Northern Illinois University

Huskie Commons

Policy Profiles | Center for Governmental Studies

3-1-2012

Policy Profiles Vol. 11 No. 1 March 2012

Northern Illinois University Center for Government Studies

Norman Walzer

Melissa Henriksen

Follow this and additional works at: https://huskiecommons.lib.niu.edu/ctrgovernment-policyprofiles

Recommended Citation

Northern Illinois University Center for Government Studies; Walzer, Norman; and Henriksen, Melissa, "Policy Profiles Vol. 11 No. 1 March 2012" (2012). *Policy Profiles*. 13.
https://huskiecommons.lib.niu.edu/ctrgovernment-policyprofiles/13

This Working Paper is brought to you for free and open access by the Center for Governmental Studies at Huskie Commons. It has been accepted for inclusion in Policy Profiles by an authorized administrator of Huskie Commons. For more information, please contact jschumacher@niu.edu.

Vol. 11, No. 1 March 2012

policy profiles

Center for Governmental Studies Northern Illinois University

- *Illinois' 51 Critical Access Hospitals (CAHs) provide essential health services in Illinois' rural areas.*
- *Illinois' CAHs are also a major state industry, recording a $2.1 billion cash flow and employing over 10,000 people in 2009.*
- *CAHs are facing severe threats as they struggle with an unstable economy, an aging rural population, and inadequate and delayed reimbursements for their health care services.*
- *Illinois CAHs reported a 126 per cent increase in charity care costs between 2006 and 2009.*
- *CAHs are cutting costs through collaborative efforts involving shared services and equipment, and upgraded service delivery systems, but these efforts alone are not enough to cover rising costs.*
- *Continued monitoring of the impact of proposed legislative changes to health care delivery systems on CAHs' finances is critical to their survival.*

issue: *Health Care in Rural Illinois: The Role of Critical Access Hospitals*

by Norman Walzer and Melissa Henriksen

Editor's Note: To understand better the contributions that rural hospitals make to the economy and quality of life in their communities, the Illinois Critical Access Hospital Network (ICAHN) commissioned the Center for Governmental Studies at Northern Illinois University to provide updated information on the economic impact and financial condition of critical access hospitals (CAHs) in Illinois. Two surveys, one focused on management approaches, finance issues, service delivery methods, and other concerns, and a second on personnel expenditures, construction costs, and operating expenditures, generated excellent responses by both CEOs and CFOs in 36 (70.6 per cent) of the state's critical access hospitals. This *Policy Profiles* is a summary version of the final report which is available at ***www.niucgs.org.***[1]

Rural hospitals' critical role in maintaining the quality of life in rural areas has long been understood, but neither the impact such hospitals have on the economic health of their communities nor the threats facing rural hospitals' own financial well-being have been well recognized.

Indeed, rural hospitals are especially important to rural Illinois. Not only do they provide critically important health services, but they are typically one of the largest employers in the areas they serve and they attract better educated and more highly paid residents to rural communities. Because of their economic and community impact, threats to their financial health pose a double risk: reducing the quality of life and desirability of an area plus weakening one of a rural area's important industries.

Despite their important role, Illinois' rural hospitals face an uncertain future. The State of Illinois' current financial difficulties have caused delays in payments for rural health services which, in turn, have caused some health care agencies and businesses to close their doors. Even when paid in a timely manner, if reimbursements do not cover the full costs of providing services, hospitals and other health care providers must find alternate revenue sources, ways to cut costs, or go out of business.

The *Patient Protection and Affordable Care Act* passed by Congress and signed into law in March, 2010, by President Barack Obama will also affect rural hospitals. The Congressional Budget Office estimated the legislation will expand coverage to 32 million people. A Rural Policy Research Institute (RUPRI) report released in December 2010[2] claims that the health care legislation has the potential to benefit rural communities and residents because it creates health insurance opportunities through expansion of the Medicaid program, as well as new opportunities for small employers.

This *Policy Profile* examines a unique and essential piece of the rural health care landscape, Critical Access Hospitals (CAHs): their functions and characteristics; their roles in rural health care; their community and economic impact; the challenges they face; and the responses they are making to those challenges.

What is a Critical Access Hospital?

