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A CASE STUDY OF EXTENSION'S RESPONSE TO HEALTH CARE REFORM

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Health care reform may be seen by some as an issue outside the traditional concerns of extension. Yet, it is a consequential issue for rural people and communities. More than any other residential group in society, rural Americans experience the greatest deprivation of access to quality, affordable health care. For this reason, the fulfillment of our traditional mandate to improve the quality of life of rural peoples and communities demands a comprehensive response from extension. This paper highlights some of the spatial inequalities in access to health care services and considers the consequences of these inequalities. It then explores some approaches to empowering rural citizens to become involved in the public discourse and decision making about health care reform.

Spatial Inequalities in Health Care

In our urban society, geographic place has been all but dismissed as a significant factor in social life. Social science research has tended to ignore the question of residence, while policymakers, responding to the demography of politics, ignore the spatial consequences of policies and programs. Because we have all failed to recognize how geography or physical space remains a significant factor in social life, spatial inequalities have emerged and persisted. Spatial inequalities refer to the differences in life chances that arise merely from residential location in either rural (nonmetropolitan) or urban (metropolitan) places. In other words, where you live affects your life chances over and above the effects of any other defining characteristics of individuals, their families or their households. Spatial inequalities exist because space is not simply a "given social fact," an objectively neutral canvas on which significant social processes occur. Rather, space is a key factor shaping the structure and functioning of all institutions and organizations, especially the health care system.

The significance of spatial inequalities for rural Americans is all too easily demonstrated. The preponderance of medically underserved areas are rural. One study found that underserved counties were three times more likely to be rural than urban, and one half the states had more than 75 percent of all their rural counties classi-

fied as underserved. This means rural people have less access to health care providers and facilities than urban residents. Indeed, in some rural areas, there are *no* primary care providers, including obstetricians, and this means pregnant women must travel great distances for prenatal care and delivery. For example, in 1988, there were sixty-one obstetric care providers per 100,000 women in urban areas, but only twenty-five per 100,000 rural women. Studies also show that when health services are available, rural residents have fewer choices among health care providers and facilities, and are less able to obtain all levels of care within their communities. Finally, even when services are available, rural residents are less able to utilize them because of a higher proportion of uninsured persons and families within the population.

Quite simply, if you live in a rural area, health care reform may well be a matter of life and death. As a rural resident, you are at greater risk, than if you lived in an urban area, of dying within your first year of life, developing a chronic disease, becoming functionally impaired, having no health care providers within your community—or, if they are present, having no choice among providers—and having no financial access to services. All this just because you live in a rural community. This is the meaning of spatial inequality and why health care reform is so critical to rural America.

Is There a Health Care Reform Role for Extension?

Extension's national health initiative provides an institutional mandate for the development of new programming in this area, but does not necessarily insure the institutional resource base for developing such programming. Some may argue that health care reform involves questions beyond the human resources of extension. From one perspective, this is true. Most extension systems do not have persons who are health care providers on staff. However, this interpretation of the question of health care reform is very narrow, defining health care reform as only an economic or technical problem requiring expert knowledge for analysis and decision making. Indeed, nearly all the debate over reform focuses on the economics of the health care system—how to control the spiraling upward rate of health care costs—as if finding a better way to finance the health system will solve all the spatial and other inequalities inherent in the organization and functioning of health care in America.

An alternative perspective asserts that health care reform is not about the technical issues of more efficient billing systems or more cost-effective ways of financing health care. Rather, these answers will only “tinker” with the system of health care in America without addressing the more fundamental issues of prevention, access, consumer health and the relationship between social inequality and health status inequality. These issues are at the heart of a redesign of our health care system into one that assures equal access to high

quality, appropriate care for all Americans. Health care reform should not be decided simply on the basis of economics, for such an approach ignores more substantive concerns. If the current national debate over health care reform does not address questions of spatial and socioeconomic equity in access to the health care system, then we will have simply perpetuated an essentially flawed institutional system.

Extension has a key role to play in this arena by helping to redefine the current debate over health care reform. To best serve the interests of rural Americans, we must move the debate from a narrow focus on economics into the broader, more substantively significant questions of prevention, access, health education and social inequalities. And we must broaden the debate to include not just the experts and those with vested special interests, but all Americans, for these value-based decisions will affect all our lives.

Extension is uniquely situated to broaden the focus of the debate and engage more citizens in the decision making. Extension's reach into every county of every state is its organizational structure facilitating public discussion. Extension's educational programming and its emphasis on collaborative work are the organizational processes on which the public discussion can be built. Extension's traditions of neutrality and information transfer as well as its organizational mission are the philosophical justifications for assuming a leadership role in the public discussion of health care reform. All that is needed is the organizational commitment to the development of focused programming in this area. What follows is a description of how one state extension service has developed its commitment to this issue.

