Surgeon General's Conference on Agricultural Safety and Health
FarmSafe 2000 • A National Coalition for Local Action
Convened by the National Institute for Occupational Safety and Health
April 30 - May 3, 1991, Des Moines, Iowa

RURAL HEALTH POLICY

By Jeffrey Human, M.A.
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Has this not been a terrific conference so far? We have outstanding attendance. We have had one excellent speaker after another. The commitment to improve agricultural safety and health has also been striking in these presentations.

Groups like the National Coalition for Agricultural Safety and Health and the Farm Foundation have been working extra hours to form consensus on the national agenda we need to develop. This is a time of hope.

One of the most interesting things about several of the presentations so far was the emphasis on the movie *Field of Dreams*, and its use as a metaphor of hope. I asked a city dweller last evening what movies urbanites relate to these days. "Well," he said, "I'd include *Deathwish, Taxi, Mean Streets*, and *Escape from New York*." I think there is more hope in the country.

This morning's *Des Moines Register* ran a nice story on Dr. Novello's speech, which I thought was a high point of the meeting. What an anachronism to call her the "Surgeon General."

Her message makes it clear that she is both the "Pediatrician General" and the "Family Medicine General." And that is what we need in rural health. Yesterday, everybody had a different ranking for agriculture as a dangerous occupation. It was first, second, third, and fourth within an hour.

Chris Atchison, and this morning, Dr. Bill Halperin seemed to me to have the best idea. Let us set up and run farm health and safety surveillance systems in all states as they do in Iowa. Let us keep track of injuries and deaths and let us export this record-keeping to the other states, so we can keep track on a national basis and so that we can intervene for prevention. We also need to educate the nation's public on the nature and extent of the dangers of farm work to get the assistance we need.

It is very fitting that this meeting should be in Des Moines. It was in this city, in 1984, that the *Des Moines Register* won the Pulitzer Prize for a series of articles entitled "A Harvest of Harm." Those articles argued, persuasively, that agriculture has become our most dangerous occupation.

It was in Des Moines and Iowa City, in 1988, that Jim Merchant and Kelley Donham held a conference on agricultural health and safety; the conference led to the publication of *Agriculture at Risk: A Report to the Nation*, a report that has brought the issues we are talking about today to the nation and to the Congress.

The 1988 conference also led to the formation of the National Coalition for Agricultural Safety and Health—a coalition that is continuing to keep these issues in the forefront of national efforts to improve rural health; a coalition that has now integrated its work with the National Rural Health Association; a coalition whose work at

raising consciousness made this meeting possible.

Iowa's leaders have been very influential in other rural health endeavors. In the mid-1980's, the administrators of small rural hospitals detailed the problems they were experiencing to the Congress. Don Dunn and Art Spies (who is with us today) of the Iowa Hospital Association, were among the chief spokespersons of the movement.

The Iowa Congressional Delegation has been as united as any in the country in rural health advocacy. Senators Harkin and Grassley helped build a Senate Rural Health Caucus of 65 of the 100 members of the Senate, and they have delivered better-funded programs and new programs through the Senate Appropriations Committee, on which they serve. Former Iowa Congressman Tom Tauka was the first co-chairman of the House Rural Health Care Coalition, which now has 165 of the 435 members of the House, including all of Iowa's Congressmen.

There is one other Iowa leader we should speak of, but he is our next speaker. I will get to him soon.

I am supposed to say something about the Office of Rural Health Policy, which I direct. We act as a voice of the rural constituency in the Department of Health and Human Services and coordinate its rural activities. So I come to meetings like this as much to listen as to speak.

Our primary responsibility is policy, but we also run some programs. For example, this year we will be making around 38 grants to states to help them establish or enlarge state Offices of Rural Health. These offices work like our federal offices but at the state level.

I think they can be very effective in representing rural constituencies in the state capitals, in working with communities and their health providers to solve local problems, and in working with the farm community on health and safety issues.

This year, we will be making anywhere from 60 to 200 grants for local innovative health services programs or programs that support health professionals through education, telecommunications, or similar means. We expect several agricultural health and safety proposals.

We fund seven rural health research centers nationwide. All of them have some involvement in agricultural health and safety and one center—the Marshfield Medical Foundation—has agricultural health and safety as its principal emphasis.

We heard about one of their projects yesterday from Secretary Sullivan. It illustrates the practical applied research I ask for from each center.

