more favorable to rural hospitals**

Please consider a financial contribution, either personal or from your (hospital). I am not asking you to act out of charity but out of self interest (a little charity is OK). If more of us dig a little deeper, NRHA can further expand its role as an "in their face" advocate for rural health. I need this to happen and I believe you need that as well.

Working together, with reasonable resources and with an "attitude," we can make a difference.

If you are already a NRHA member you are helping a lot by paying dues but please consider a contribution toward the Annual Giving Program c/o NRHA, One West Armour Blvd, Suite 203, Kansas City, Mo 64111.

If you are not a member, please join us today. Learn about the features and benefits of NRHA membership or to find out more about other services and programs, visit the website at www.NRHArural.org or telephone (816) 756-3140.

National Focus On Our Economic Importance

From *Operation Rural Health Works: Project Briefing Report*, Vol.1 No.1, 3/12/99; the complete report is available at <www.rupri.org>:

The Economic Importance of the Health Care Sector

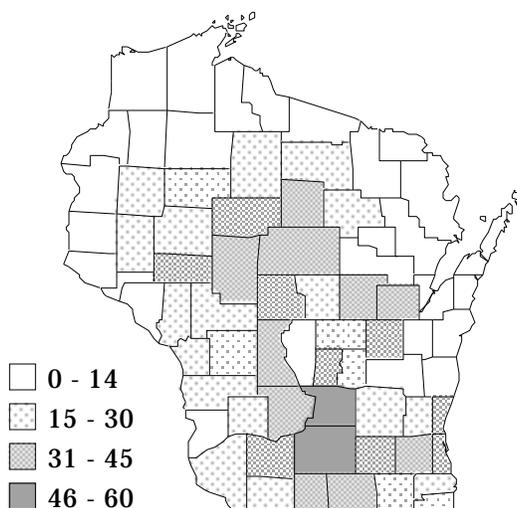
"The health care sector plays a vital role in the economy of rural communities, and should be an essential component of any economic or community development project. Many rural residents, including community leaders doing planning or business recruitment, often overlook this aspect of the community's economy, and this opportunity for future economic growth. The health care sector is an employer, a catalyst for industrial and business growth, and an inducement for retirement growth. As an employer, the health care sector is often the largest employer in rural communities."

"Research shows that the health sector provides 10 to 15 percent of the jobs in many rural counties, and that if the secondary benefits of those jobs are included, the health care sector accounts for 15 to 20 percent of all jobs. On an individual employer basis, hospitals are often second only to school systems as the largest employer in rural counties. Studies on industrial and business location also conclude that schools and health services are the most important quality-of-life variables in these decisions."

Five-State Study Planned

"Recognizing the magnitude of this impact, representatives from five states met in June, 1998 to initiate a pilot project that will expand public awareness of the

Managed Care Continues Growth In Rural Wisconsin Counties



Percent of Population in HMOs (Closed Panel Plans) and Point of Service Plans as of 1/1/98

Data: WI OCI 3/99
Graph: RWHC 3/99

economic impact of the health care sector and highlight its importance and natural tie to rural development. This initiative, called Operation Rural Health Works, will be tested in five states: Kentucky, Missouri, Nevada, Oklahoma and Pennsylvania.”

“Sponsored by the Rural Policy Research Institute, the federal Office of Rural Health Policy, and the U.S. Department of Agriculture's Cooperative State Research, Education, and Extension Service, the initiative will develop a template for estimating the economic impact of the health sector on each county in the five-state demonstration area. The project also will develop educational and public awareness materials to help explain and publicize the results. Targeted to local, state, and national decision makers, the information will clearly indicate the importance of a quality health care sector in maintaining viable, strong rural communities, and, therefore, the need for community leaders to be proactive in planning health care services.”

Why Does This Matter?

“The delivery of health services in rural counties is changing rapidly, and has the potential to greatly impact the availability of health care services in the future. These changes, positive and negative, include:

1. “the movement to managed care that may cause (or require) patients to bypass local health care services;
2. reductions in Medicare and Medicaid payments to hospitals and providers that may force a reduction in the provision of primary care services;
3. the creation of provider networks that may substantially change the delivery of and access to local health care services;
4. the use of telemedicine that could increase access to primary, consultative and specialty care services at the county level; and
5. the development of critical access hospitals that could help health care services remain available in rural counties.”

