

Four future scenarios for South Dakota's nurses

Art Kleiner

Written for the South Dakota Board of Nurses to report and reflect on a scenario workshop convened in February, 2001

Retreat Participants:

**Linda Benedict
Diana Berkland
Sandra Bunkers
Carey Duffy
Gloria Damgaard
Marge Hegge**

**Carol DeSchepper
Deanna Larson
Mina Hall
June Larson
Margaret Nelson
Nancy Nelson**

**Roberta Olson
Diana VanderWoude
Deb Soholt
Nina Kruschwitz
Becky Rice
Art Kleiner**

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Introduction

No one can confidently predict the future. But while we can't be sure what will happen, we *can* be prepared for it – by rehearsing a range of futures in our collective imagination. If we have thought and felt our way through several plausible futures, even if they seem uncomfortable at first, then we will most likely be prepared for whatever the actual future brings.

In the winter of 2001, a group of prominent nurses, nursing educators, and nursing administrators – all associated with the Colleagues in Caring project – met to consider the future of nursing in South Dakota. We knew that health care was poised to change – but how? What social, technological, regulatory, and economic factors might affect that change? Within the context of that change, who would represent the knowledge, craft, and perspective of nursing? How would nurses avoid obsolescence (or would they)? How would such looming issues as the shortage of nurses and the rising costs of health care be resolved?

We crafted the following question to focus our attention during this week-long session:

How can we and should we position nursing for a sustainable future in South Dakota?

In other words, how can we change and articulate nursing preparation and practice to be ready for tomorrow's needs, structures and attitudes while remaining true to the quality of life issues important to humankind through

- our role as a caring presence;
- our role as influencers of policy; and
- the scholarly discipline of health practice?

We emerged with four scenarios for the year 2008, seven years from now. These four futures chart the possible evolution of the most critical trends in health care in South Dakota.

● **Haves and Have Nots**

Present trends continue, with no successful full-scale reform of the health care system. The distinction grows more dramatic in South Dakota (and everywhere) between people with a sense of health care security, and those who live on the edge of health-care related bankruptcy. There is still a shortage of nurses, but as survival tactics in the fringes of society multiply, more people take on the roles that nurses play today.

- **Technofix**

Technological advances have changed the balance of power and economics in health care. The “medical-industrial establishment” (physicians’ groups, commercial health care institutions, and pharmaceutical corporations) lose control over the availability and price of technology. Medical ethics becomes a major issue as biotechnology makes previously impossible “fixes” of medical, fertility and lifestyle problems commonplace. Health care can happen anytime, anyplace.

- **Pockets of Community**

Institutional health care has constricted around the “haves,” an increasingly smaller group. In response, in a few small towns, city neighborhoods, and university centers, self-reliant community efforts emerge, led in part by entrepreneurial nursing professionals, organized around the idea of living balanced lives in harmony with neighbors and the environment.

- **(The Road to) Universal Health Care**

In response to the chaos of a “have-and-have-not” healthcare system (as well as a recession and a growing set of ethical dilemmas stemming from biotech), government is once again seen as the vehicle for an equitable and affordable system. This leads to a highly regulated, Canadian-style system, which is just beginning to be implemented in some places in 2008. Those who have more money get higher-quality care by paying additional fees.

By giving names to these four futures, we now have an easy way to talk about the flavors of current events. Yet these futures are not just extrapolations of current trends. Each describes a kind of threshold that the world must cross, a boundary to a different way of life. None of them – even the relatively utopian world of Pockets of Community – is a world in which the state of nursing, and health care, can remain as it is today.

Predetermined Elements

All four futures have some elements in common – “predetermined” facets of the world to come, facets that we can feel reasonably sure will come to pass, no matter what else happens. Most of these are well established; some may seem like clichés. But some of their implications may be surprising. The predetermined elements include:

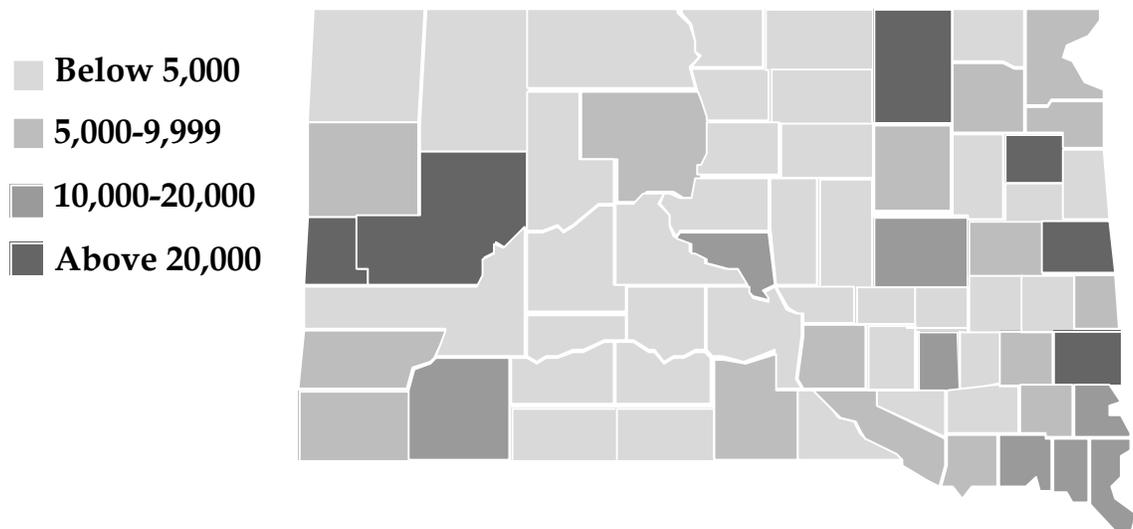
- **Population**

In South Dakota, the Native American population will grow larger and younger. The rest of the state’s population will decrease, and will (like most of the U.S. population) grow proportionately older. Unless there is a dramatic change in the economy (or other aspects of the state’s quality of life), younger people will continue to leave the state, settling in nearby metropolitan areas, just as they do today. Older people will continue to stay or return. At the same time, the average human life span will grow longer.

- **The “Empty Middle”**

As family farms decline and rural communities close and consolidate, people will continue to move from the middle of the state to the urban areas at the edges. There will not be enough people and resources to keep institutions like churches, schools, government services and rural hospitals operating in much of the central part of the state. Some people may have to travel hundreds of miles for health, legal, or even educational services.

Projected population in South Dakota counties, 2005



This map shows the character of the “empty middle” in South Dakota’s future. The lighter the county, the sparser the people. Only

the four dark counties are expected to have populations above 20,000.

- **Health Care Needs**

New diseases will continue to emerge, and spread.

- **Medical-Technological Change**

New treatments will continue to be developed. Biotechnology will continue to advance. "What we teach them in sophomore year is obsolete by the time they graduate." Moore's law (the doubling of computer power per dollar every 18 months) will continue to hold true during the next seven years. \$1000 will therefore buy devices with 16 times the speed and capability as their equivalent devices today.

- **Political Reality**

The basic nature of government, politics, and community relationships will not change. Influence and power will continue to come not just from preexisting status and position, but also from "showing up and doing stuff." It is also predetermined that South Dakota will get a new Governor before 2008.

- **Attitudes About Health Care**

People will not change their personal health habits significantly - some will adopt healthier lifestyles, but others will not. At the same time, most people will continue to view adequate health care as a right that society should grant. Specifically, the "save a life" ethic will continue: People will continue using every means possible to keep themselves and their relatives alive, no matter the cost.

- **Depleted Nutrition**

The nutrient value in food will continue to be low, or lower. Since 1973, this has dropped about 19%. The trend is linked to agribusiness farming methods, which deplete nutrients in soil over time while artificially inflating nitrogen levels.