Because conditions confronting the smallest rural hospitals are fundamentally different from those affecting larger hospitals, the Critical Access Hospital (CAH) Program was authorized by Congress in 1997 to ensure access to quality health care for rural residents and to stabilize small rural hospitals.

A CAH is a licensed, acute care hospital with 25 or fewer beds that is required to maintain an average length of stay less than 96 hours, furnish 24-hour emergency services, be located in a designated rural area, and meet the program and distance requirements established by Medicare for participating hospitals. In return,

Figure 1. Illinois Critical Access Hospital Network 2010 and Population Changes

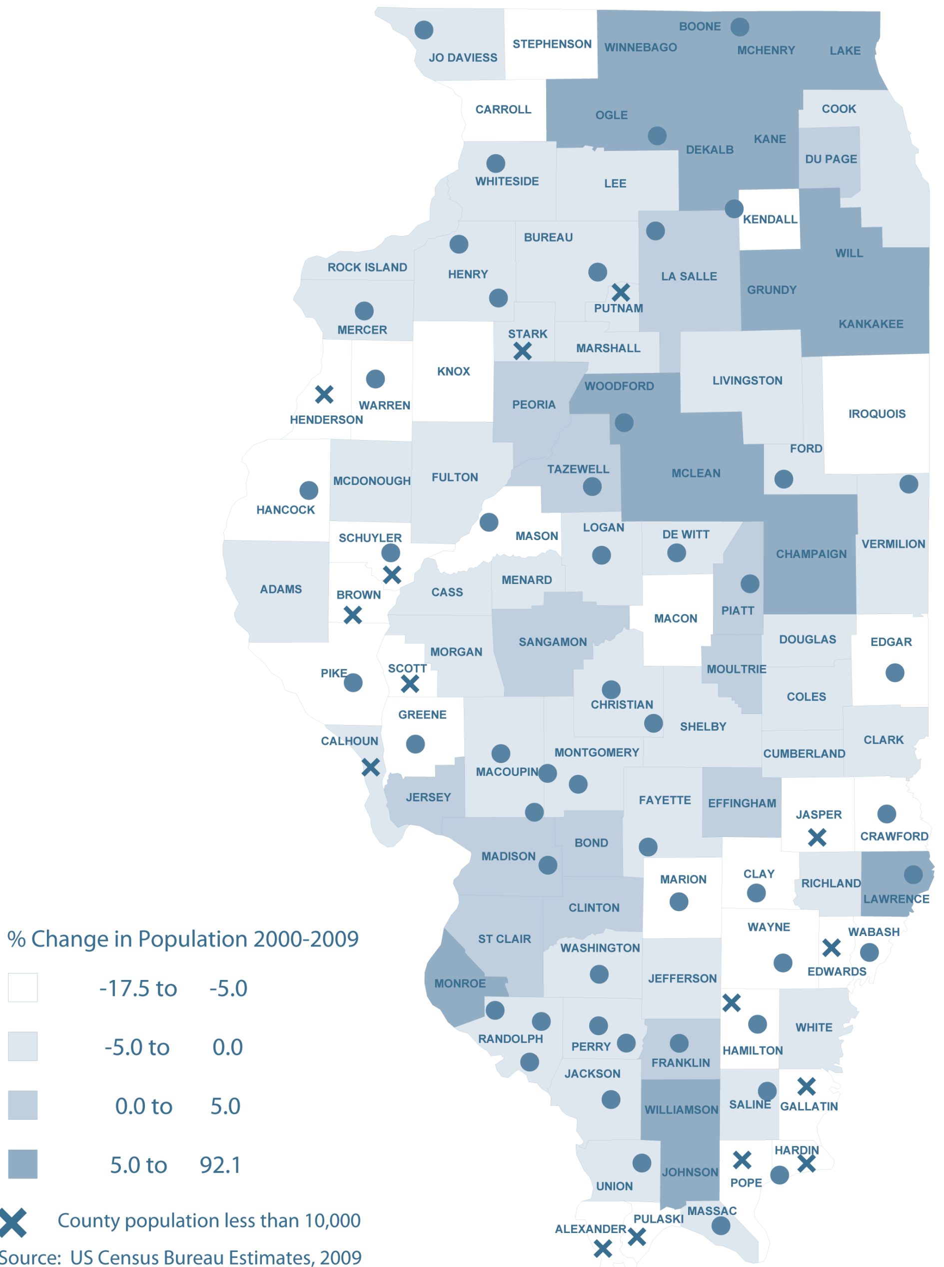

Table 1. 2009 Total Impacts of CAHs on Region

Impact Type	Direct Impact	Indirect and Induced Impact	Total Economic Impact
Employment	10,241	7,769	18,010
Employee Compensation	$576,266,570	$241,539,347	$817,805,917
Gross Revenue (output)	$2,135,521,821	$844,293,686	$2,979,815,507

