Cooperative Extension Service's Potential To Meet the Needs in Rural Health Education and in Rural Institutional Development

MARVIN E. KONYHA, PhD

THAT THE HEALTH CARE needs of rural Americans are greater than those of urban Americans is well known. The factors associated with this relative health disadvantage of rural people are well documented. A widely dispersed population, lower levels of income, less available medical facilities, fewer services and trained manpower, and less extensive coverage by health insurance are part of the long list of oft-repeated factors leading to rural Americans' relative health disadvantage *(1,2)*. Knowledge of these various factors is helpful in understanding rural-urban differences and is essential in the design and operation of the nation's health care delivery system.

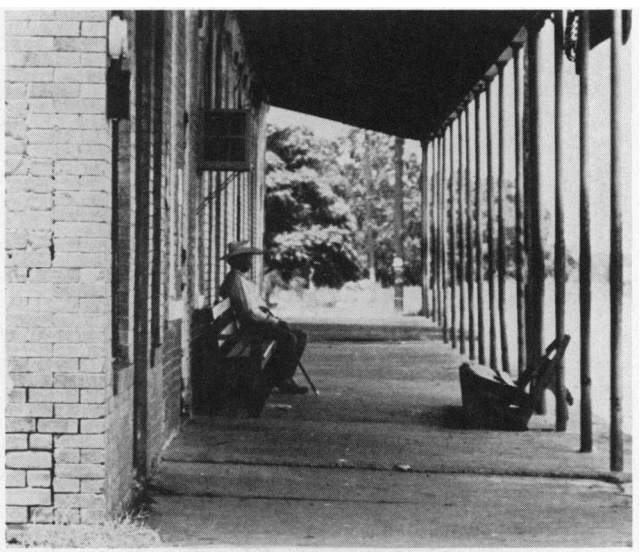
Changing People or the Environment

As with any social welfare issue, the basic alternative courses of action in the area of rural health are to effect changes in people or in the environment *(3)*.

Changes in people to improve their health would include modifications in their behavior vis-à-vis preventive health practices and in their utilization of health care services. Such modifications will be made only when *(a)* rural people are aware of the behavioral changes that need to be made, *(b)* learn how to make these changes, *(c)* perceive both the economic and social incentives for doing so, *(d)* and have access to adequate health treatment services and facilities when they are needed.

Changes in the environment would include increasing trained health manpower, improving the methods of financing health care expenditures, and increasing health services and facilities, including institutions that emphasize preventive health practices.

Maximum improvement in the health status of rural people will require changes in both the environment and personal behavior. In much of rural America, however, changes must take place in the environment before significant changes can be made in personal behavior. The institutional structure of the health services delivery system has to be altered. Once such environmental changes are made, rural people respond positively by increased utilization of the system *(4)*.



Residents of rural communities have benefited little from national categorical health programs

A number of efforts are continually underway at the national level to effect changes in the health care delivery system. Such health legislation as Medicare, the Hill-Burton Act, the Regional Medical Program, the National Health Service Corps, the Emergency Medical Services Act, and the Health Maintenance Organization Act illustrate such efforts. With the possible exception, however, of the National Health Service

□ *Dr. Konyha is program leader for Manpower Development and Community Facilities, Community Resource Development Section, in the U.S. Department of Agriculture's Extension Service. Tearsheet requests to Dr. Marvin E. Konyha, Extension Service, U.S. Department of Agriculture, Washington, D.C. 20250.*

Corps and some specific programs for Indians and migrant agricultural workers, few benefits of these programs reach rural people on a scale commensurate with rural needs *(5)*. Few of these categorical programs appear to function well in rural areas.

There appear to be two basic reasons for the poor functioning of the health programs: *(a)* existing nationally funded health programs achieve inadequate rural outreach because the rural institutional environment is not equipped to fully utilize them as they are now structured and *(b)* national health programs are structured so that they fail to reflect or to be responsive to the uniquely rural conditions because rural input into the national health legislation process has been insufficient.