“Based on these changes, it is imperative that local decision-makers become pro-active in maintaining and revitalizing their local health care services.”

Project Purpose

“The purpose of Operation Rural Health Works is to expand public awareness of the importance of the economic impact of the health care sector and stress its critical role in rural development. Armed with this knowledge, it is anticipated that local decision-makers will then become proactive and involved in planning and supporting their local health system. This project will provide information to support strong, visionary

leadership in rural communities, resulting in healthier rural communities and economies.”

For more information please call: National Rural Health Resource Center, (218) 720-0700

Domestic Violence In Our Back Yard

From “Domestic Violence Is a Rural Health Issue” in *Rural Health News*, Winter, 1999:

“In spite of a lack of resources and isolation, many rural communities are dealing with domestic violence with the help of their health care providers--an approach that victims prefer and providers are learning.”

“When asked about preferred confidants, victims of domestic violence, both urban and rural, overwhelmingly choose physicians-not clergy or police. But studies reported in the *Journal of the American Medical Association* have shown that although almost 90 percent would like to speak to their doctors, less than 10 percent of physicians take the time to ask them questions about violence in their lives.”

“ ‘We think all physicians should screen for violence as part of a routine physical,’ says Maine physician Dr. Robert McAfee, who helped launch the American Medical Association's Campaign Against Family Violence in 1993. ‘Not screening because you're in a rural area with few resources is a cop-out.’ ”

“Several states and communities have experimented with different approaches to engage rural health care providers in the battle against domestic violence. Whether the program starts in a rural health facility or as a state program, initiated by the state's Attorney General's office or by farm worker women in California, the dual theme running through all of these approaches is: ongoing staff training for rural providers and community collaboration to expand resources for referral.”

“Getting local health care providers involved is a key because they are in the front lines, according to several domestic violence experts.”

“ ‘One of the most common reasons for females aged 15-45 to go to the Emergency Room is domestic violence,’ says Dr. John Nelson, obstetrician/gynecologist in Salt Lake City and spokesman for the AMA's National Coalition of Physicians Against Family Violence. ‘As physicians, we miss the diagnosis of family violence 85 percent of the time,’ he says. ‘If I can ask a patient questions about the most intimate details of her sex life, I can certainly make clear that she can talk to me about family violence. Rural is not an excuse for doing nothing.’ ”

“But health care providers often hesitate to ask these questions because they lack training and information, and they fear the amount of time it may take to respond, says Gwen Wright, director of the Health and Human Services Bureau in New York State's Office for Prevention of Domestic Violence.”

“‘One advantage rural providers may have, however, is familiarity with their patients,’ says Wright. ‘Unlike urban physicians who often rotate in clinics, rural providers know their patients well, and the patients are familiar with and rely on them. These kinds of relationships can lead to useful interventions.’”

Creative Organizations Just Don't Happen

From “Building Ambidextrous Organizations: Forming Your Own ‘Skunk-Works’ Organizations” by Michael L. Tushman and Charles A. O'Reilly, III in the Health Forum Journal, 4/99:

“Organizations can sustain their competitive advantage by operating in multiple modes simultaneously--managing for short-term efficiency by emphasizing stability and control, and for long-term innovation by taking risks and learning by doing.”

“Different kinds of innovation require different kinds of organizational hardware--structures, systems and rewards--and different kinds of software--human resources, networks and culture.”

“During periods of incremental change, organizations require units with relatively formalized roles and responsibilities, centralized procedures, functional structures, efficiency-oriented cultures, highly engineered work processes, strong manufacturing and sales capabilities and relatively homogeneous, older and experienced human resources.”

“These efficiency-oriented units have relatively short time frames and are often relatively large and old with highly ingrained, taken-for-granted assumptions and knowledge systems. They are characterized by a high degree of inertia, and often have glorious histories. Their cultures emphasize efficiency, teamwork and continuous improvement.”

“In dramatic contrast, during periods of ferment--times that can generate architectural or discontinuous innovation--organizations require entrepreneurial ‘skunk-works’ types of units. These units are relatively small, have loose decentralized product structures, experimental cultures, loose work processes, strong entrepreneurial and technical competencies and relatively young and heterogeneous employees.”