a CAH receives cost plus one percent reimbursement for services provided to Medicare patients. A CAH is also required to develop network agreements with resource hospitals, and they may provide an unlimited selection of outpatient services.

As of March 2011, there were 1,327 CAHs in the United States, with 51 in the State of Illinois **(Figure 1 on the previous page)** representing 25 per cent of the state's rural hospitals. In a comparison of CAHs by state, Kansas has the highest number (83), followed by Iowa (82), Minnesota (79), and Texas (79). Most of the states with large numbers of CAHs are in the Midwest and they feature large areas with relatively low population density and a large number of small towns. Five states—Connecticut, Delaware, Maryland, New Jersey, and Rhode Island —have no CAHs.

What is the economic and community impact of CAHs?

Communities with access to high quality health care have a distinct advantage in attracting and retaining businesses and residents, including retirees. Businesses seek a dependable and productive local labor force. Because good health is essential to productivity, community investment in health care services is important.

Because of their relatively large employment, CAH facilities have an important economic impact on host communities, regions, and the state due to the revenues they generate and the payrolls they maintain. The relative stability of hospital and health care employment, even when other employers are cutting back, increases the local economic importance of CAHs.

Furthermore, hospital purchases stimulate local employment and income (wages, benefits, and proprietor income) making health care an important driver of local economic activity, especially in rural counties.

What are the impacts of annual CAH operations?

This economic impact analysis[3] focused on the 51 Illinois CAHs. In 2009, they, collectively, had gross revenues (output) of $2.1 billion, 10,241 employees, and a payroll of approximately $576 million **(Table 1)**. The direct effects of CAH employment and spending are regional, rather than specific to the county where the CAH is located, because some employees commute from surrounding counties and may purchase goods and services beyond the county in which the CAH is located.

The employment multiplier links CAH employment to job creation in the community. In essence, a statewide employment multiplier of 1.76 generated by the IMPLAN model means that for every 10 people employed by the CAHs, an *additional* 7.6 jobs depend indirectly on the economic activity they generate. As a result, in addition to the 10,241 individuals employed directly by CAHs, another 7,769 jobs are supported indirectly in other business sectors for a total employee compensation figure of nearly $818 million.

Annual operations are only one measure of the impact CAHs have on their regional economies. The community impact of CAH capital projects was also examined. The 18 CAHs that completed the survey on management and expenditures reported they had initiated or completed a construction, renovation or expansion project between 2007 and 2009. These large and small scale construction projects totaled approximately $149.9 million and created 218 FTE positions as self-reported by the 18 responding CAHs. The $149.9 million of CAH construction expenditures produced:

- Short-term or temporary employment (mostly construction) of approximately 1,000 workers, with employee compensation of $36.2 million as a direct result of projects;

- $41.8 million in sales or revenue in other business sectors with 370 jobs supported and employee compensation of $11.1 million.

Although the short-term impacts of construction projects are more visible and more easily quantifiable, long-term impacts also include higher quality and variety of services offered by CAHs plus new health care employment opportunities.

Impact analyses for operations and construction projects show the importance of CAHs in local and regional economic activity beyond direct employment and revenues from annual operations. Although the economic impact is felt primarily through hospital expenditures for local services and payroll, employee spending in local retail and service sectors plus the related effects on the supply chain are also important.

What is the profile of a typical Critical Access Hospital in Illinois?

Although every critical access hospital is unique in services provided and patient demographics, most address many of the same issues. The 2000 median population of Illinois counties with a CAH was 26,733, but by 2009 it had decreased slightly to 25,738. Only three CAHs are in counties with fewer than 10,000 residents, with a majority (76.5 per cent) in counties with populations between 10,000 and 49,999. Forty-one CAHs (80.4 per cent) are in counties that lost population between 2000 and 2009.