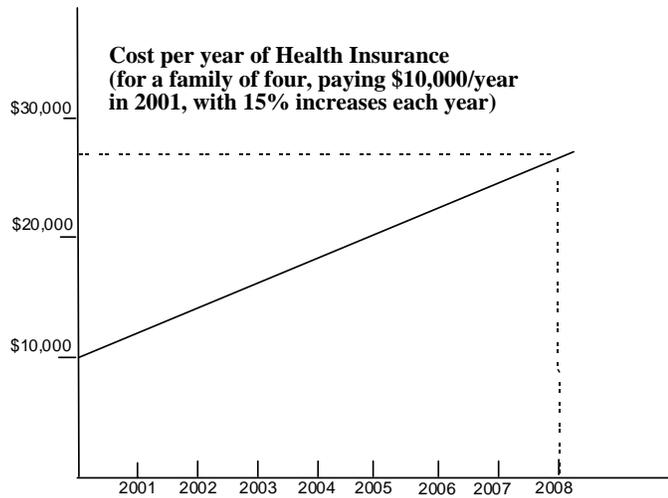
- **Medical Privacy**

The lack of privacy around medical records and information will be at least as great as in 2001; indeed, unless something is specifically done legally to regulate and limit privacy abuses, it will be greater.

- **Health Care Costs**

Efforts by managed care systems to reduce costs (through capitation, gatekeepers, etc.) will not work. The last 60 days of life will continue to be the

most costly. In 2001, health insurance costs are rising 15% each year. Will that continue? It is uncertain; but if it does, then the costs will be untenable, and the health care industry will have reached a cost crisis, long before 2008:



- **Insurance**

Health insurance will continue to exist as a product and an industry. Current trends toward distinguishing insurance populations will accelerate: People who are susceptible to particular diseases, whether through genetic inheritance or lifestyle choices, will be increasingly penalized by insurance companies through higher premiums.

- **Gambling**

It is not predetermined that gambling in South Dakota will continue, except on the Native American reservations (destination gambling). If local gambling (such as video slot gambling) continues, then the social costs associated with it -- addiction, young people without support, suicides, breakdown in social capital -- will continue as well. If it ends, then the state will need a new compensating source of revenue.

- **Nursing Profession**

It will be increasingly difficult to recruit nurses from other states to South Dakota -- especially if there is no concerted effort to find jobs for nurses' spouses. The number of men in nursing will increase 5-10%, unless there is a recession. As their work becomes more fluid and fast-changing, nurses will need critical thinking, priority setting, caring, and collaboration skills. The viability of the profession, as with all professions, will continue to depend on the presence of a community -- a critical mass -- of professionals. Public attitudes about nursing remain positive; they continue to be the most trusted of the major professions.

- **Educated Women**

As a group, South Dakota women will be well-educated in 2008. More women than men will attend graduate schools. For men who still work on farms, their spouses will often need to find jobs off the farm.

- **Social Capital**

Sociologist Robert Putnam credits “social capital” (the amount of time and effort that people invest in informal networks of civic engagement) as a key factor in quality of life and the viability of democracy. In his book *Bowling Alone*, he traces the rapid decline of social capital after 1973. Our group felt the continued decline of social capital was predetermined; even if any of it is regained before 2008, it is predetermined to dip first.

- **Family-owned Farms**

The number of full-time family-owned farms will decrease and disappear. Farming will become a part-time supplemental source of income. The number of people farming will decrease.

- **South Dakota Economy**

South Dakota will continue to have relatively low labor costs, compared to the rest of the United States. Agriculture will continue to be an important part of the local economy, but the attraction of high-tech support industries, like “call centers,” to the state will continue (to some greater or lesser extent).

- **Climate**

Winters in South Dakota will continue to be as cold as they have ever been.

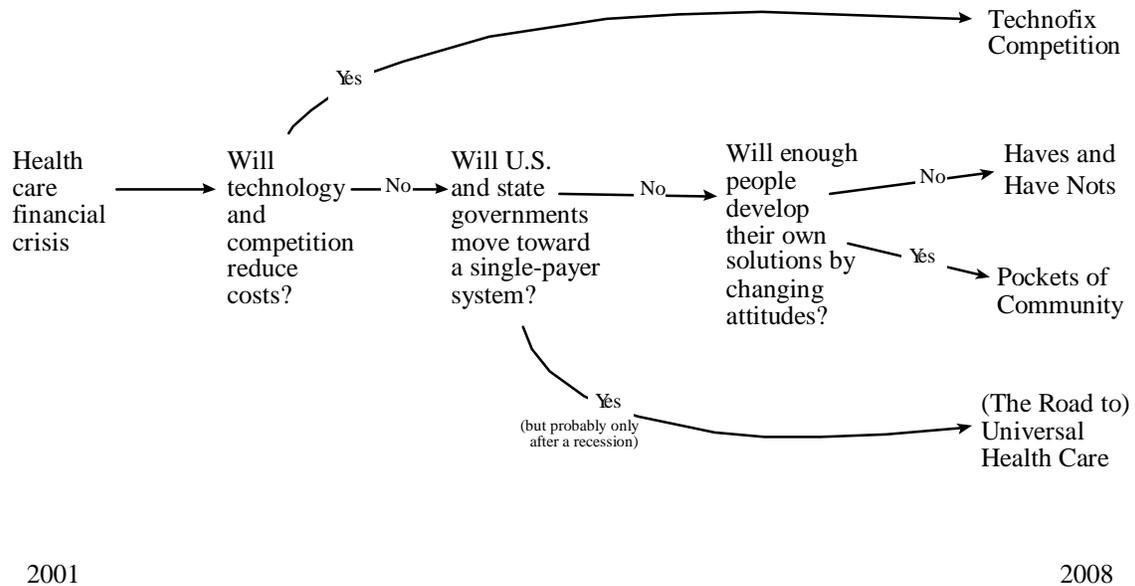
- **Most of all...**

Human nature will not change. People will still be the same mix of noble and ignoble, wise and ignorant, energetic and slothful, far-visioned and short-sighted. The only thing we can say for sure about each individual: He or she will be seven years older in 2008.

Four alternative worlds

The four futures described in the next few pages represent four imaginative pictures of South Dakota health care in 2008. They contain a general description, some notes about how they might evolve, comments on their implications, and a few “first-person” stories, as told by residents of each scenario. All of this material is drawn directly from our scenario exercise.

Each story represents a snapshot, not just of how the world might evolve, but of how some of us tend to think about the potentials of that future. None of these futures will come to pass; but if we are ready for each of these, we will probably be ready for whatever future does emerge.



Have and Have Nots

The year is 2008. Nothing, really, seems to have changed during the past seven years. But gradually, almost unnoticeably, the world has slipped over a threshold from difficult to impossible for many people. People live and work in an infrastructure perpetually on the brink of collapse. Computer technology is cheap, but nothing else is.

Health insurance premiums, in particular, have almost tripled since 2001. Premiums are so high that half the population is uninsured, and employers are going out of business, or offering cash payments in lieu of insurance. Those who tried paying them with credit cards ran over their credit limits long ago. Many people have a "bare minimum" form of coverage, or no coverage at all. The health care system, in hundreds of large and small ways, caters to people who can afford insurance; they are the only people who can enter a hospital these days without feeling like intruders. In other ways, as well, the gap between rich and poor, between privileged and unprivileged, is greater and more noticeable than it has ever been, even in a state like South Dakota, with its reasonable cost of living and small-town, close-knit community traditions.

Large tertiary facilities have closed. There are few rural facilities; they focus on "T&T:" triage and transfer. They tend to be staffed by nurse practitioners, linked by telephone and computer network to larger health care centers. People do not seek health care unless they are in a crisis. Access to critical care is still possible, but in danger of disappearing too. Some people, to keep their health insurance, agree to measures that would never have been accepted in the past. For instance, they waive their right to privacy, and sign agreements that if they contract certain chronic diseases, their insurance can be automatically cancelled. They even sign a waiver of their right to catastrophic health care in the last 60 days of life - a waiver which has been challenged in court, and the case is still working its way through appeals.

