



The Rural Health Initiative

A New Venture for MSU Extension Service

By David Young, PhD

Rural Health Resource Specialist

Extension Service, Montana State University

The Extension Service is dedicated to improving the quality of people's lives and strengthening the social, economic and environmental well-being of families and communities.

Health matters. Health matters to individuals. Health matters to communities. Health matters to institutions. And health care is expensive. Health care costs are the number one cause of family debt and bankruptcy for Montana residents as well as for all Americans. Health matters also to local, county and state governments, not to mention the federal government. Issues of rising health care costs, access to health care and increasing health disparities have surfaced as top priorities locally and nationally. The National Association of Counties (NACo) recognizes that county governments have multiple responsibilities for health care and thus play an essential role in policy making that impacts the health care delivery system. In most states, county governments are ultimately responsible for health care of the poor, uninsured, unemployed, incarcerated and indigent, regardless of their ability to pay. This increasing cost burden of uncompensated care is depleting many county budgets.

Health matters to the MSU Extension Service. The Extension Service is dedicated to improving the quality of people's lives and strengthening the social, economic and environmental well-being of families and communities. The Extension Service encourages Montanans to take advantage of opportunities to be a positive force for change in their own lives as well as for their families and communities. One new venture for MSU Extension is the establishment of a Rural Health Resource Program designed to assist rural under-served, under-represented, vulnerable and special needs populations and communities in taking advantage of opportunities to improve their quality of life and daily functioning. Some opportunities come in the form of calls for grant proposals. However, most rural Montana communities lack the necessary resources to prepare competitive applications. Unfortunately, a significant amount of public funds go unused each year because the application process is too confus-

ing and/or too time consuming. In addition to federal grants, a large amount of funding was awarded in 2004 to state and local governments and organizations from various philanthropic, charitable, and private foundations.

So what will be the inter-relationship between this new Rural Health Resource Program, the MSU Extension Service and healthier Montana communities? Land-grant institutions, such as MSU, were originally designed to be 'people-serving institutions.' Starting in 1862, the federal government granted land to each state for the development of an institution of higher education that would serve the citizens in the areas of research, education and extension.

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"reaching out and extending resources, solving public needs with university resources through non-formal, non-credit programs." The key operative phrases in the mission statement are 'reaching out' and 'solving public needs.' The range of unmet social and health service needs across Montana's rural communities is shocking. A review of applications submitted over the past three years from Montana

organizations requesting funds to build capacity in health and social services has provided a revealing spectrum of unmet needs. This observation, along with Montana's poor ranking in a number of key health indicators, underscores the critical nature of health and social services that need to be addressed in order to improve quality of life. For example, nationally Montana ranks as follows:

- 1st in percent of state and local government expenditures used for health programs
- 1st in percent of Medicare beneficiaries living in rural areas
- 1st in alcohol abuse/dependence by children ages 12-17 (twice the national average)
- 1st in those needing but not receiving treatment for alcohol use in the past year for children ages 12-17 (twice the national average)
- 2nd in illicit drug abuse/dependence by children ages 12-17 (40% above the national average)
- 3rd in those needing but not receiving treatment for illicit drug use in the past year for children ages 12-17 (25% above the national average)
- 6th in percent of the population without health insurance (approximately 20%)
- 6th in health care expenditures as a percent of gross state product.

In addition to these dismal health-related rankings, health care costs in Montana are running in excess of \$4.4 billion annually, nearly twice the annual cash receipts credited to Montana's agricultural industry. So the primary mission of the Rural Health Resource Program will be 'reaching out' to needy rural Montana communities and providing technical assistance to local government, Extension Agents and health-related organizations in addressing 'health and social service needs.' A major objective will be to assist needy communi-

ties in seeking outside sources of funding to address unmet health and social service needs.

Health matters locally, too. The saying that “*all health care is local*” is supported by reports showing that individual health is closely linked to community health, and community health is influenced by collective beliefs, attitudes and behaviors. Thus, issues of health, health care and health care outcomes are both personal and communal. The increasing numbers of uninsured and rising cost burden of uncompensated care has pushed local governments to work more closely with state governments to find and implement solutions. This fact, along with a widening gap in health disparities between rural and urban rural residents, provides a great opportunity to enlist community stakeholders in the pursuit of the two overarching goals of the national health agenda, *Healthy People 2010*: (1) to increase quality and years of healthy life, and (2) to eliminate health disparities. *Health disparities* are defined as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health events that exist among and between specific sub-population groups. These differences are usually the result of complex interactions involving a multitude of factors including genetic, social, economic, ethnic, cultural, behavioral, geographic, and environmental factors.

In addition, access to health care, health promotion, diagnostic screening and personal life style choices are key elements of the health disparities equation. A *health inequity* is a lack of fair and appropriate distribution of resources such that all individuals have ‘fair and equal’ opportunity to achieve their full health potential through affordable access to the known prerequisites and treatments for good health and disease prevention. *Healthy People*

2010 challenges communities, states and other organizations to take a multidisciplinary approach to achieving *health equity* – “an approach that involves improving health, education, housing, labor, justice, transportation, agriculture, and the environment, as well as data collection itself.”

In the face of a national effort to achieve health equity and reduce (eliminate) health disparities, an assessment of key health indicators

reveals a widening gap in health disparities between urban and rural communities. For instance, rural residents are more likely than their urban counterparts to: (1) have unintentional injuries and injury-related deaths; (2) suffer

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premature death from heart disease, cancer, diabetes and suicide; (3) self-report being in poorer health and suffer from chronic or serious illness and disability; (4) be uninsured or under-insured; (5) have low income or be living in poverty; (6) have high incidence of substance abuse and domestic abuse; and (7) lack access to health screening, health care and home and community-based services. In addition, rural areas have a higher percentage of Medicare beneficiaries and a disproportionate number of elderly living with chronic conditions. Furthermore, people living in rural areas do not have ready access to emergency services or specialty care and are less likely to exercise regularly, use preventive screening services or use seat belts. The combination of a depressed agricultural economy, rising health care costs and increasing numbers of uninsured and underinsured has resulted in a health care crisis for many rural residents,

families and communities.

Finally, America's rural history is replete with stories of pioneers, frontiersman and settlers heading west in search of riches, such as gold, silver and oil. At the same time, Native peoples traveled the plains in search of the abundance of the buffalo. Ironically, rural America sits on a vein of untapped riches in the form of social capital - *those specific processes among people and organizations, working collaboratively in an atmosphere of trust, that lead to accomplishing a goal of mutual social benefit.* The principles of social capital – collaboration, partnerships, alliances, coalitions – are cornerstones for community health promotion strategies. Studies have shown that well-planned community-based programs do yield positive results. Successfully mining Montana's rich vein of social capital will make rural communities healthier by promoting healthier lifestyles through education, advocacy, prevention and intervention. Once again Montana will be known as the 'Treasure State.'

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