The composition of residents in the counties also affects the clientele of the hospitals. A population decrease, combined with an increase in elderly residents (65 and older), affects patient demand, coverage by Medicare, reimbursement issues, and services needed. Critical access hospitals in Illinois had median gross revenues of $38,607,677 in 2009, with a majority (58.8 per cent) between $25 million and $59.9 million. The average full-time equivalent employment (FTE) for Illinois CAHs was 201 in 2009.[4]

What issues do Illinois CAHs face?

Illinois CAHs face several interrelated demographic and financial issues. First, populations decreased in many rural counties with the out migration of young families, leaving an even higher proportion of elderly residents with greater needs for medical and health services. Of significant concern for rural hospitals are the long-term projections of populations older than 65 because this cohort represents a large proportion of their clientele. Between 2010 and 2040, Woods and Poole Economics, Inc. project an increasing number and share of seniors in nearly all Illinois counties.[5] Elderly residents often are less able to afford health care without supplemental revenues, placing a strain on rural hospital resources because of an increase in charity care costs.[6]

Second, CAHs face significant challenges as they struggle with an unstable economy, changing demographics, and costs associated with implementing technological changes. Other sources of financial strain are reimbursements that often do not cover full operating costs and delays in payment. In addition, the current recession, with persistent high unemployment, has increased the overall number of charity care cases that hospitals must manage, thereby further reducing their profitability. While the Medicare Rural Hospital Flexibility Grant Program has enabled CAHs to remain financially sound, a comparison of financial trends in recent years suggests that these hospitals are vulnerable to changes in reimbursement programs. This is especially true for CAHs in smaller markets. Thus, it is important for policy makers to recognize the impacts of health care reforms and regulatory mandates on rural areas where CAHs are the main health care delivery mechanism.

Third, in response to challenges from changing demographics, financial stability, reimbursement difficulties, and other issues, hospital administrators and health care agencies are exploring alternative approaches for delivering services. More specialized treatment options have caused hospitals to collaborate with other agencies to share personnel, equipment, and pursue other creative solutions to costly specialty tests or procedures.

Finally, because the implications of hospital financial conditions are so serious for the quality of life and financial viability of rural communities, it is critically important for local policy makers to understand fully the impact of CAHs on employment and sales, which goes well beyond direct employment. This impact was discussed above on pages 3-4.

What demographic trends are most threatening to CAHs?

The most threatening population trend is the aging of the population. Demographic projections indicate that, over the next 30 years, rural areas in Illinois will experience a significant increase in the number of persons age 65 and older.

Table 2. Long-Term Projected Population Trends

	CAH Counties	Non-CAH Counties*	Illinois Totals*
Average population 2010	45,145	101,048	7,746,073
Average population 2040	52,277	135,153	10,003,938
Average percent change	4.1%	11.5%	29.1%
Average population 65 & over 2010 (per cent of population)	6,727 (14.9%)	12,014 (22.4%)	980,771 (9.8%)
Average population 65 & over 2040 (per cent of population)	11,024 (21%)	23,653 (17.5%)	1,833,297 (18.3%)
Average per cent change in senior population	46.4%	60.8%	86.9%

Source: Woods & Poole, 2010 *Note: These figures do not include Cook County

As the median age of rural residents increases, so will the amount and type of health care services they require. When CAHs chief executive officers were asked about the increase in the amount of care needed by an aging population, 25 (80 per cent of respondents) said it is important or very important to the future of their hospitals. Only two counties showed a minor decline in number of residents 65 and older by 2040 **(Table 2)**. Very small counties may also experience continued depopulation and still experience an increase in the number of people 65 or older. However, only three of these small counties have a CAH.

Demographically, the CAH client base will be secure. CAH counties in Illinois are projected to see a 4 per cent increase in their overall populations during the next 30 years, but an increase of 46 percent in their senior populations over the same period. Counties with a CAH are likely to find 20 per cent of their populations in the senior citizen category.

What are CAHs financial challenges?

To remain financially viable, communities rely on positive demographic and economic trends. Like demographic trends, economic trends are not encouraging for CAHs. The agricultural move toward fewer, larger farms and farming operations has not helped all rural communities. Neither has the industrial outlook.