When we looked at the tractor-rollover problem with Marshfield, we decided that there was no need for further research on the problem. What we decided we needed was a way to help farmers who wanted to retrofit older tractors with roll bars or other rollover protective devices to find those "ROPS," as they are called.

So we asked Marshfield to develop and publish a catalog of all American manufacturers of "ROPS," all products they produce and what make of tractor, model of tractor, and year of tractor they will build. Then Marshfield sent the catalog to all extension agents in the country, so it is available where it is needed.

Producing that catalog is not the best step we could take as a society. As we have seen in the slide on the Swedish experience, the best step we could take would be to require "ROPS." But as an Office, it was the best we could do.

We fund a national information center on rural health. It is a part of the U.S. Department of Agriculture and is within their National Agriculture Library. So if you want some rural health information, call 1-800-633-7701.

The nice thing is that you can also get agricultural information or rural economic development at this same number. Add $24.95 and postage, and we will include all the hits of *Boxcar Willie*. That is 1-800-633-7701. Offer is not valid in Mexico or Canada.

My own office is also a sort of information clearinghouse. In my presentations, I try to share ideas on the things that are happening in the states and communities and in Washington that affect rural health.

Thus, I talk around the country about the problems of rural health and about the potential solutions. For example, I tell state officials that they should train more nurses because we have a national rural nurse shortage. If they ask where to get the money, I suggest they cut back on training so many lawyers at taxpayer expense.

If we are short of nurses, we are short of essential health services for our people. If we grow short of lawyers, however, what are we short of? Essential lawsuits?

Certainly with a few less lawyers we might have fewer malpractice suits. Seriously, let us confront conventional approaches and make new choices with limited funds, choices that help solve rural health problems.

I tell people in other states about the package of programs offered to local subscribers by the University of Iowa's Institute of Agricultural Medicine and Agricultural Health. I do not have time to tell you the specifics today, but I will mention three features of the program, which is based on a Swedish model.

1. It is hospital based and contributes to the viability of rural hospitals. That is important because 10 percent of all of America's rural hospitals closed their doors during the 1980's.

2. The program includes continuing medical education for physicians. A 1979 survey showed that 70 percent of all medical schools offered no instruction in agricultural medicine. The other 30 percent offered an average of four hours of instruction during four years of medical school. The young physician new to an agricultural community may be baffled by pulmonary and cardiac conditions caused by agricultural dusts or chemicals. Ellen Widess' stories yesterday play out over and over again, and many times with worse endings when we do not prepare our physicians properly.

3. The program trains farm families to be responsible for their own health and safety. For example, they are shown how to make animal confinement houses safe for themselves and the animals. For more information, see Jim Merchant or Kelley Donham or David Pratt, who know more about these and other similar programs than I do.

I want to tell you about one last program. It is called "Stress Country Style," and it is in Illinois. A network of health workers throughout the state are available to help farm families. Farmers call an 800 number, and help comes to them. There is no stigma because the encounter is private at the farm. Counseling is offered. Referral to mental health or debt consolidation or one of 100 other programs is offered. Oklahoma and Iowa have similar programs.

> Seriously, let us confront conventional approaches and make new choices with limited funds, choices that help solve rural health problems.

We need more innovative stress reduction programs like these. In Ontario between 1979 and 1982, 95 of the 273 farm deaths were suicides, and the farm suicide rate has been documented to be high in this country as well. Mental health must be an important part of our national strategy.

Incidentally, we need to place a special emphasis on teenagers when we look at mental health in the farm community. A survey by the University of Minnesota's Extension Service and the Medical School indicated that 5 of every 100 rural adolescents surveyed has attempted suicide within the past month.

Nationally, the figure was 2 of 1,000. This was in the early 1980's during the height of the farm crisis, but other studies have shown pervasive high levels of depression among rural adolescents.