Changing the Institutional Environment

Federally funded health programs can be made more responsive to rural needs, but first changes will be required in the general institutional structure in rural areas. These changes can then lead to the needed modifications in both the rural health care delivery system's institutional structure and the Federal and State health service programs. To be most effective, changes in the general institutional structure must originate at the local level rather than be superimposed on local communities by outsiders from the State or Federal level.

Several steps would be required in such a process of rural institutional development and rural institutional change.

1. Education about public issues—the creation of awareness on the part of rural people at the local level that alternative solutions to local problems of health services delivery do indeed exist. To create such awareness, some type of open, public forum to air the issues and the alternatives would be required. A "neutral" local person or agency may be needed to convene and conduct such a forum.
2. The creation of local organizations that would decide upon the most favorable alternative solution for that community and would then create the institutional structure to implement the alternative.
3. The establishment of rural health facilities and services incorporating both economic and social incentives for the adoption of preventive health practices.
4. The provision of systemic linkages to the full range of health services available in urban areas.

Rural Input Into Health Legislation

As already noted, the reason that many federally established health programs apparently function poorly in rural areas is that they do not reflect rural conditions. This poor functioning results from inadequate rural input into the legislative process.

An illustration of the failure to reflect rural conditions is the recently enacted Health Planning and Resources Development Act. The act does specify that "the boundaries of health service areas shall be established so as to recognize the differences in health planning and health services development needs between non-metropolitan and metropolitan areas." Nevertheless, the very large population bases for health planning areas mandated by the act reflect a lack of appreciation of the need for more rural input into the planning and implementation of national health programs.

Before the national health legislation process and subsequent health programs can adequately reflect and be responsive to rural conditions and needs, again, several steps will be required:

1. Initially, provision will need to be made for specifically rural input into the health legislation process.
2. The freedom and ability to adapt to local needs will have to be incorporated into Federal and State health programs.
3. An arrangement will need to be made for feedback from local rural areas to State and Federal health policymakers about the functioning of government health programs.

The Cooperative Extension Service is one organizational structure that already exists which, with adequate resources, can address itself to achieving changes in the rural institutional environment and increasing rural input into the development of health legislation.

Cooperative Extension Service

The Cooperative Extension Service (CES), which was established in 1914, represented a new and unique system of education. Designed to take knowledge directly to the people of rural America, the system was based on the belief that human progress would be enhanced if the products of research could be translated into lay language and made available to rural people to help them improve their decisionmaking. The contribution this system has made to the development of the world's most productive agriculture has been recognized throughout the world.

Through the years, the Cooperative Extension Service also has demonstrated its ability to improve the quality of life of those it has reached. It has encouraged youth and contributed to their development and has helped rural people improve their homes and communities.

The key to the Cooperative Extension Service's success has been its unique structure as a partnership of Federal, State, and county governments, with strong guidance in its priorities from those it serves. The system has survived and grown because of its objectivity and its ability to adapt short-range priorities to longer-range public needs. Its strength lies in its ability to use research-based facts in logical relationship to national goals. The CES system has great flexibility, and it has in place a framework for providing the kind of problem-solving education that can be applied to a wide range of emerging national, State, and local problems *(6)*.

Photo courtesy Palladium-Item, Richmond, Ind.

Cooperative Extension Service specialist discusses drug abuse with a 4-H youth group

As part of its commitment to improve rural life, the Cooperative Extension Service has long displayed a concern about the health of rural people. CES educators support health professionals by providing leadership to State and local CES personnel in several areas of health education, including occupational health and safety; nutritional requirements; preventive health; screening for cancer, hypertension, and diabetes; drug abuse and venereal disease; community health services and facilities; and the safe use of pesticides.