Illinois lost 240,000 manufacturing jobs since 1998. Among the 102 counties in Illinois, only eight are estimated to have gained manufacturing jobs between 2000 and 2010, and they are all urban counties. The service jobs that commonly replace manufacturing jobs often pay less, may be part-time, and do not always provide benefits. All of these trends have implications for health insurance and hospital services.

Table 3. Factors Affecting CAH Financial Health Reported by CEOs

Factors	# of Responses	Percent
Higher costs to implement technology into hospital services	27	85
Increase in charity care because of unemployment	26	81
Inadequate federal reimbursement for services	24	75
Greater share of outpatient services	24	75
Unfunded state mandated programs	24	75
Delays in state reimbursement for services	23	72
Local business closures/higher unemployment/reduced demand	20	63
Inability of an aging rural population to pay health bills	16	50
Increased competition from other health service providers	14	45
Patient revenues do not meet expenses	14	45

Source: ICAHN/CGS Survey, 2010

Added to the long-term declines in both agriculture and manufacturing are the effects of the current recession. There are no CAH counties with less than 7 percent unemployment and approximately one-third of CAH counties had higher than 10 percent unemployment rates in August 2010. Unemployment often means loss of health insurance coverage. With more people between jobs, fewer people have health care coverage and state Medicaid and Comprehensive Health Insurance Program resources are stretched thin.

Likewise, future jobs will be lost in local governments and school districts as the effects of the recession continue. These trends will more seriously affect those counties that depend on federal or local government employment, as well as CAHs that serve many of these rural patients.

CEOs responding to the survey in 2010 were asked how economic changes would affect their financial situation between 2010 and 2012. Did they foresee substantial improvements, conditions remaining the same, or substantially worsening? Most respondents (52 percent) expected no change and only four expected improved conditions. The uncertainty about state and local economic conditions makes effective planning difficult since hospital personnel are unsure about patient demand and revenues.

While CAHs receive higher Medicare reimbursement rates than Prospective Payment System (PPS)[7] hospitals, the adequacy of patient revenues still remains an issue. Forty-six percent of responding CAHs reported inadequate revenues as an important or major factor affecting their financial health **(Table 3)**. Delays in state reimbursements and inadequate federal reimbursement rates are especially important as is the impact of competition from other health care providers.

Responding CEOs also reported serious concerns about the costs of implementing necessary technology and, to a lesser degree, the effects of adverse local economic conditions on revenues. Faced with the prospect of adding expensive technology in the near future, 27 CEOs (85 per cent) rated these costs as "important or of major importance." CEOs concerned with the costs of technology also reported concerns over the growing share of services being delivered on an outpatient basis and the inability of an aging rural population to pay bills. While new technologies may

improve services available to residents, CAHs may not have a ready source of revenue to pay for them.

CEOs were divided over the importance of increased competition from other health service providers. Fourteen CEOs (45 percent) reported that this competition had an important or major impact on their financial condition. However, 28 per cent reported it as minor or having no impact. CEOs who reported the greater impact of competition more often reported an inability to hire specialized expertise and expressed concern that patient revenues do not cover costs.

Is charity care an increasing burden?

A recent Illinois Hospital Association report, *Illinois Hospitals' $75 Billion Economic Impact on Our Economy*, stated that hospitals across Illinois experienced a 100 per cent increase in charity care costs since 2005. Responding CAH executives reported the burden at an even higher level, presumably due to poorer economic conditions in rural areas. On average, 25 CEOs reported a 126 per cent increase in charity care costs from $166,794 in 2006 to $377,446 in 2009.

How are CAHs responding to financial challenges?

Health care reform is underway in the nation and will substantially affect the face of health care. Buoyed by this movement, and faced with immediate issues posed by the stagnant economy, many rural hospitals in Illinois are positioning themselves for viability and profitability in the future.

CEOs can respond to changing demographics, markets, and financial conditions in many ways, including reducing expenditures, increasing revenues, or both. Each strategy has implications for the communities in which the CAHs are located.

To reduce expenditures, common measures include delaying future construction projects and postponing capital purchases and other activities that do not immediately compromise health care services. These strategies, however, can only continue for so long before future expenditures required to make-up for these delays exceed the cost savings.