All across the country, nursing schools (and even medical schools) are having a harder and harder time recruiting qualified students. The best and brightest go into law and business consulting. Nurse salaries, and even physician salaries, have dropped noticeably because of the huge number of "doctor defaults" - health care account receivables that remain uncollected when the debtors declare bankruptcy. Because the bankruptcy laws have been so strict since the early 2000s, most of these people also lose their homes. These are sometimes converted into vacation homes for wealthy Texans who come to South Dakota to hunt.

Communities and church groups do their best to pick up the slack. There are hybrid fee-for-service programs. People trade vegetables for health care for their children. They go from day to day, hoping that they won't lose their jobs or get

sick. They stay home from work to take care of aging relatives. Life spans decrease. Homelessness increases. Industries concentrate where the wealthy are. People leave the state looking for work. The Argus Leader publishes an editorial with the headline, "Will the Last Young Person to Leave the State, Please Turn Off the Lights?"

- **Voices from the world of "Haves and Have Nots"**

Gladys, a 75-year-old retired woman in Lemmon

I used to be a physical therapist. My husband was a farmer. But when he contracted cancer, we lost the farm. We had no health insurance, and the co-payments for his oncology care were so enormous that our savings were exhausted within a year.

Frank was hospitalized 34 days that year, and it nearly wiped us out. I kept him home caring for him as best I could, but eventually I just couldn't manage it anymore. He lasted another eight months until he died. And I couldn't pay the hospital or the hospice bills anymore, so I had to declare medical bankruptcy.

I couldn't afford to live in Rapid City any more, so I moved in with my sister, who still owns a house in Lemmon. There isn't much of a town left. The school and the nursing home are abandoned now. Kids have to either go to boarding school in Rapid City, or get home-schooled. The only grocery store in town closed two years ago; now a Schwan's truck drives in every Wednesday and we put our orders online every Tuesday. Our mother and aunt in their nineties also live in the house, along with our uncle, who has Alzheimer's Disease. We all pitch in and help each other out. We garden in the summer and put stuff up in the freezer so we can live through the winter.

Things were going smoothly until the chilly winter of 2007. (inaudible) I fell on the ice and broke my hip. There is no clinic in Lemmon any more, so the ambulance came to take me to Rapid City. That cost \$8,000, and nobody covered that.

By now, of course, I'm on Medicare. Luckily, it pays for 20% of my first two days in the hospital. They did laser surgery and I was back home within 24 hours, because I couldn't afford to stay a third day. I didn't choose rehabilitation because I would have had to stay in Rapid City and pay \$1500/week for physical therapy. And no insurance covers that.

Since I'm a PT myself, I decided to manage my own rehab at home with support from my family. We check in with our cyber-nurse practitioner everyday via the Internet. I carefully record my vital signs, my exercise, and my range of

motion. While this service costs us \$200/day, it is far cheaper than traveling to see a real provider and waiting 26 months.

The church in Lemmon is helpful. We don't have a pastor except once a month, but we still go to church every Sunday. Ladies bring us food, and my friend Alma who broke her hip last year shares her medicine with me because neither of us can afford to buy our own.

There's a new administration in Washington, DC talking about including medicine in the Medicare package next year, but since that has never happened before (and they've promised it for eight years now), I doubt that it's likely.

We've been reading in the paper about the new medical cruises that have become popular; six weeks for \$2,000,000. There are laser surgery clinics on board, physical therapists, recreational therapists, aging consultants, and nurses and counselors available 24 hours a day.

We're holding our own as a family, but barely. And we pray each day that none of us get sick. We've managed to keep the house payments and pay the medical bills every month. We only hope to die peacefully in our own home, and not to saddle our kids and grandkids with our medical bills.

Some of our friends have taken their own lives when diagnosed with a terminal illness to avoid this. One of my daughters moved to Canada where she and her husband can take advantage of the healthcare system. If I had had any sense, I'd have moved there when I was still working so I could have it too.

Margaret, a 29 year old ER nurse in Rapid City

Both my husband and I are employed here at the hospital and have health insurance coverage through our work place. Even though our deductible is at \$2500 and monthly premiums are \$750 a month, we do have coverage for serious illness. We also have enough income to enjoy camping and fishing and an occasional trip to other states with our two children. I realize I am one of the more fortunate people in our society; I see patients and their families struggling every day to make tough decisions on care and comfort issues.

Families seek the very basic care in the emergency room because they are denied care in clinics, since they have no insurance to pay the doctor and clinic fees. Yesterday, I saw a 53-year-old man with no health insurance who needed chemotherapy but refused it, knowing it would bankrupt his family and drain any resources they had accumulated. We see more and more of this type of ethical dilemma every day.

Burt, a 55-year-old CEO of a major hospital in Sioux Falls

My second wife and I have 3 children and live in a fairly prestigious district in the southeastern part of the city. Our neighborhood is gated now, to protect our home from vandals and intruders who began to target the area 3 years ago. We just returned from our winter vacation in the Caribbean.

When I arrived at the hospital Monday morning, feeling tanned and well rested for the first time in months, I was greeted by a group of very angry nurses. They were furious over the recent insurance premium hike and the decision by the governing board and medical staff to close our free community health clinic. I tried to explain to the nurses that the hospital had no alternative, due to the rising cost of our services. We just added several new physician contracts, and I feel like the owner of the New York Yankees, signing up relief pitchers.

If the nurses only knew how much those contracts cost, I would be threatened with another unionization attempt. I have been able to survive the last two attempts but the troops are really getting restless now. Many nursing staff are opting out of the health coverage plan this year, and taking the straight cash pay out. We have had to garnish the wages of many of our workers for their hospital bills, but at least it prevents more of them from filing medical bankruptcy. I don't need another visit from the *Argus Leader* about that. The people visiting the clinic have skyrocketed and we need to refocus our resources in our acute critical care area, because that's where the money is.

My next meeting is with a group of family practice doctors who are complaining about the quality of their offices compared to the new orthopedic surgery. Given the reimbursement rates for those new orthopedic surgeries, it was well worth it. Too bad I can't say the same for the reimbursement rates at the family practice center. Building them a new office would be like building a new stadium for the Sioux Falls Skyforce. Actually, I need to inform the family practice docs that we are laying off the majority of the group and replacing them with nurse practitioners. It will save us a lot of money, and we can pay for those new "relief pitchers" we signed.

By the end of the day I am exhausted and long for the beach in the Caribbean. It isn't easy keeping all of those doctors happy and keeping the necessary workforce here in place. I reminisce about the "good old days" back in 2001 when there was so much more collaboration. Now the tension around here made my job much more difficult. At least the governing board recognized how much more difficult my job is and gave me a long-overdue bonus last month.

- **How we got to "Haves and Have Nots"**

It was not necessary to have a recession to get to this future. Indeed, the country (and the state) had been moving in this direction all through the boom

years of the 1990s. To be sure, the economic downturn of the early 1990s didn't help matters much – it led to the closing of several hospitals and a few large employers in the state – but it never got bad enough to force any significant change in the system.

And that was the problem. Premiums for health care continued to rise 15% per year. Bond ratings dropped, support programs without revenue closed. 33% The number of uninsured people skyrocketed, social issues worsened, homelessness increased. We continued to muddle through, knowing that while we might have our problems, by all standard measures we were still the most capable, most prosperous nation in human history.

- **Nurses in “Haves and Have Nots”**

Nurses have two choices in this future. They can remain within the existing health care system, or they can strike out as entrepreneurs.