“Entrepreneurial units build new experience bases and knowledge systems; they generate the experiments, the

failures, the variation from which the senior team can make bets on possible dominant designs and or technological discontinuities. In contrast to the larger, more mature units, these small entrepreneurial units are inefficient, rarely profitable and have no established histories. They often deliberately violate the norms valued in older arts of the organization.”

“When faced with a new technology, ‘skunk-work’ companies typically establish teams of relatively young staff headed by an esteemed elder statesman and charge them with developing breakthrough products. To ensure that they are not hampered by the existing organization, the teams are moved into isolated quarters, well separated from the main firm. The group members are exhorted to violate the culture of the larger organization and do whatever it takes to develop the new product.”

“In building ambidextrous organizations, management teams provide the drive for incremental innovation even as they challenge other parts of the organization to recreate the future. Ambidextrous organizations build in contradictions as they operate both for today and tomorrow. But the certainty of today's incremental innovation can often destroy the potential of tomorrow's architectural or discontinuous innovation.”

“The contradictions inherent in the multiple types of innovation create conflict and dissent among the organizational units--between those historically profitable, large, efficient, older cash-generating units and the young, entrepreneurial, risky, cash-absorbing units. Because the power, resources and traditions tend to be anchored in the more traditional units, these units usually try to ignore, trample or otherwise kill the entrepreneurial units.”

How to Integrate Opposites

“If the diverse capabilities of ambidextrous organizations can be harnessed, they permit the organization to lead streams of innovation. Unless these capabilities are integrated, however, the potential of ambidextrous organizations is lost, the challenge for managers and their teams, then, is to create coexisting, highly differentiated and highly integrated organizations. Differentiating units is easy; achieving integration is not.”

“Three tools can help senior leadership teams achieve integration: (1) Articulate a clear emotionally engaging and consistent vision, (2) build a senior team with diverse competencies and (3) develop healthy team processes.”

“The need for creativity must be balanced with the need for execution. Senior teams must be intellectually fresh, able to balance old and new perspectives, and not get caught up on a single viewpoint. Those that cannot resolve conflict or do not collaborate create highly unstable, politically chaotic organizations, which squander the potential of ambidextrous organizations.”

“In managing streams of innovation, senior teams are like jugglers, keeping several balls in the air at once--articulating a single, clear vision while simultaneously hosting multiple organization architectures without sounding confused or, worse, hypocritical. Most management teams can do one thing well, but keeping a multitude going at once requires greater skill.”

A RWHC Service Passes Major Hurdle

The RWHC Credentialing Service has received certification for 10 out of 10 verification services by the National Committee for Quality Assurance (NCQA). The National Committee for Quality Assurance is an independent, non-profit organization that certifies credentials verification organizations, and accredits managed care organizations. As of February 12, 1999, approximately 47 other organizations in the country have received such certification.

The NCQA certification process includes a rigorous on-site evaluation conducted by a team of health care professionals and certified credentialing specialists. A national oversight committee of physicians analyzes the team's findings and determines certifications based on RWHC's compliance with NCQA standards.

As a result of being fully certified by NCQA for 10 out of 10 verification services, managed care organizations that contract with RWHC for credentials verification services are not required to maintain documented oversight of the ten verification practices listed above. Using the RWHC service saves clients considerable time and resources, while assuring verification of credentials in compliance with NCQA standards.

The Rural Wisconsin Health Cooperative has been providing credentialing services to physicians, hospitals, clinics and health plans since 1991. RWHC provides primary source verifications for physicians, dentists, podiatrists as well as other licensed independent practitioners. The certification covers both managed care organizations (MCO) and managed behavioral healthcare organizations (MBHO) practitioners, and is current until February 4, 2001. Contact: Bonnie Laffey, at 608-643-2343 or blaffey@rwhc.com

Test Your Rural Health IQ

What Do You Know About Rural Health? Questions for our new on-line quiz <www.rwhc.com> are taken from 1998 issues of RWHC's newsletter, *Eye On Health*. Only you will know your "true rural health IQ;" confidentiality assured.