An alternative strategy is to find additional revenues to support operations. In some instances, new revenue sources are completely under the control of the CAHs while others require actions by governments or may involve a long period before the revenues materialize. Political resistance to tax increases may delay or prevent use of some remedies. The most likely set of strategies for responding to the current recession is a combination of expenditure cutbacks and revenue enhancements determined by the unique characteristics and situation of each CAH.

Table 4. Efforts to Engage in Regional and Local Collaborative Effort

Collaborative Effort	Number	Percent
Partner with other hospitals to compare performance	13	62
Partner with other hospitals to share services	12	57
Avoid malpractice costs by improving quality of service	11	52
Work with local economic development agencies	9	43
Partner with hospitals to share equipment	9	43

Source: ICAHN Survey, 2010

Are CAHs collaborating to find solutions?

Changing demographics, financial stability, and the ability to provide affordable access to health care have made CAHs reconsider their approaches for delivering services. Most CAHs reported financial strain which, coupled with a demand for quality services, quality data, and needed technological advances, have forced rural hospitals to be innovative in sharing costs and approaches. When critical access hospital CEOs were asked if they are exploring regional or collaborative efforts to reduce costs, more than 60 per cent reported engaging in these efforts **(see Table 4 on the previous page).**

The "sharing" approaches being utilized fall into three categories:

Sharing Specialized Services

Health care reform legislation and changes in rural health care encourage hospitals to focus on efficiency, collaboration, and health information technology (HIT) to continue to meet evolving community needs. Hospitals and physicians use HIT to record health information electronically, facilitate decision-making, and monitor patient health, all to serve patients better and lower long-term costs. The issues for most CAHs in implementing these systems will be time and resources. Although 2010 survey respondents view the electronic health records (EHR) transition, and other technology issues, as challenging in a financially constrained environment, they are making the necessary changes.

One important collaborative effort involves sharing specialized services (53 per cent). Hospitals share services including compliance activities, risk management, IT, and security practices. Sharing IT services is especially important because the cost of implementing the new EHR regulations will affect hospitals financially. Sharing a staff person with expertise in these issues could represent substantial cost-savings in smaller hospitals.

Sharing Specialized Equipment

Another effort involves sharing equipment, such as MRI and digital mammography equipment. This sharing allows rural hospitals to offer services that might otherwise be too expensive and thereby promotes higher quality service, especially in preventative care. Nearly 43 per cent of hospitals used equipment-sharing both to provide services to patients and to avail themselves of the most updated equipment and technology.

Changing Service Delivery Approaches

Telemedicine and EHR will require hospitals to invest in high-speed broadband digital access to make the technologies function most efficiently, which will also affect profit margins due to the expense involved. Adapting service delivery approaches, collaboration, and shared technology services will be increasingly necessary in the future as patient needs and demographics in rural health care continue to change. Advances in telehealth and telemedicine have expanded the potential for remote rural areas to provide high quality local health care through partnerships with larger institutions. However, for internet-based services, the collaborations between remote rural hospitals and those in major urban centers are just beginning to develop. The broadband initiatives underway in rural Illinois have the potential to help this process.

How will collaboration improve efficiency and CAH performance?

Since many CAHs have limited financial, technological, and staffing resources as compared to their urban counterparts, CAHs depend on the services of external agencies to help improve the quality of care. Survey responses show that critical access hospitals are working hard to integrate quality improvement processes into future plans. This is especially significant since recent health care reforms will impose even greater demand for accountability, transparency, and comparative data.

Among hospitals reporting collaborative efforts, a majority (62 percent) partnered with other hospitals to compare performance among peers, improve service quality, and share best practices. This collaborative effort will help hospitals achieve better utilization of existing resources and enhance the safety and quality of the services provided.

In a *Journal of Rural Health* article[8] entitled, "Comparative Performance Data for Critical Access Hospitals," the authors explain that relatively little comparative performance data specific to critical access hospitals existed as of 2006. They explored how such data for CAHs could facilitate performance and quality improvement, assessed the potential benefits and drawbacks of such data, and identified some of the critical issues in developing and implementing this data.