CES and Rural Institutional Development

Just as rural health services needs are unique and require unique organizational responses, so do other rural needs. The Cooperative Extension Service has assisted in creating and establishing new rural institutional structures to address these needs. When, for example, the lack of rural credit institutions posed a serious threat to the continued viability of American agriculture, the Cooperative Extension Service assisted in establishing a system of farm credit institutions, including the Farmers Home Administration, to deal with rural credit needs. Similarly, it has helped create rural electric and telephone cooperatives in response to uniquely rural needs that were not being served by private utilities.

Several CES functions would lend themselves to effecting the rural institutional changes needed in the health services area. CES personnel conduct ongoing educational activities in which public issues are addressed through 4-H youth groups, extension homemaker clubs, agricultural producers, special interest groups, forums, and local community decision makers. Local health needs are public issues that have become the subject of such ongoing educational activities.

Community resource development personnel of the Cooperative Extension Service have the responsibility and capability to help local communities develop the needed organizational structure for dealing with local problems. Given the necessary resources, they can assist rural communities in establishing the needed health service organizations and institutions.

A unique feature of the Cooperative Extension Service is that its educational activities are programed in response to locally identified needs and objectives. It also meets the criteria for a neutral agency and therefore could provide the needed forum on rural health issues. Its ability to function as an objective, nonpolitical education and information system in cooperation with other government agencies is growing. A recent survey showed a notable apparent lack of interorganizational friction between the Cooperative Extension Service and health system agencies. CES officials of only 3 of 45 States responding reported a lack of cooperation from key health agencies or groups *(7)*.

Rural Input Into Health Programs

The Cooperative Extension Service has the potential to provide both direct and indirect rural input into the process of health program development at the State and national levels. Its national policy board, the Extension Committee on Organization and Policy (ECOP), has recently established a subcommittee on health education. Members of this subcommittee include CES State health education specialists, who by working closely with local CES personnel can clearly perceive rural health issues and problems.

Through this health education subcommittee's recommendations, the CES national policy position on health issues will be formulated. This national ECOP health policy position will then be reflected in the health education activities of the CES and in the USDA position on national health legislation. Again, CES programing in response to locally identified needs and issues will strongly influence the ultimate ECOP policy position.

Indirectly, CES personnel at the local level may participate in implementing the new Health Planning and Resource Development Act. This act permits the establishment of subarea councils which can provide rural input into the newly established area health planning agencies.

CES personnel can perform two major functions with these subarea councils. CES community resource development personnel may assist in organizing them, and with other CES personnel, can provide ongoing educational input to council members.

Provided that the necessary resources and interagency linkages are made available, both the direct and indirect rural health inputs of the Cooperative Extension Service could be expanded to encompass many of the current rural health needs and issues.

▶

An exercise in community decisionmaking is just one way Cooperative Extension Service specialists help people to focus on community concerns, such as health care

References

1. Matthews, T. M.: Health services in rural America. Agricultural Information Bulletin No. 362. Rural Development Service and Economic Research Service, U.S. Department of Agriculture, Washington, D.C., April 1974.
2. Health services and rural America. Conference working paper No. 4. First National Conference on Rural America. Rural America, Inc., Washington, D.C., March 1975.
3. Hazen, M., and Cordes, S.: Changing the poor or changing the system?—A basic issue in improving the poor's use of medical services. Publication A.E. & R.S. 113. Department of Agricultural Economics and Rural Sociology, Pennsylvania State University, University Park, Pa., November 1974.
4. Freiberg, L.: Estimated effects of national health insurance upon the demand for hospital care in Kentucky. Morehead State University, Morehead, Ky., 1975.
5. Rural development. Fifth annual report of the President to the Congress on government services to rural America. Rural Development Service, U.S. Department of Agriculture, Washington, D.C., appendix table 1, p. 56. Undated.
6. The Cooperative Extension Service—A nationwide knowledge system for today's problems. Extension Committee on Organization and Policy, Colorado State University, Fort Collins, July 1974.
7. Porter, W.: Preliminary report—National extension health education survey. Extension Service, U.S. Department of Agriculture, Washington, D.C., March 1975.