I should also mention that our office provides staffing for the National Advisory Committee on Rural Health. I have left some brochures about our office at the registration desk. If there are none left, call 1-800-633-7701, and they will have us send you one.□

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MEDICAL INTERVENTION PROBLEMS AND OPPORTUNITIES IN RURAL AREAS

By Governor Robert D. Ray
Chairman, National Advisory Committee on Rural Health Policy

Mr. Jeffrey Human: My last assigned task is to introduce our next speaker. My honest impression is that Bob Ray is a real enigma. This is a guy who was elected to five terms as Governor of Iowa, and then found a life after politics on his own. He did not lose an election—he quit. There was no scandal. He just left the political life. He wanted to try something new. This is almost unprecedented in American politics. Then Bob went out and got jobs on his own and made a mark. He ran a successful insurance company, and now he is president of Blue Cross and Blue Shield of Iowa, with a million subscribers. He is not some absentee figurehead president either. A top official of Blue Cross nationwide tells me he has personally turned the program around in this state. Secretary Sullivan told us yesterday that Bob Ray is one of his advisors. Well, he should be, because Bob is chairman of the National Advisory Committee on Rural Health. That committee has provided Secretary Sullivan and the Congress with a series of challenging recommendations on rural health that have led to changes. For example, the Outreach program I told you about is partially a result of a recommendation of the committee. There is a great revival of interest in national health reform. There are many competing proposals. One of the best and most influential, based on universal insurance coverage, is from the National Leadership Commission on Health Care. The Commission's members read like a *Who's Who* in American health policy. The chairman is, of course, Bob Ray. Bob Ray also was a U.S. Delegate to the United Nations and former chairman of the Indochinese Refugee Panel, providing leadership in efforts to resettle Vietnamese and Cambodian refugees. Bob is a graduate of Drake University's Law School, and he has a lot of honorary degrees and distinctions. Those of us who work with him and for him with the National Advisory Committee on Rural Health have discovered more important things about Bob. We have found him to be intelligent, funny, caring, realistic, charming, articulate, and an excellent leader. He is one of the best listeners I have ever met. He knows more about health care than most of us. It is a pleasure to introduce one of America's great leaders, Robert D. Ray:

Jeff, thank you. Thank you very much. I just learned a great deal about Jeff Human. I have always admired him and his talent and his ability and I have watched him in Washington, knowing that he is not just a bureaucrat. He is a person with tremendous compassion and understanding of people, their needs, and their problems.

Jeff, what I did not know about you is how flexible you can be. You have talked to us about education; you have talked to us about tractors; you have talked to us about Federal programs; you have talked to us about *Boxcar Willie*; and you have talked to us about me. I am here to tell you that I am sure thankful I do not practice law anymore.

I am not sure I should have been invited to speak to you today at all because I am not sure of my own commitments. There is probably no one who is working harder or who believes more that we should hold down health care costs than I.

Earlier this year, I was in an automobile accident and was taken to the emergency room. I was laying there flat on the slab and looking up, and two white spotlights were shining down on me. It was very, very warm and very comfortable.

I felt pretty good about that, but then I looked kind of from one side to the other, and I saw these green things running around. There were doctors standing here and there. Once in awhile one would lean over and look at me, and I would look at him. The funny thing about it is that never one time did I look up and say, "How much is it going to cost, Doctor?"

And so there are conflicts within all of us. We want the best health care system possible. We do not always want to pay for it. We believe that there are ways in which we can cut and save—but not on the service that we get.

So, it is very difficult when we talk about what is needed and what is doable. If at first blush you think it is just overwhelming and impossible, you would quit.

Then when you realize that things do happen—maybe slowly, but they do happen. There is always change going around. Maybe the change will inure to a system that we want to change. That is the reason it has been exciting to me to work with Jeff Human and the people in Washington and DHHS.

Some of the business people and the major leaders of this country are trying to do something about health care. We have long learned that you can not do something about cost alone because if you control cost, you reduce access.

You cannot do something about quality of care alone, even though that, by itself, might reduce health care costs 30 or 40 percent, because it costs money to do certain things.

You cannot just provide more access for everybody without affecting costs and quality. So we have to deal with all of those aspects of health care and the health care delivery system together.

I think that it is awfully easy for us in the rural areas to be neglected because we do not have the votes they have in the big states: California, how many congressmen do they now have? New York?

It has been very impressive, what has happened in Congress over the last several years. Jeff already mentioned how many members belong to the House Coalition on Rural Health. So, a lot of good things have happened, and our advisory committee, I think, has had some influence, some impact, and I am pleased to be associated with them.

I am pleased that the Surgeon General decided that we should have this conference and that our senators endorsed it, and Tom Harkin helped to get it here in the State of Iowa. There is no better place we could have a conference on rural health than right here in the State of Iowa. I think we ought to have one of these every 50 years.

An awful lot has happened to change the landscape of American health care during this past 50 years. Advances in technology and the proliferation of medical specialties allow us to live longer and healthier lives. That is good. But unfortunately, farm families, farm workers, and rural farming communities do not share equally in all of this achievement with our neighbors in urban areas.