Those remaining within the system see their practice increasingly oriented toward the “Haves.” They need strong clinical skills as well as an understanding of economic principles of healthcare to do their jobs. The second group, the entrepreneurs, spend much of their time (or all of their time) outside hospitals, teaching lay people how to be health care practitioners. Some of these nurses are parish nurses (associated with churches, and paid for by them). Others may be connected to schools, colleges, and local community centers.

Nursing education has changed visibly since 2001. In this future, fewer people can afford luxuries such as higher education. There are fewer scholarships, and education is more expensive in general. Some scholarships and student loans may be available from private industry and foundations, trying to counter the shortage of qualified health care workers. There are more sponsored faculty appointments, joint appointments, tuition reimbursement arrangements, and “Northern-Exposure”-style student subsidies involving deferred work obligations.

Nursing education is more oriented to the needs of the vulnerable population (and the tradeoff decisions that nurses with limited resources must make). Clinical experience with the homeless is a standard part of the curriculum; there is more attention given to understanding people from diverse cultures. Nor have we eliminated the need for tertiary and geriatric care; end-of-life and hospice work influences the design of nursing education. At the same time, the incentive for lifelong learning is not high. Once a nurse leaves school, it is generally assumed that she or he will not have much incentive to boost skills and remain current with technologies and methods.

Nurse-entrepreneurs, caring mostly for “have-nots” who pay directly (or not at all), will have to be innovative, resourceful and creative practitioners to

thrive. The nurse as the leader will provide care in many alternative settings, often without a physician available. Nurses will also (along with some social workers and educators) become primary advocates for the have-nots in legislative issues policy. For anyone who cares about humankind and ethics, this will be an exhausting future.

- **Implications of “Haves and Have Nots” for 2001**

Despite the references to “rich Texans” and snorkeling doctors in some of the stories, there are no villains in this future. Nobody, not even the wealthy, deliberately chose to live this way. Everyone is concerned about the deteriorating quality of life around them. Everyone feels caught up in a system they didn’t create, making decisions to just go along. But nobody is capable of doing anything about it, because they do not have any easy venue to work (or even talk) together.

In scenario planning, scenarios like this are often called the “Official Future.” They represent the future that would come to pass if the established institutions continued to prevail — in the sense that decisions would continue to be made to reinforce their view of “the way things ought to be.” Spend some time imagining that you live here. If nothing is done to change current trends, it may be all too easy to get here. This scenario raises the question: “How bad do things have to get before we recognize the need to change?” And it raises the question of leverage: Where is the optimum place to intervene to make the whole system better?

- **To the reader of this document**

What have we left out of this description of “Haves and Have Nots?”

What rings true? What doesn’t ring true?

What opportunities or challenges come to mind in this future?

Technofix

The year is 2008. Society has embraced technology, and it has radically changed the health care environment. Health care is far more universally accessible than it was seven years ago, but often not with face-to-face physicians.

We are still getting used to the many advantages of this environment. People can still live in rural settings without fear of losing access to good health care. Professionals are not tied to physical buildings and administrative bureaucracy. People can live and work almost anywhere they want. Education is available on-line, and the rate of people entering higher education programs has doubled. With robotic surgery prevalent, doctors can perform most procedures from vantage posts thousands of miles away. There is very little invasive surgery; microsurgery is commonplace. Tertiary institutions still exist, but few people need them. Procedures that were prohibitively expensive years ago are now very affordable; they are handled by a combination of technology, nurse practitioners, and consulting doctors at a distance. All medical systems and records, in a hospital and in the state of South Dakota as a whole, are fully integrated together. Robots and computers take care of many routine tasks now, theoretically freeing up professionals to spend time with people. (Somehow, however, they always seem to end up spending that time rebooting and resetting the machines instead.)

Yet there are also negative sides to this environment. It's an isolating system, particularly for solo practitioners in the many remote clinics. Technology often seems to take away the human touch. (If you want a "high-touch" medical experience, you have to pay extra for it.) Elderly no longer go to the doctor as entertainment; the row of self-diagnosing machines is not quite as entertaining (though it does remind some people of gambling machines). More significantly, this future has taken the impetus out of the holistic health movement. Most people believe that when they have a medical problem, there's a pill, shot, or laser cut that can "fix it" in an instant. And they are stunned with disbelief when they find out that, in the end, most of these instant fixes have unexpected consequences, even in the most high-tech environments.

Medical privacy is almost non-existent; it's too easy for insurance companies (or anyone) to obtain information records about anyone. There are also new avenues for fraud and abuse, including new forms of fraudulent medical risk management. And the ethical issues around biotechnology have never been resolved. One of the first human cloning facilities for infertile couples opened in Sioux Falls in 2006. They boast a 92% success rate, compared to only 71% for in vitro fertilization. (Back in 2001, IVF clinics were lucky to get a 25% success rate.) This clinic, and its ancillary businesses, have become one of the central features

of the new South Dakota economy. However, the cloned children have a slight tendency to chronic immune system disorders; and the picket lines opposite the clinic have been active every day since it opened.

South Dakota has embraced biotechnology in other ways, driven by the strong agricultural and farming entrepreneurialism in the state's heritage. Several communities along the Missouri river have set themselves up as "techno-havens," where people come together to experiment with micronutrients, technologically enhanced organic farming, bioengineering, and new types of crystallized organic building materials. These farms are associated with universities - not just SDSU and Iowa State, but the Universities of Michigan, Durban (South Africa), Moscow, and Kyoto. To attract these new ventures, the state has developed tax incentives and public/private partnerships. Schools are routinely wired into the internet, especially in the secondary schools, where children take advanced placement courses taught by faculty from all over the world.

- **Voices from the world of "Technofix"**

Eva, a 17-year-old living in Chamberlain

I live with my family. There are 6 of us at home, including my 75-year-old grandmother. My father is a CRNA. He loves it here because he can enjoy good fishing all year long, and hunt in season. He works for Avera, but he says it's a "virtual business relationship," because he really works in many different locations. My favorite hobby is reading. I have access to every national and international library. I can even attend virtual ballet and symphony, which was important to me when we moved out here. Because of the remote training I have received in my home ballet studio, I will advance my level to professional in the next few months. I have been studying long-distance at the Julliard Academy of Arts in New York. I am very happy that I was able to take this track of learning during my high school years at Full Middle High School. I am considering applying at several Ivy League schools for my undergraduate work. My parents want me to stay close to home for the first year or two, so I will probably take this course work through the virtual campus at Full Middle Missouri Campus. This is the demonstration campus that combined SDSU, USD, ISU, and DSU all right here. Even though they did such a great job of joining up all the tech and aggie schools, they knew they would need to bring the Ivies and Berkeleys here for all the former Silicon Valley families.

I am not sure what I want to do as an adult. I think I want to do something real with my body. Dad spends some of his time actually talking with people, but most of the time he is working from his "fidgit." He likes it when he can do anesthesia the old way, on-site, but this rarely happens now. Usually he wakes

up around 7 a.m. when the locals have the patient all hooked up to digitwires. Then he turns on the fidgit and the patient appears, in a vapor-like hologram on a table in our room. I can put my hands right into the surgical field because they aren't really here. There are personnel on site that assist Dad if he can't get good readings. They have never had any problems. There was one surgeon they used to worry about in Florida, because of his microtechnique, but since they refit his robotics and head gear, there haven't been any oversensing problems. Avera keeps some flying surgeons on standby in case of emergency. Dad says that's the job to have; they never work.

A lot of the guys my Dad used to work for live around here too, but they don't work for Avera. Some of them work through the fidgit, but some of them work for Geekoid, the firm that builds the fidgets. I guess they are working on something that will replace my Dad's role. I think that will be OK because he has a lot of other work too. He always wanted to go back to farming, so he started the Rich Soil plantation. We grow a lot of stuff, and once you eat it, everything else tastes like straw. The business is going really well.