RWHC Forming Speakers Bureau

RWHC and its member organizations understand that to survive and prosper in our ever changing and demanding environment we must be learning organizations. While traditional conferences play an important role, particularly in terms of networking and being able to hear from a number of different speakers within a day or two, logistical barriers for board and staff tend to limit participation.

An additional approach that is being increasingly utilized is to bring the speaker to the audience as part of a regularly scheduled board or staff meeting. To facilitate these activities, we have decided to organize our prior system of informal suggestions into an organized Speakers Bureau.

If you are interested in being listed in our speaker's bureau, please send Monica Seiler at RWHC the following information:

1. Your name and contact information?
2. Topics you are interested in addressing?
3. Range of preferred audience size?
4. Range of presentation/discussion duration?
5. Range of speaker fees, if any.
6. Expectations regarding expense reimbursement.

Please feel free to let us know of any other suggestions or resources relevant to this initiative.

New Mega-Health Site On Web

From "General Health" in *Business 2.0*, 3/99:

“Dr. C. Everett Koop isn't just a living legend. He's a living brand. As U.S. Surgeon General during the Reagan era, he went head-to-head with tobacco giants. He was among the first public health officials to declare the benefits of condoms in preventing AIDS. Today, the 82-year old maverick is turning to the Internet to spread his message. Through his Website [www.drkoop.com] Koop hopes to help Americans take charge of their health in an age of managed care. 'Most people my age think I'm crazy because I'm talking Internet talk,' says Koop. 'I believe that knowledge is empowering in the doctor-patient relationship and helps patients make decisions about diagnostic and therapeutic procedures.' ”

“And it's knowledge that consumers can access at drkoop.com, which launched last July and is expanding this spring. The site offers more than 50 online support groups, ecommerce space for drug-store items, including prescriptions and refills, and an area called Ask Dr. Nancy Snyderman where users can ask questions, get feedback, and find out about hot-button issues such as adverse drug reactions. In the next year, the site will offer patients a personalized medical record that belongs to them, in an age when medical records typically belong to insurance companies. Koop also hopes to sell insurance policies on the site.”

“Unlike the new cyber drug-stores that are struggling to create a trusted online presence, when people click on Koop, they know who they are getting. ‘My message to patients all my life has been: Take charge of your health,’ Koop says. ‘Now, with managed care, I add a caveat--if you don't, nobody else will.’”

“Ask Marilyn” Answers The “Unanswerable”

There are an increasing number of medical tests becoming available for individuals at risk for inheriting a serious disease. Many individuals in such a situation would like to know if they *do not* have a particular gene, but do not want to know if they *do* have it. While seemingly a dumb question, is there a way for a patient to know the results of a test if it is negative but not know if it is positive? Well, actually, the answer is yes according to “Ask Marilyn” in *Parade Magazine*, 2/7/99:

“This seems impossible at first because, if the woman doesn't learn the result, this means she has the fatal gene--which tells her what she doesn't want to know. But here's a way to go about it that provides the woman with as much information as she wants: She agrees to take the test with the stipulation that the outcome will only be told to her depending on the result of the flip of a coin, as follows.”

Tools For A Healthy Future

National Rural Health Association 22nd Annual Conference May 27-29th, 1999 San Diego, California

The nation's largest gathering of rural health professionals, featuring:

New shorter three day format

Awards dinner and dance to celebrate the achievements of our colleagues in rural health

Technology Learning laboratory

Roundtables--facilitated interaction/exchange

BECK WEATHERS, MD: Mt. Everest survivor
NANCY DICKEY, President, AMA
CLAUDE FOX, Administrator, HRSA

For more information call Carlos McClain at (816) 756-3140 or visit www.NRHA Rural.org

“The doctor keeps the woman's test result private, no matter what it is--positive (she has the fatal gene) or negative (she doesn't have it). Then he privately flips a coin marked “positive” on one side and “negative” on the other. If *both* results--the woman's test and the coin flip--are negative, she is told her test result.”

“However, if either result is positive (or both are positive), the woman is not told her test result. So, in this case, she won't know whether her test result was a positive or whether it was the coin flip that was “positive” instead. If she likes, she can ask the doctor to flip the coin another time.”