This conference is very timely, and I am pleased that it is here in the State of Iowa. And I want to thank the Surgeon General for being here.

There are so many people that I would like to acknowledge on the federal level, on the state level, and on the regional level—our Senators, Congressmen, Dr. Donham and Dr. Merchant, and the list goes on and on. I am going to save you—spare you—the time that it will take to do that.

Let it suffice to say, I truly appreciate what you are doing because this is important—not just to those people who live on farms, but even those who live in small towns; it is important to every one of us. I will get back to that.

The diverse groups of people like yourself who focus specifically on rural health at this conference give us a unique chance to build and strengthen active, vital, rural health networks. It offers the opportunity to develop links between the researchers and the health professionals, between health professionals and extension agents, between extension agents and surveillance experts, and between surveillance experts and researchers. The list goes on and on; you get the picture.

We just finished a rather tasty meal. You have probably had better; you have undoubtedly had worse, but by most standards, let me tell you, there are people in this world who have never, ever had a meal that good. Let me give you some food for thought.

Just stop and pause and reflect for a moment with me about who produced that food. I am not talking about the culinary part, the chef's part, but about the people who provided the labor and the risk and the sacrifice that we enjoyed at noon: we are spoiled. We in this country try to decrease the calories that we eat, while the rest of the world measures growth and progress by the increase in calories their people eat.

Our farmers only get a very small fraction of what we spend for food. They get 4 cents for the wheat that goes into a loaf of bread, which costs roughly a dollar and a quarter. They get 5 cents for the corn that goes into a 7-ounce box of corn flakes, which sells for a dollar and a quarter.

We in this country spend a smaller percent of personal income on food than any other civilized country. You people pay, on the average, 11.9 percent of your personal income for food. It was 18 percent in 1959. It has been reduced.

Yet, in other countries, like the European countries, they are paying around 17 percent; Japan, 19 percent; the Soviet Union, 28 percent; India, 54 percent; China, 48 percent. We have a bargain.

Look at what is happening in the Soviet Union. During our lifetime we have grown up knowing about two superpowers—one the United States of America and the other the Soviet Union.

Today the Soviet people stand in lines for hours. You see them on television. You can watch them—waiting for a little piece of bread that they cannot even afford.

> Add to that the fact that the suicide rate for farmers is now 30 to 40 percent above the national non-farm rate.

We are fortunate, yet we take it all for granted. Our farmers produced the food that the chef prepared for us today, but they did it accepting some risk: the possi-

bility of an untimely death or serious injury or acute or chronic illness—all of that—while they were growing the food and raising it.

RURAL STATISTICS

Earlier at this conference, if I understand correctly, you heard some alarming statistics. Let me briefly reiterate what I think some of them were.

Although farmers and farmworkers comprise only 3 percent of the work force, they suffered 14 percent of work-related deaths, according to National Safety Council figures. Agriculture, as you heard just a moment ago, precedes mining now as the most hazardous occupation.

Unlike mining, where the death rates have been decreasing, agriculture mortality rates have remained consistently high during this past decade. The fatality rate in farm work is five times the average for all U.S. industry—five times.

Researchers have discovered that midwestern farmers have a higher-than-normal chance of dying of leukemia. The cause is uncertain. Some experts fear an unusual incidence of leukemia is linked to the use of modern pesticides in raising corn.

A serious new hazard known as "hog lung" is also one of the by-products of the modern system of raising hogs in confinement. In a half-dozen or more of our cities, water supplies contain greater than acceptable amounts of pesticides and other synthetic organic chemicals.

Millions of rural poor people are risking health problems because of substantially substandard diets. That problem is attributed to the pride of rural poor who are unwilling to accept food stamps and other assistance. These numbers do not even take into account all the children who die each year in farm-related activities.

In addition to deaths, there are 130,000 to 170,000 disabling farm injuries every year. These injuries entail an enormous hospital rehabilitation cost, and nearly half of all survivors of serious farm trauma are permanently impaired. Add to that the fact that the suicide rate for farmers is now 30 to 40 percent above the national non-farm rate.

Jeff just gave you some other information about that fact. He mentioned that I had served as a representative to the United Nations. When I was there, I found myself frequently talking to those of other countries, and especially Africans, who no longer could produce enough food for their own people.