My Grandma is doing well. My mom and the nurses from the nursing center have got a really good plan for her now. It took a while to figure out her circadian rhythm, but after a lot of observation, which was hard because Grandma kept turning off the camera, the computer printed out a personal plan. The message indicator lets us know if she is wandering or in harm's way. We set up her apartment to look just like her old kitchen and bedroom, and this helped a lot. I like the fact that we get to take care of her, and she isn't couched in with a bunch of elderly fruit waiting to get stale. She usually likes joining the virtual senior center in her hometown, where she can talk to her old neighbors. That also seems to keep her happy. When we are away, we use a combination of the skycam and humankind tenders to help her to be happy. Mom is really relieved this has all worked out. I wonder if I will be able to do the same for her?

Mary, a 47-year-old cardiologist living in Rapid City

I live in Rapid City because I love the outdoors, the Hills, and the climate in this region. I have an interventional practice, and technology has made my life so much easier. I now have a high-res computer in my home, interfaced with the dot-com system installed at the regional health center, which is headquartered in the warm climate of Arizona. A PDA allows me to assist with the management of my patient's medical care regardless of where I am. It holds all of the clinical information I need - lab, imaging, and pharmacy reports - as well as assessment information about the people I care for. The PDAs ensure that I am prescribing the correct drugs in the right dosage, with electronic signatures to verify identity. I can correlate all the information with the latest research as I review the renal functions, age, and co-morbidities of my patients. In addition, we now have

totally integrated clinical protocols and guidelines into these systems, so I can now practice the kind of “cookbook” medicine which my father adamantly opposed in the 1990s.

My father was also a cardiologist. I remember that he protested when nurses in the hospital were told to reduce variation in our practices. Efficiency experts had observed those with “good outcomes” versus those with less consistent outcomes; they had pushed the nurses to consider using the same practice standards for care with everyone. As you know, the oncology world has been a leader in this field.

My life as a doctor is very different from the life my father led. In 2001 I spent approximately two minutes at the bedside of each of my patients. Today it is not even necessary that I see the person, unless the patient demands face-to-face contact. It’s not a priority for me, and it’s less and less important to them. The techs in my lab handle almost all the routine work; the rest of it is computer-assisted. Today, I have much more time for leisure, and to spend with my family than he did. Of course, I make less of an income. The government has determined that my body of knowledge is not as unique as it once was; it is simpler to find and more standardized. Thus, the payments I receive from HCFA related to RBRVs have decreased significantly.

I have to admit that many of the people whom I work to care for would not even be staying in the hospital if they had arrived in a timely fashion, listening to what their bodies were saying to them. The missing link is nurses. In my father’s day, nurses were the backbone of the care that patients received. Today, they are no longer needed for the technical components of the role; the techs handle that. Nurses are there to address the human side of the work. They comfort and counsel people, so I don’t have to.

Steve, a 71-year-old living in Sioux Falls.

I’m a native of Sioux Falls. I don’t look 71, because I take pretty good care of myself, but I am slowing down a bit. My wife and I live here with her parents who are getting quite elderly and frail. Both have some memory and mobility problems. That’s to be expected for 90 year olds.

Our daughter Kirsten is a pediatric nurse, and most of the time she helps us with our health problems, at least advising us when we need to contact a nurse practitioner. In my spare time, I read the medical web sites and serve as the consumer representative to the Colleagues for Caring and to other groups who have worked together on nursing and health issues. I became involved with them in 2001, right when we were dealing with that big mess with healthcare.

When my daughter reminds me that I need to check in with my nurse practitioner, I contact her through the Net, and talk with her over my little handheld computer. I haven't had to visit a doctor in years. That's good, because the only traveling I like to do is to go to the college meetings and to the community center and church. That takes care of my spiritual and social needs.

Here in our house, we have pretty much what we need to take care of ourselves mentally and physically. Our fitness room has a treadmill and cross-trainer, in addition to free-weights and a bench. All four of us work out daily. The treadmill and cross-trainer have cardiac monitors, and help us maintain heart rates within our aerobic range. Since I have Type I diabetes, I also have my insulin pump. It monitors my blood sugar continually, along with my metabolic rate. I check on them regularly, as well as my cholesterol readings.

My wife and daughter like to remind me of the way I used to measure my blood sugar in the old days. They wonder why I refuse to have a stem cell pancreatic transplant. I guess I'm old fashioned. But I have to admit they may be right. Even my grandson has been genetically altered. We found out that he has the predisposition for [please fill in] disease, and he's receiving genetic therapy right now to prevent him from having skin allergies. Well got to go; time to exercise.

- **How we got to "Technofix"**

Back in 2000, the Institute of Medicine produced a landmark report that indicated that 98,000 lives could be saved every year by reducing medical errors. The healthcare profession responded with the introduction of automated processes, and by investing in high-tech interfaced information systems. The investment was less and less expensive, because Moore's Law (the continual reduction of computer power cost) did not simply continue; it accelerated.

It was clear that a meltdown was coming. Around the country, medical professionals decided to use technology to decrease health care costs and increase quality of care. The AARP, the government, and the "medical-industrial-complex" all put their muscle behind the promotion of new technologies. Physicians saw the potential benefits; insurance companies noted the ways that telehealth could drop costs. Congress, by subsidizing some health information networks and reducing the regulations on privacy, made it more feasible.

Today, a critical mass of people are connected online. At the same time, biotechnologies have been rapidly deployed – and, even more importantly, rapidly accepted. Even groups who were considered resistant have changed their approach. There was a meeting of Native American groups not long ago, aimed

at finding their own way to adopt increased computer use. They are also beginning to use the alcoholism prevention pills that Celera Genomics released last year.

- **Nursing in “Technofix”**

Nurses play a major role in this future, not just because they are cost-effective health care providers, but because they embrace technology. They embrace it because it empowers them. Or, as a popular bumper sticker puts it in 2007, “Nurses are geeks.” There are dual degrees available in Computer Science and Nursing. It is easier for nurses to assess and document patient care, and thereby provide better care, than it is for physicians.

Nurses are also becoming known as public educators. They are increasingly turned to, not just for counseling, but for intervention, teaching, coaching, counseling, and referrals. There are nurses’ stations in coffee shops and airports; tele-nurses and phone-in nurses; and nurses set up to advise home techs and all of humankind, teaching people how to interpret their self-monitoring devices in their homes. Comparatively few nurses still work in major hospitals, providing critical care. Patients tend to go home earlier, but remain monitored by computer for a very long time.

Technology draws health care workers to become more like business people. Since technology is always advancing, new training in areas like ultrasound are always needed. Nursing schools now offer lifelong learning programs that are increasingly popular, with courses in entrepreneurial health care, technology, counseling, and ethics.

It’s easier to recruit nurses in South Dakota because the economy is better. Since more people have high-tech jobs in the state, there are more jobs for newly recruited nurses’ spouses. Indeed, some critical mix of high-tech jobs, perhaps involving biotech or medical technology, has led to a specialized renaissance in the Sioux Falls area.

- **Implications of “Technofix” for 2001**

In this future, *deus ex machina*, the sudden miraculous savoir of Greek drama, literally comes to pass. (The word literally means “God from the machine.”) Technological change turns out to be powerful enough to overcome the dire forces of health care costs and lowered quality of life. Not only does technology have the power to simplify our lives (once you cross a threshold), but it can ameliorate the financial tension in healthcare today.

And there is reason to think this future is plausible. Moore’s Law is a powerful driving force; when computers double in power per dollar every 18

months, then anything can happen. The accelerating power of genetic engineering (along with other medical research) could further enable this future.

It may not happen by 2008. Nonetheless, something like this future is probably predetermined to emerge sometime in the 21st century. Nurses, either as individuals or as a self-contained profession, will have very little control over the evolution of the technology; its fate is out of your hands. But you have a lot of choice about how you react to it, how soon you prepare for it, and ultimately what its effect will be for humankind.