During the 2010 survey, CAHs still did not have financial incentives to submit

performance measures to the central data repositories maintained by the Centers for Medicare and Medicaid Services (CMS). Instead, local hospitals could report data for any or all of the core indicators of care only if they choose to do so. As of August, 2011, however, efforts were underway to increase both the level of data being submitted and the number of CAH facilities reporting.

What is the outlook for CAHs in the years just ahead?

Rural hospitals are in better position today than they were in the 1980s and 1990s, partly because of changes implemented in the Medicare program. In the future, however, the level of public funding available is likely to be an even more important determinant of the financial and operational health of small, rural hospitals. If the current health care reform results in broader coverage for rural people, rural hospitals could be strengthened. This would not only improve the quality of life in rural America, but would also strengthen the viability of CAHs. Just as important, it would also improve the economies of the rural communities being served.

The CAH program has significantly contributed to the financial viability of Illinois' eligible rural hospitals. Most CAHs in Illinois are currently financially stable, partly because of Medicare reimbursements and related CAH program provisions. In spite of this improved stability, however, there are signs that the recession and loss of population are negatively affecting the financial condition of some CAHs.

Despite their importance as an economic engine in the communities served, CAHs face significant challenges as they struggle with a down economy, changing demographics, and requirements to implement technological changes. While their financial conditions have improved with the CAH program, significant changes in reimbursement programs or other provisions currently under discussion could adversely affect the financial margins of rural hospitals and their viability. Thus, continued monitoring of proposed legislative changes to the state and national health care delivery systems is essential if the financial viability of rural hospitals is to be assured.

Northern Illinois University's Center for Governmental Services continues to work with the Illinois Critical Access Hospital Network and other groups on issues affecting rural hospitals and on the contributions such hospitals make to the quality of life and economic vitality of rural Illinois. Additional reports will be forthcoming.

Endnotes

[1] A special thanks to Pat Schou, Executive Director of the Illinois Critical Access Hospital Network (ICAHN) and Curt Zimmerman, Director of Business Services and Development (ICAHN) for their contributions to the report.

[2] A. Clinton MacKinney, A.C. MD, MS and J.P. Lundblad, Ph.D., MBA, (2010), RUPRI Heatlth Panel, “Securing High Quality Health Care in Rural America: The Impetus for Change in the Affordable Care Act.”

[3] In this analysis, the IMPLAN input/output model developed by the Minnesota IMPLAN Group was used to measure the economic impact of Illinois CAHs. This approach generates three types of multipliers: direct, indirect, and induced. The direct multiplier shows the initial impact of hospital spending for goods and services. The indirect multiplier picks up the effects of spending by suppliers to the hospital. The induced multiplier adds the household purchases resulting from higher incomes generated by the hospital in the region. The total economic impact, then, is the sum of the direct, indirect, and induced economic impact multipliers.

[4] RUPRI. 2010. “Securing High Quality Health Care in Rural America: The Impetus for Change in the Affordable Care Act.”

[5] Woods and Poole Economic, Inc., www.woodsandpoole.com

[6] “Charity care,” or uncompensated care, refers to health services provided with no expectation from a hospital of being paid either in part or in full by the patient.

[7] Prospective Payment System is a Medicare Part A reimbursement system where payment is made based on a predetermined, fixed amount (www.cms.gov).

[8] George H. Pink, et. al., “Comparative Performance Data for Critical Access Hospitals,” Journal of Rural Health, 20(4), 374-382.

Past *Policy Profiles* can be dowloaded from the web at: http://www.cgsniu.org/portfolio/policy_profiles/index.html

Vol. 10 No.4, August, 2011
Illinois' New Look: How the Past Ten Years Changed the State

Vol. 10 No.3, July, 2011
Developing the Arts: A New Tool for Community Development Programs

10 No. 2, April, 2011
Local Government Structure and Public Employment: A Fresh Look at Illinois' Predicament

Vol. 10 No. 1, February, 2011
Do Home Rule Governments Work Better? A New and Different Perspective

Vol. 9 No. 3, November, 2010
Small Governments and Intergovernmental Collaboration

Vol. 9 No. 2, August, 2010
Governments in Difficulty: Evolving Trends Make Life Harder for County Governments

Vol. 9 No. 1, January, 2010
Affordable Housing in the Chicago Area: The DuPage County Experience

Vol. 8 No. 3 February, 2009
Globalizing Local Economies: Making It Happen Through Local Action

Vol. 8 No. 2 November, 2008
Globalizing Local Economies: The Chicago Region's Record To Date

Vol. 8, No. 1 May, 2008
Building Effective Network Governance in the Chicago Region

Vol. 7 No. 2 November, 2007
Networking: The Key to 21st Century Government

Vol. 7 No. 1 October, 2007
Illinois Police Officers And Fire Fighters: How Good Are Their Pensions?