“With this procedure, she can accommodate her desire to know by asking the doctor to flip the coin (always privately) as many times as she likes. If her test results is negative, she will eventually

hear about it. If she wants to stop at three flips to avoid increasing discomfort, she can. And even if her test results positive, she will never know for sure.”

Learning Life's Last Competency

As baby boomers age, they continue having the benefit of their issues receiving a lot of attention, given the large audience/market they represent. No exception are the major life tasks related to terminal illness and death. We all will be seeing more stories intended to help this generation and all of us learn the necessary competencies related to carrying on, learning from and “letting go” of parents and friends. One of the most popular books on this topic is: *Tuesdays With Morrie: An Old Man, a Young Man, and Life's Greatest Lesson* by sports columnist Mitch Albom (He is also the Reader; tape version highly recommended as this is as much a play as a book). (Another book, just released to very strong reviews, is *Eligible For Iris* by John Bayley.) Following is a review of *Tuesdays With Morrie* from <www.amazon.com>:

“This true story about the love between a spiritual mentor and his pupil has soared to the bestseller list for many reasons. For starters: it reminds us of the af-

fection and gratitude that many of us still feel for the significant mentors of our past. It also plays out a fantasy many of us have entertained: what would it be like to look those people up again, tell them how much they meant to us, maybe even resume the mentorship? Plus, we meet Morrie Schwartz--a one of a kind professor, whom the author describes as looking like a cross between a biblical prophet and Christmas elf. And finally we are privy to intimate moments of Morrie's final days as he lies dying from a terminal illness. Even on his deathbed, this twinkling-eyed mensch manages to teach us all about living robustly and fully."

Living Wills And Power Of Attorney On Web

You can now access from the State of Wisconsin's Department of Health and Family Services two important medical legal forms for patients (perhaps in partial exchange for what some state lawyers may get from the tobacco settlement). Forms are available, with instructions, to execute a Declaration to Physicians (Living Will) as well as a Power of Attorney. As always, you may want to consult your own lawyer to explore other options. You can get these documents from the web at < <http://www.dhfs.state.wi.us/consumerinfo/>>.

The Living Will form "makes it possible for adults in Wisconsin to state their preferences for life-sustaining procedures and feeding tubes in the event the person is in a terminal condition or persistent vegetative state."

"Before signing the Wisconsin Basic Power Of Attorney For Finances And Property, you should know these important facts. By signing this document, you are not giving up any powers or rights to control your finances and property yourself. In addition to your own powers and rights, you are giving another person, your agent, broad powers to handle your finances and property. This basic power of attorney for finances and property may give the person whom you designate (your 'agent') broad powers to handle your finances and property."

Title Creep

The following is from an item by Stephen Labaton in *The New York Times* 3/15/99:

"The Clinton Administration may have reinvented the Federal work force by cutting nearly 400,000 lower level jobs, but it has also reinforced an already top-heavy bureaucracy with more layers of lavishly titled officials in the upper ranks of the Government, according to a new study."

"In fact, the study, by Paul Light of the Brookings Institution, concluded that the Administration has created as many new job titles among the Government's higher tiers in the last six years as the seven prior administrations."

"Some of the newer positions include Deputy to the Deputy Secretary, Principal Assistant Deputy Under Secretary and Associate Principal Deputy Assistant Secretary. Titles that have already spread like kudzu through the agencies since 1960 include Deputy Assistant Secretaries (484), Associate Assistant Secretaries (148), Assistant Assistant Secretaries (220) and Deputy Assistant Assistant Secretaries (82)."

Pagan Rurals Named The Days Of The Week

From *The Year 1000, What Life Was Like At The Turn Of The First Millennium, An Englishman's World* by Robert Lacey and Danny Danziger:

"The word pagan comes from *pagus*, Latin for 'the countryside,' and it was among the rustics that the old magic lived on. Rather than sacrifice to Mother Earth, Anglo-Saxons were encouraged to direct their prayers to the Virgin Mary, and having accepted Sunday and Moon-day, the church also tolerated Tiw's-day, Woden's-day; Thor's-day, and Frig's-day, the English days of the week that were named after the old Norse gods Tiw, the god of war, Woden, father of the gods, Thunor, the god of thunder, and Frig, the goddess of growing things and fertility. Saturn's day was another pagan hangover--from the Romans."

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and raise you five."**