In “Techno-Fix,” the delivery of healthcare becomes swallowed up into other kinds of infrastructure. It will be up to nurses, in particular, to stand up for human contact as a social good; and to insist on the development of social capital. Nurses may also develop a special role (if they are up for it) as opinion leaders about some of the ethical issues to come, particularly those related to fertility, adoption, childbirth, and control over sexuality. In short, as medical technology changes human capability, people will turn to nurses to help them make sense of their terrible new powers and dilemmas. Will nurses be ready for this role?

- **To the reader of this document**

What have we left out of this description of “TechnoFix?”

What rings true? What doesn't ring true?

What opportunities or challenges come to mind in this future?

Pockets of Community

The year is 2008. Traditional health care has failed most people. So have other opportunities. Many people have given up – but some have found a new set of opportunities in their local towns and neighborhoods. They are thinking differently about the places they live; trying to live balanced lives with little money, working together to make the most of the resources they have, and investing in each other.

In some communities, this takes place around the school. In others, it takes place around a cooperative business. And in others, the seed crystal is the health care crisis. Nurses become the organizing spirit, the glue, the linkages, that allow people to help each other in ways that haven't been seen since the Great Depression. In some communities, the people involved are related to each other; in others, they are not. In some areas, the impetus comes from elderly people who have moved to South Dakota (or stayed there) because the cost of housing is low.

In rural areas, in particular, nurses coordinate and set up nutrition, exercise, and health promotion. They bargain for assistance exchange services. Instead of “paying for illness,” as the old medical model was set up to promote, people invest in health. They hope they won't need hospital care, and they focus on the activities and mutual support that can keep them well.

One factor that contributes is the shift to minimal insurance policies. Insurance companies have learned to lower premiums for people who don't use their hospital coverage. A few hospitals, picking up on this trend, have morphed into experimental community centers.

Only 20% of the population of South Dakota (and, by extension, of the nation) are in such “pockets of community.” But it's enough to make an impression on the other 80%. These new centers have gone unnoticed for several years, but they are now becoming more visible. It's hard to label them, because all of them are different from each other. The strength and richness of this future lies in its diversity.

● Voices from “Pockets of Community”

Connie, a 50-year-old woman in Hartford

I love my town. We are 800 people, but we've always had a wonderful way of living, almost as one large family. My husband has worked the land on our family farm for 25 years. I've always been somewhat self-sufficient, as I've taught Math in Hartford High School for years. We have a son who graduated from

high school and luckily he scored very high on his SATs and got a full scholarship. We were not sure how we planned to get him to college otherwise.

My 78 year old mother lives with us. Dad died many years ago. We are very grateful for Sarah. She is our co-op nurse. And we thank God that I still have insurance from my work. We only have to pay a low premium, but you have to be really ill in order to access it. My mom is on Medicare.

Sarah is trained as a nurse practitioner, and she grew up around here. About four years ago when we lost our local hospital, she organized us to start our own cooperative clinic. She also helped us to understand that we had critical family decisions that we could make to improve our health. Well it's been amazing what's happened since that meeting. We made a community decision to develop a health co-op, and Sarah makes this work. Each person in town that wants to participate pays \$25/month. Dr. Bill in town wasn't interested at first, but ultimately he decided to participate in the co-op, providing an annual health physical for \$10.

We have people come into the Church and they exercise three times a week. Sarah has brought Herbalife nutritionists to town. Who would have ever thought that at some time I would take a vegetable taco for my lunch at work? We also got a pharmacist from Sioux Falls to give us a co-op price on all of the prescriptions that we order. For my mother, it reduced her cost by \$150/month. Dan and I have both reduced our cholesterol and both of us seem to be feeling much better. [Note: Much of this was inaudible, so we lost a lot of detail. Sorry.]

John Chancer, 41, living in Sioux Falls

I came to Sioux Falls on a dare to myself. I had heard about "The Prairie Promise Project" and it caught my imagination. It is a community health care project originating from the expressed concerns of people in various Sioux Falls neighborhoods. I'm sure it is a response to the health care institution collapse. I've been a clinical nurse specialist in Community Health for the last 15 years. I came from Seattle, WA where I had been in a case management role for over 10 years. I wanted something new and exciting; I have found it here. I share a three-bedroom condominium in Prairie Trees Estates with two other colleagues, Donna Stand-Alone and Joseph Longing. We all like to golf so it is a good place for us to live. Before describing my roommates' contributions to what is happening here in Sioux Falls, I would like to describe my own involvement in "The Prairie Promise Project," which has several community pocket projects.

I work in a partnership model that exists between Sioux River Valley Community Health Center and Augustana College Department of Nursing. The project is called "Main Street Meanings." As a clinical nurse specialist I spend my

time in the soup kitchens of Sioux Falls, the drop in centers for the homeless, and the bus depot. I make myself available to individuals and groups and work with whatever their health concerns are. I practice from the theoretical framework of Rosemarie Rizzo Parse's theory of human becoming. This perspective honors the human freedom to choose their quality of life. It establishes that the nurse's presence with others is of primary importance; what I believe about other people, and how I conduct myself with them as a nurse, greatly impacts what happens to their health. Many of the individuals I come in contact with, I refer to the Sioux River Valley Community Health Center for medical treatment. The community health center is seeing three times the people they saw last year. Most of the new clients are my referrals. My practice continues to grow to the point I need more clinical nurse specialists to work with me.

My colleague Donna Stand-Alone came from Texas. She was recruited because she is a full-blooded Cherokee with a Master's degree in nursing. She has helped develop the "Dreamcatcher" neighborhood project, where she works with the medicine woman Spider Woman. Donna is skilled in therapeutic touch and massage, and is certified in community health and adult health nursing. Together, Donna and Spider Woman (who conducts sweat lodges, healing ceremonies, and naming ceremonies) address a variety of health and quality of life issues. The native American population in Sioux Falls is starting to take an active interest in endorsing the Dreamcatcher project; they are seeking federal funds to ensure ongoing support for this project, which was first funded by a philanthropist using gambling casino money. Donna is also enrolled in a 6 week summer PhD program and has four years to complete the program. When she is gone those weeks she is paid as if she is working, and the health centers contribute to paying her tuition costs. I might think about doing this too, as it is a great way to get an education.

Joseph, my other roommate, loves gardening. Besides working in a Head Start program in the city, he has been named as responsible for "Project Rabbit." This is a neighborhood project concerned with helping people establish gardens to help meet their nutritional needs. At garden sites there is also a mobile health clinic van staffed by a Family Nurse Practitioner. Project Rabbit also focuses on nutritional and gardening issues on a national and international level, and is involved with shaping public policy.

The hope in our projects lies in the fact that we are part of an organized, meaningful whole. But we have recently been asked to present our model at national and international health care meetings, and we will need to center on surviving the undertow.

- **How we got to “Pockets of Community”**

In the mid-2000s, there was a clear movement toward a future of “Haves and Have Nots.” Healthcare costs rose continually, despite a variety of efforts to cap them. 40% of the poor population was uninsured. Many elderly people couldn’t afford to pay the rising co-payments of Medicare. Small employers stopped covering health insurance for their employees. Working single mothers were particularly vulnerable; often, they were likely to become homeless. South Dakota also had a growing number of refugee and immigrants disenfranchised from most healthcare and other services. The Native American population, meanwhile, were also struggling to regain their culture; they were more distrustful all the time of the “official” government services on which they ostensibly depended.