They had joined a crowd of socialized countries, and soon learned that they just could not produce food like they used to. They liked talking to me because they knew that I came from the State of Iowa, one of the best farm states in the country, in the world.

We spent hours talking about how our farmers could produce food better than anybody in the world. I believe that we could help them. We used to talk about how we might do that.

One day I was telling them about how wonderful our farmers were and how well they could produce food. Then, the very next day, I picked up the *New York Times* and there on the front page was a dateline story from Spencer, Iowa; and this is a quote, "More suicides on Iowa farms." I just hoped that my friends I talked to the

day before did not read that. But it was and it is a fact of life. It is a shocking fact of life.

I have just given you a few statistics that I think indicate the importance of your getting together today for this conference. Let me turn our attention to the big issue of rural health care and rural health care delivery.

RURAL POVERTY

Many of you are undoubtedly familiar with the agricultural, occupational, and environmental health conference that was held here in Des Moines a couple of years ago. That conference report was called *Agriculture at Risk.*

It described the need for occupational health and safety services. It discussed the challenges facing the rural health care system, challenges like failing rural hospitals, pay disparities between urban and rural physicians, difficulties in retaining both rural health providers and patients, and the need for a strong emergency medical services system. Although the public's image of rural America is one of picturesque countrysides and healthy lifestyles, this image belies the reality of life in much of rural America. These are hard times for many rural communities, the result of both economic and demographic trends.

For example, the rural poverty rate increased steadily during the 1980's and for the first time is now higher than the urban rate. Rural residents are much more likely than urban residents to have no health insurance coverage at all—public or private.

Rural residents are plagued by chronic disease, higher rates of infant mortality, and dramatically higher rates of injury-related mortality. Some of these figures reflect the corn prices of the 1980's. You probably are not surprised to hear that the number of farm foreclosures reached 650,000 between 1981 and 1987.

You may not know that rural America also lost over 500,000 manufacturing jobs at the same time. It is estimated that for every seven farms that have been lost, one rural business has closed.

The rural population increased in the 1970's. The 1980's saw a dramatic shift. Growth was stagnant at best and some midwestern communities lost population, Iowa being one of them. All of you know we are going to lose a Congressman. We do not want to lose that Congressman; we have no choice.

These economic and demographic trends together with changes in the delivery and financing of health care have taken a huge toll on the rural health care systems, especially the rural hospitals. Ten percent of all U.S. rural hospitals closed during the 1980's, and it was estimated that about 25 percent of those still serving patients were in serious trouble.

With greater rural poverty has also come a rise in uncompensated care provided at rural hospitals. Under Medicare's perspective payment system, rural hospitals, since 1983, have been paid at a lower rate than urban hospitals, as much as 25 percent lower. This has been devastating to many rural hospitals because Medicare patients represent an exceptionally high percentage of their patients.

One of the first recommendations that the National Advisory Committee on Rural Health made to Secretary Sullivan was to establish a single national standardized

payment for Medicare hospital reimbursements. I am pleased to be able to say that Secretary Sullivan has been successful in seeking a higher annual update for rural hospitals. The Congress has now legislated a phase-out of the rural-urban differential in Medicare payments.

In 1989, the Federal Government implemented the Rural Hospital Transition Grant Program to address rural hospital vitality. Under this program about 180 new grants were made to rural hospitals each year for the past two years. Hospitals can receive up to $50,000 a year to help them with strategic planning and implementation of programs to help them with that change in rural health care needs and practices.

Iowa has fared very well under this program. Twenty-three of these grants were awarded to Iowa hospitals in 1990. That totals $819,000 and represents 10 percent of all the federal funds awarded.

The second program that the Federal Government is implementing right now is the EACH/PEACH Program. EACH means Essential Access to Community Hospitals. PEACH means Primary Care Hospitals. The Congress authorized this program in 1989 to provide financial incentives for rural hospitals to downsize and to focus on providing primary care and limited inpatient services and emergency care.

The program also encourages these primary care hospitals to form networks anchored by larger full-service, essential-access community hospitals. Seven states will receive funding this year to develop networks in primary care in essential-access community hospitals.

RURAL HEALTH PERSONNEL

Another rural health issue receiving a lot of attention is the shortage of rural health personnel. To maintain a rural health system, we have to have physicians, nurses, emergency medical service helpers, and other health personnel.