Vol. 6 No. 3 December, 2006
The County Administrator Form: A Modern Approach To Illinois County Government

Vol. 6 No. 2 October, 2006
Illinois County Government: Overlooked, Underappreciated, Very Important

Vol. 6 No. 1 February, 2006
Planning for Metropolitan Growth: Guidelines for Strengthening Local Control. The Prairie Parkway Series Conclusion

Vol. 5 No. 2 May, 2005
Telecommunications and the Future: The U.S. and Illinois are Falling Behind

Vol. 5 No. 1 January, 2005
Growth Management in the Western Suburbs. Part 1: Planning the Prairie Parkway

Vol. 4 No. 1 April, 2004
Illinois Public Education Undermines Democracy

Vol. 3 No. 4 December, 2003
Safeguarding Farmland From Non-Agricultural Uses

Vol. 3 No. 3 July, 2003
Growth Management in Illinois: A Perspective on Statutory Authority

Vol. 3 No. 2 April, 2003
Attack the Achievement Gap

Vol. 3 No. 1 February, 2003
Can Government Accounting be Trusted? An Experiment in Accounting and Accountability

Vol. 2 No. 6 September, 2002
Educations Problems: Teachers' Perspectives

Vol. 2 No. 5 November, 2002
New Homes in Rural Areas: Agricultural, Fiscal, and Public Safety Impacts

Vol. 2 No. 4 September, 2002
A View of Elementary School Problems in Poor Neighborhoods by Three Elementary School Principals

Vol. 2 No. 3 August, 2002
The Uses of Home Rule With Special Emphasis on Taxation

Vol. 2 No. 2 February, 2002
Implications of the Federal "Leave No Child Behind Act"

Vol. 2 No. 1 January, 2002
Public Sector Collective Bargaining: The Illinois Experience

Vol. 1 No. 5 May, 2001
Educational Funding in Illinois: Some Thoughts for Reform

Vol. 1 No. 4 May, 2001
Why Rewrite Illinois' Telecommunications Law?

Vol. 1 No. 3 April, 2001
The Election Debacle in Florida: Lessons for Illinois

Vol. 1 No. 2 April, 2001
Citizen Perceptions of Illinois Taxes

Vol. 1 No. 1 February, 2001
Illinois Home Rule: A Thirty Year Assessment

August, 2000
Illinois Adult Literacy Failing the Workplace. Alternative Solution Needed

About the Authors

Norman Walzer is a Senior Research Scholar in the Center for Governmental Studies at NIU. An Emeritus Professor of Economics at Western Illinois University, he was the founder and, for eighteen years, the Director of the Illinois Institute for Rural Affairs at WIU

Melissa Henriksen, MS, is a Research Associate in the Center for Governmental Studies at NIU. She recently conducted an assessment of the community and economic impact of critical access hospitals in rural Illinois and is now researching major issues affecting rural hospitals in Illinois and the Midwest

policy*profiles*

Policy Profiles is a publication of the Center for Governmental Studies, Northern Illinois University, and may be reproduced in its entirety with attribution to the Center for Governmental Studies, Northern Illinois University, DeKalb, Illinois.

Interim Director:
Diana L. Robinson

Editor:
James M. Banovetz, Ph.D.

For more information contact:
Center for Governmental Studies
815-753-1907
fax 815-753-7278
www.niucgs.org

The views expressed in this edition of *Policy Profiles* are those of the author and do not necessarily represent the views of the Center for Governmental Studies or the officers and trustees of Northern Illinois University. For more information please contact James Banovetz at jbanovetz@niu.edu.

PRESORTED
FIRST CLASS MAIL
U.S. POSTAGE PAID
Northern Illinois
University

policy*profiles*
Center for Governmental Studies
Northern Illinois University
DeKalb, Illinois 60115