Institutions lost much of their funding through the decade. Write-offs for the uninsured became unbearable to institutions, so they capped the amount they would spend on the uninsured. In a few communities, consumers began to get together and invest in each others’ wellness. It only took a couple of examples, spreading through the state networks of nurses, for health professionals to realize that they had a great deal of leverage – creating not just new jobs for themselves in the face of layoffs, but high-quality lifestyles. The first such family nurse practitioner clinic was established in a small town; the second, in a city neighborhood. They both became models. They included nutrition counseling, community health centers, physical therapy, and labor networks. Based on the “Hours” model developed in Ithaca, New York, some local communities developed their own local currency; plumbers and electricians, for instance, swapped their time in exchange for health care.

Some resistance came at first from the remaining health care institutions; but a few farsseeing administrators began to realize that these communities represented a path out of the unsustainable, high-pressure, current health care system. They began to set up neighborhood networks on their own. This could only take place because of a movement of deregulation – for example, relaxation of rules to allow nurses to offer free medical examinations in informal settings. Any source of funds was used; Medicare and Medicaid block grants, private philanthropy, and the creative use of prevention insurance (lower-premium insurance that partially covered the costs of nurse-run clinics and alternative providers).

One or two of these communities were closely linked with university nursing programs, in education/service partnerships that drew creative innovative nurses from all over the country to live and learn together. South Dakota became a place to study for people trying to redefine the concept of professional care, anywhere in the world.

“You don’t think your way into a new way of living,” was the motto of one such community. “You live your way into a new way of thinking.” This was a slowly growing, organic movement. It started out small, and it could never be simply rolled out everywhere. It would only thrive where people were willing to invest in it – sometimes because they had no choice, and sometimes because it fit their deepest hearts’ aspirations.

- **Nurses in “Pockets of Community”**

Nurses are experts in the center of many of these care communities. They are poised to assist in the community, and can do assessments. They can act as health counselors or coaches, and set up networks with other nurses, other professionals, and citizens. Nurses are also advocates. They have the time to do long-range planning, and are “politically connected.”

This future is possible, in part, to the extent that schools educate nurses to be entrepreneurs, community mobilizers, collaborators, and reflective advocates. Nursing school now teaches students how to listen to the communities where they work and the needs of the people that they serve. The education of nurses is seen as paramount; the “intangible” benefits of nursing (quality of care, high touch) are recognized and valued.

- **Implications of “Pockets of Community” for 2001**

There’s a lot of diverse activity in this future; its richness and strength stems not from any particular “right way” of organizing communities, but from the variation. Pockets can not exist without both financial and community support, but the nature of that support is varied, even from one town to the next.

This future may seem idyllic, but it involves a lot of hard work and counterintuitive thinking. Nurses, educators, and social workers are often at the forefront of the change, and they have to change their attitudes – to learn to trust each other and work together more than they have in the past.

- **To the reader of this document**

What have we left out of this description of “Pockets of Community?”

What rings true? What doesn’t ring true?

What opportunities or challenges come to mind in this future?

(The Road to) Universal Health Care

The year is 2008. The recession is almost over now, but the memory of it still lingers. Governor Thune is in his second term; President Daschle is running for re-election. He's running on a platform of instituting throughout the "South Dakota Plan" throughout the United States. The name is not quite fair, because the "Plan" has been adopted in half a dozen states. Like welfare reform before it, it is moving from the states where it has "worked" to be considered at the federal level. It is popular because it represents a government response to a long-festering problem. The response is a single-payer universal health care system, and it looks like it could finally pass.

This is not a luxury plan. It's known as the "skateboard" package: everybody gets a pair of wheels, and those who can afford more can buy their own Cadillacs. Most health care is provided through facilities connected in small towns to nursing homes or hospitals, often managed by nurse practitioners, with very limited catastrophic care allowances. An expanded Medicare program is the basic benefit package.

The level of chronic illness was supposed to level off, but it is actually increasing, because too many people continue their old, unhealthy lifestyle. But gradually the incentives toward healthier living are making an impact. Immunization rates are up. Fewer people smoke. Nurse-practitioners are thriving in independent practice. The video lottery is gone, and state taxes are in place.

We live in a highly regulated world; the recession made people more tolerant of government control. There is a lot more documentation needed, partly because there is more opportunity for fraud. At the same time, however, the organizations are slimming themselves down. The single-payer system is cumbersome at times, but not as cumbersome as the old insurance systems. Nurses are freed up from most of the administrative duties, like processing forms; those jobs are conducted by aides and outsourcers, freeing nurses to spend time with their patients. Or to conduct community health work. Most hospital billing around the world is largely handled by one of two companies – one in Ottawa, and the other in Arizona.

The South Dakota model has fixed one major flaw in the Canadian model of health care. The Canadian system never included support for upgrading and maintaining infrastructure: buying and maintaining equipment, keeping up the buildings, and installing the kinds of new technology that leads to cost controls. New methods of assessing healthcare success have been developed, and both the healthcare professions, and the public at large, are getting used to talking about

them. This future is called “the road to” universal health care because we’re not quite there yet; but the path ahead is plain and inviting.

- **Voices from “(The Road to) Universal Health Care”**

George, age 41, living in Sioux Falls

I’m the director of a Sioux Falls shelter for battered women and children. A few years ago, I didn’t know what I was going to do. There were more people every day needing our services. We had no more room and all the other shelters were overrun by the disenfranchised from all over the state. We had no money to help them with the healthcare they needed, especially for the children.

I was sensitized to this because my wife has a good paying job at the hospital as an RN in the critical care unit. I’m thankful for my family, my wife, and my five children. Two of our children are birth children. The other three we adopted (inaudible). Years ago we bought an acre outside of town where we are able to grow much of our own food organically.

Two years ago, we heard that the state government was going to provide a basic health care package for everyone. I couldn’t wait to see it. Now it’s here, and it has taken a lot of the pressure off. But it hasn’t lived up to what I expected. I would like to see more...

Elizabeth, age 62, living outside Aberdeen.

I am still very active in nursing, since people don’t retire like they use to. We work and continue with society as long as we’re able. My rural housing group is where I provide most of my services. The other people in this community bring their children and family members into the community center.

Everyone is on the universal healthcare plan. In our group, treatment begins primarily through nurses. We accept the patient, conduct the initial interview, and consult with the computer physician if necessary, for treatment and follow-up. We do most of the things that primary care doctors would have done in the past. The doctors mainly reside in the large cities. If our patients need acute types of services like surgery, we contact the insurance carrier for direction. If they determine that the procedure can occur, then our patient is placed on a waiting list. If the procedure is denied, then we inform the patient that it is not warranted treatment and we will follow up with Medicaid-authorized measures.

Births are handled by the nurses here in the birthing room, authorized by the insurance company. It’s a very community and family oriented thing we have

going here. We don't have a school building, so this is our community focal point.

- **How we got to “(The Road to) Universal Health Care”**

In retrospect, it's clear how much the recession of 2002-2003 was driven by health care costs. Hospitals were closing throughout the country; corners were cut. There was not just a financial crisis, but a crisis in quality of care. In the days following the Aetna-Microsoft merger, the ethical ramifications of insurance became a focus of public attention. How appropriate was it to spend 80% of health care costs on the last 60 days of life? How much money should be spent on costly operations for people with marginal quality-of-life outlooks? Such questions were increasingly debated in news shows and even in state legislatures – including the South Dakota legislature.

Health care reform, this time around, represented a natural evolution from programs already in existence. Medicaid covered the uninsured. Health insurance for government employees had grown every year. These were combined with Medicare, Indian Health Service, and Veterans Insurance into one large bureaucracy – which, surprisingly to some, worked better than the individual bureaucracies had worked before. The “haves” of the state were paying an average of \$26,000/year in premiums, some of which was tax-deductible. Meanwhile, the social costs of “have-not” health care were becoming enormous, much of it in emergency rooms. Aging and crime had increased; rural hospitals were closing. Medical bankruptcies were more prominent than ever. The “haves,” essentially fed up with the cost of supporting the “have-nots,” recognized that there was no acceptable way to shut the doors of clinics and emergency rooms. So they turned to a single-payer plan as a last resort.