Kentucky's Health Extension Programming

A year ago, Kentucky's state extension task force on health and safety was formed. The task force membership includes not only state extension specialists and county agents, but also health professionals in other sectors of the University, e.g., the Rural Health Center, the College of Medicine and the Markey Cancer Center's Prevention Program. Our approach has been to open participation in the task force to anyone with an interest in health and safety issues. This broad membership has provided the task force with the technical knowledge base to address a wide variety of health issues with new programs and materials.

The task force has two subcommittees: one focused on community health services, the other oriented to individual health behaviors. Educational materials and programming are done by the subcommittees as well as by the committee as a whole. For example, the individual health practices subcommittee surveyed all county extension agents to identify programming topics for specific audiences. The community health services subcommittee is in the process of devel-

oping a survey to assess the availability, access, convenience and use of county health services as well as attitudes toward the quality of these services. The survey will first be administered to county extension agents. Then training will be offered to agents so they can use the survey as the basis for community programming.

The task force has adopted the issues-gathering approach for its work on health care reform and related community development efforts. Issues gatherings are based on the Kettering model of study circles designed to encourage "public talk" about community and national life. Issues gatherings provide a structured opportunity for citizens to express their opinions on controversial topics. All participants begin with a common understanding of the issue as presented in an issues brief and discussions encourage participants to evaluate the strengths and weaknesses of action choices. As the discussions proceed, participants are asked to consider the values underlying action choices and to identify points of common ground. We believe issues gatherings are a method for conveying information on contemporary issues that involve the allocation of scarce community resources or the transformation of community resources, organization or goals. With the ground rules for discussion clearly defined, this approach can successfully guide reasoned discussions among opponents of the most contentious issues.

Three examples will illustrate how this approach to engaging citizens in public talk about critical issues has guided the educational programming of the task force. The first issues brief was part of the Appalachian Civic Leadership Project, a Kellogg-funded program in which extension participates. When it became apparent the current governor would move forward on state health care reform as promised during the election, the Appalachian Civic Leadership Project mobilized to provide a forum for public discussion of the issue. An issues brief based on the governor's proposal was prepared for a series of issues gatherings around the state. The discussions focused on the strengths, weaknesses and values underlying the proposal, guided by questions such as: "Who benefits?" and "Who loses with the plan?" and, ultimately, "What is best for the common good?" The Appalachian Civic Leadership Project has trained nearly one hundred issues-gathering facilitators, many of whom are county extension agents. These trained facilitators joined others to conduct a series of issues gatherings statewide, producing an organized public input to the reform process.

A second example occurred just prior to the appointment of the task force when some members were involved in the development of a guide evaluating advanced life support (ALS) versus basic life support (BLS) emergency services. Research shows that a trained paramedic and an advanced life support emergency service, responding within the "golden hour" following a life-threatening injury or heart attack, can increase an individual's chances of survival and recovery

by two and one half times. For Kentuckians, access to ALS is not equal. More than half of all counties (primarily the rural counties) have only BLS and virtually none of the eastern Kentucky counties have ALS. Yet, upgrading to ALS represents a significant commitment of community funds for equipment, training and personnel at a time when most rural Kentucky counties face serious economic stresses. Thus, rural counties face some important choices with respect to a critical component of the local health care system. They must make value-based decisions on the balance between the investment of a given amount of community resources against a given improvement in the quality of local health services. The issues brief describes the differences between basic and advanced life support services and then discusses some community options. Community residents thus have a basis for public discussions on their health service options.

Our most recent publication is an issues brief on health care reform that also includes simple definitions of key health reform, health care and health insurance terms. The issues brief introduces the debate over health care reform, summarizing the reasons for the current movement and some of the major proposals for change. The accompanying definitions of key terms offer a simple introduction to the bewildering world of health care terminology, providing participants with a common ground for discussion. Two training programs on health care reform will be offered to county extension agents this fall to introduce the new materials and enhance the agents' skills as facilitators for public discussions of controversial topics.

Although only in the early stages of its work, the educational materials and professional expertise of the task force have already been seized on by county extension agents. For example, one county agent has provided the health care reform issues brief to the local chamber of commerce, which has now requested a special program for chamber members. In another county, the extension agent, who last year organized a social services agency council, is planning outreach discussion groups on health care reform with clients of the various service agencies. In addition, the state Rural Health Center will be using the educational materials in their programming while also contributing to the development of new materials.

Summary

Reform of the health care system must move beyond the economics of the system into broader questions of equality of access, quality of services and the underlying socioeconomic inequalities that compound the limited life chances associated with the spatial inequalities in health care. But this will not happen unless citizens, especially those most vulnerable to the inefficiencies and inequalities in our current health system, force the public discussion into these areas. Currently, the public debate has been defined by those with a

vested interest in the current system and concerned primarily with the economics of change. What is needed is a foundation for a new public discourse. Extension can contribute to this effort. But, to do so, extension must build coalitions with health professionals and others who share these broader concerns. The multidisciplinary task force provides the expertise necessary to develop educational materials, while the study circle issues briefs provide a vehicle for opening the discussion of health care reform to all citizens.

***Public Issues Education
and the NPPEC***