Rural counties have only one-third as many physicians per capita as the nation at large. In these counties, 20 percent of physicians are over the age of 65 and, obviously, are going to retire very soon. Communities also have problems recruiting and retaining physicians. Right now 165 Iowa communities are looking for doctors. Rural communities particularly find it difficult to recruit and retain registered nurses, physical therapists, occupational therapists, x-ray technologists, and other health professionals critical to health care systems.

Some recent federal efforts may help address a few of these problems. The National Health Service Corps was re-authorized last year. Its funding was increased. This program places physicians, nurse practitioners and physician assistants in the underserved areas. In recent years, about 70 percent of the placements have been in rural areas.

A Medicare bonus was implemented two years ago for physicians practicing in rural underserved areas. The bonus was increased just recently to 10 percent.

That represents just a very small incentive, but given the substantially lower rate that many rural physicians receive as compared to urban physicians, it is at least a step in the right direction. Both of these provi-

sions, I might add, were recommended by the National Advisory Committee for Rural Health.

Congress has also mandated a new Medicare physician payment system. Under this payment system, primary care physicians are going to be reimbursed at higher levels than they currently receive, and that ought to help.

At the same time, we should not overlook the issue of rural emergency medical services. In Iowa there are more than 400 ambulance services and approximately 10,000 trained personnel. Seventy percent of these people are unpaid volunteers, and most all of them are in the rural areas. The difficulties of recruiting and retaining these dedicated individuals who have other jobs, spend long hours in training, and donate their time free to an important health service are, I think, rather obvious.

Rural volunteer ambulance services also struggle to purchase equipment. An ambulance, fully stocked, is going to cost $70,000 and rarely is there money from government to pay for that.

So they have their chili suppers and their chicken barbecues just to raise the money for an ambulance. That, actually, is where most of the money comes from. It seems kind of strange to think that the emergency services upon which we depend so heavily, particularly in rural areas—services that treat farm injuries, heart attacks, highway traffic accidents—are actually provided by volunteers.

RURAL MENTAL HEALTH

Now, the third and last rural health issue I want to mention is rural mental health. As I said a moment ago, the farm crisis of the 1980's caused incredible stress for rural individuals and families, but the accompanying drop in land values and tax bases made it increasingly difficult for rural communities to finance mental health services.

As we look at ways to strengthen our rural health care system, we have to make sure that mental health services are a part of that system. Mental health personnel are also trained for rural practice. Iowa State University, for example, has recently been awarded a $4.5 million grant to establish a center for family research in rural mental health.

Right now Iowa has about $24 million in rural health related federal grants, employing a variety of programs.

Mercy Hospital here in Des Moines, for example, has received $750,000 for a cancer screening and control program for farm families in 35 Iowa counties.

CONCLUSION

Well, what is the sum and substance of it all? I think, notwithstanding the problems and all the difficulties, we can be somewhat encouraged by the recent progress in both rural health and in agricultural health and safety. Make no doubt about it, we have a long, long way to go.

Public policy items all have their life span on the national agenda. The challenge that we face is to keep rural health and agricultural health and safety issues on that agenda long enough so that we can make and see a very substantial difference.

If we can do that, we are going to see that the time and the effort and the money were all well spent to ensure a future for our rural areas. This conference is unique

because of the range of the players that it has brought together.

I would suggest that we have a second conference; in fact, I already did before the Surgeon General left. I think I am not speaking out of school—she said she agrees. We really ought to have one.

I think it would be nice if we had it before 50 years, because I would like to come back. I would like to see what we have done between now and next year or the next year or whatever time that conference is set for.

The last Surgeon General's Occupational Health Conference resulted in something maybe very important, the elimination of mercurial poisoning in the hatting industry. We do not have much hatting industry anymore. In contrast, this conference has the potential to lead to dramatic decreases in agricultural deaths as well as advances in preventing and treating agriculturally related diseases and injuries.

To wrap it up, I would like to just share a quotation from the newsletter of the Center of Rural Affairs, Walthill, Nebraska. It puts what you are doing here in a broader context of rural development and, in a sense, summarizes what I think this conference is about. I am going to quote:

> "Good rural development conserves the best in people; the resources they live from, the values that nourish them, and the institutions that sustain them. We need not try to prevent change but to shape it in ways that conserve our future."

I would add to that, the health and future of our rural farmers, farmworkers, and the farm community. If we succeed at doing that, every one of us will benefit. I appreciate so much you being here, because that is what you are here for, to do exactly what that quote says. Thank you very much.□