Some interested players, including a portion of the AMA and some of the larger health care companies, protested; but it was startling how little opposition there was, in the end. One factor that made a difference was the recognition that some health professionals, including nurses, were willing to see their roles change under the new system. Nurses were also evident in their willingness for rule-making to be a relatively open process. “If people perceive it as regulations from above,” said one nursing association leader, “it's just not going to get that far.”

- **Nursing on “(The Road to) Universal Health Care”**

The new health care infrastructure in South Dakota has provided a great opportunity for nurses to demonstrate their capability as leaders. Nurses set up their own demonstration projects these days, looking for grants and funding on

their own. Some nurses have become lobbyists, advocates, and even legislators, advocating for marginalized populations, higher standards, and private practice.

Nursing care is highly regulated in 2008. It is critical, therefore, for both higher education and health institutions to have nurses with PhDs available at least on a part-time basis. Increasingly, nurses have become the gatekeepers to health care services – the point of first referral. They are case managers and even primary care providers. This makes hospitals a very different place than they were back in 2001. Nursing education increasingly includes training in policy making, political processes, and research.

- **Implications of “(The Road to) Universal Health Care” for 2001**

As the old saying goes, “be careful what you wish for.” In this future, nursing and health care in general are very highly regulated. Nurses may be influential in this regulation, but at any moment the influence could change. The parameters are all defined by someone else – first, the state legislators and then eventually Congress. Assessment is mandated. There is not too much incentive for learning, even in the face of new technology.

On the other hand, this future suggests that it is possible to create a government-organized infrastructure that works, in which the rules and regulations are not *too* constraining. It all depends, perhaps, on the ability to develop an emergent, self-organizing process, in which the rules are not “rolled out” to all fifty states at once, but instead develop a frame of operations on their own.

- **To the reader of this document**

What have we left out of this description of “(The Road to) Universal Health Care?”

What rings true? What doesn't ring true?

What opportunities or challenges come to mind in this future?

Some early indicators of the four scenarios

- **Early signs that “Haves and Have Nots” is coming**

- Slow, but enduring recession

- Corporations drop health care benefits

- Sharp increase in medical bankruptcies

- Newspaper articles about people who have sacrificed other aspects of their lives to pay their health bills.

- Accelerated hospital investment in “have”-oriented facilities.

- **Early signs that “TechnoFix” is coming**

- Competition in long-distance health care

- Employers take charge of prevention, penalize with higher premiums if you don't quit smoking, clock your weight when you come to work, etc.

- Computer-enabled variable premiums

- Increased popularity of do-it-yourself health monitors.

- **Early signs that “Pockets of Community” is coming**

- Increasing popularity of alternative medicine.

- Growing use of “medical information” networks.

- Communities of seniors organize.

- Philanthropists begin to fund self-organizing community health care projects.

- Churches get more involved in health care

- A few “company towns” emerge with health care (nutrition, exercise, mutual support) as an integral priority.

- **Early signs that “(The Road to) Universal Health Care” is coming**

- Consolidation of health care programs.

- Political attention (in South Dakota and nationally) to the “health care crisis.”

- Employers and businesses press for government-organized insurance systems.

- Ira Magaziner elected to U.S. Congress.

Options

- Key

 "Must-do" ("If we haven't taken this path, we will be in trouble in this future.")

 Positive ("In this future, we will be glad we took this path.")

 Neutral. ("Taking this path will have made little difference to us in this future.")

 Negative ("In this future, we will regret we took this path.")

 Unknown ("We don't know whether this option will succeed in this future.")

	HHN	Techno	Pockets	UHC
A. Organizing support for team-based health care practice.	 Teams may include lay people	 Yes, but flexible. Teams are for specializations. Technical people will be part of team, for tracking, data, info, etc. Teams will look different - virtual, remote, collecting stats. A Florence Nightingale approach.	 Some may have 1-2 practitioners, some will have more. Teams include lay people.	 Yes, very important. Will keep costs down, and many more people will be seeking services. Some services will be subsidized.
B. Reconfiguring education to support programmed lifelong learning for nurses	 Programs need to be accessible, convenient for every nurse. Include learning components - mentors and JIT.	 Nursing programs need to specialize. Nursing faculty will have to figure out how to learn about technology.	 Need entrepreneurialism.	 Need business and managerial savvy

<p>C. Adopting a role as political activists; collaborating with AARP to create a voting bloc in favor of quality health care. (AARP will be @ 23% of the state population.)</p>	<p></p> <p>As elderly grew older they moved into Have Nots. Helps provide angry voice for leverage.</p>	<p></p> <p>The elderly have the time. We can develop a group that embraces the technology and comes up with creative solutions.</p>	<p></p> <p>Elderly may be a prototype. They are a policy-making voting bloc; potential philanthropists ; have time and talent for creative initiatives.</p>	<p> </p> <p>Might be detrimental. The elderly may believe that “we made it on our own, our children can too.” Or they may want to make things better for their children and grandchildren.</p>
<p>D. Act now to develop nurse competence as administrators and generalists.</p>	<p></p>	<p> </p> <p>Needs rural nurse relationship to technological applications. “Geek component” Mixed with rural thinking, it will help deal with sense of isolation.</p>	<p></p> <p>Prerequisite</p>	<p> </p> <p>Nurses will need good leadership qualities to understand benefits. They’ll be the provider, case manager, will help people negotiate system. Critical for stepping into the role of gatekeeper -- or others might.</p>

	HHN	Techno	Pockets	UHC
E. Don't add supply; take no steps to increase the recruitment and development of nurses.	 <p>Has get what is available. There is a major crisis. Somebody else does the work - nurses will be replaced or substituted for. The quality of life goes down.</p>	 <p>Demand will drop on its own. A different kind of education will be needed; society may not need as many nurses. Nursing moves away from nursing professionals. The critical issues become standards and clinical outcomes. Quality of life slips over time.</p>	 <p>There won't be as many pockets. Some will emerge, but other people will be running them: there is a shift of nurses into pockets.</p>	 <p>This is the worst case scenario for supply and demand. Everything becomes more difficult. Doctors will have aides and no nurses, substitutions will be made.</p>
F. Offer higher salaries for nursing faculty in South Dakota		 <p>To attract geek PhD nurses.</p>		
G. Support for Baccalaureate through PhD, and scholarship for future faculty. This is a "grow your own" higher ed policy.				
H. Create a support system for women in Masters and PHD Studies				

<p>I. Build consulting practices linked to universities. Develop new types of university department structures.</p>	 <p>Suggested in the discussion of this scenario.</p>			
<p>J. Create new types of faculty structures (challenge the doctoral requirement for faculty)</p>	 <p>Provides leverage.</p>	 <p>Can't aggregate big enough audience.</p>		 <p>Nurses can acquire data, but can they use it effectively?</p>
<p>K. Develop new types of financial supports for nursing students here</p>				
<p>I. Develop new types of financial support for South Dakota nursing students studying out of state.</p>				

	UHC	Techno	Pockets	HHN
J. Establish differential compensation, based on differentiated competencies.		 Employers see the differences in nurse capabilities. An AD nurse might be hired with a Compsci degree.	 Employer sees the difference.	 Case management competency is a clear difference.
K. Encouraging entrepreneurial systems and business creation by nurses, operating in independent practice, education, and consulting.	 Less important.	 Very important.	 Most important.	 Has high resistance and low pay. There is no sustainable funding. The greatest opportunities are with the have nots.
L. Taking on a higher-profile policy rule.			 Hard to do right, but you look like a hero if you can pull it off.	 Hasn't helped very much. Might have been wise to have policies in place, better than not having been there. Tried and learned.