

The RURAL MONITOR

A Publication of the Rural Assistance Center

Editor's note: This issue marks a significant transition in the life of this newsletter. Formerly known as Rural Health News, it is now The Rural Monitor. The change in name reflects the broadening of its scope from one of rural health to one of rural health and human services. The rationale for this expansion lies in the fact that the health of people and their communities depends not just on a narrowly defined system of health care, but also on their economic situation and opportunities, education, family support mechanisms, and much more. Thus, The Rural Monitor will cover these other important facets of health and wellbeing while continuing to cover more traditionally defined health issues.

The transition also marks a change in publishers, from the Rural Information Center Health Service at the U.S. Department of Agriculture's National Agricultural Library to the Rural Assistance Center—a collaborative effort of the University of North Dakota Center for Rural Health, the Rural Policy Research Institute, and the Welfare Information Network.



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Phone: (800) 270-1898

E-mail: info@raconline.org

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Making Family Farms Safer

By Thomas D. Rowley

The family farm is not thought of as a particularly dangerous place to live and work, but few occupations pose as serious a threat.

With more than 700 fatalities on all U.S. farms each year, and tens of thousands more injuries, agriculture is one of the nation's most hazardous occupations. Tragically, many of those injured and killed are children. Each year, farm and ranch accidents take the lives of an estimated 104 people under the age of 20.

While some progress has been made, experts agree: the numbers can and should be reduced.

"Sadly, incidence rates have not changed a lot, for reasons that we all understand," says Jim Meyers, Farm Safety Specialist at the University of California, Berkeley. "That raises questions about what we're doing."

According to experts, several factors contribute to the persistence of agricultural injuries.

As a workplace, a small farm is largely unregulated when it comes to safety. The federal Occupational Safety and Health Administration (OSHA) does not have the authority to inspect farms with ten or fewer employees and many farmers would



bristle at the notion if OSHA did have the authority. Thus, many farm safety measures are voluntary.

On top of that, and related to it, our society is not entirely sure how to view agriculture.

"We let these things go on in agriculture because we get confused as to whether it's an industry or a way of life," Meyers says. And that confusion, he adds, hampers efforts to improve farm safety.

Finally, there are the work conditions themselves. Farming and ranching involve a host of potentially dangerous elements. Machinery, livestock, noise, dust, and toxic chemicals are an everyday part of the job. The work is physically demanding and often must be performed in the dark, in the rain, even in the snow. The family farmer is often

(continued on next page)

tired, under the stress of pressures ranging from low prices to bad weather to family strife, and is, almost by definition, a risk taker. The young and old regularly work on the farm despite the physical and mental limitations of age.

Finally, medical assistance, should it be needed, can be hours away.

Together, these conditions can be a recipe for disaster. Tractors roll over. Augers entangle and amputate. Toxins sicken. People, their families, and their communities suffer the consequences.

Renewed Attention

Some experts believe that the federal government needs to do more to improve farm safety. The chances of that happening, however, appear to be small. Indeed, the most recent Farm Bill—the nation's flagship legislation on all things agricultural—is largely silent on the issue, merely reauthorizing existing efforts that many say are insufficient.

One exception is the establishment of ten Centers for Agricultural Disease and Injury Research, Education, and Prevention.

In 1990, the federal government's National Institute for Occupational Safety and Health (NIOSH) established the centers around the country to protect the health and safety of agricultural workers and their families. To do that, the centers conduct research, education, and prevention projects.

According to Meyers, the centers have brought new and much-needed attention to the problems of farm

The Centers for Agricultural Disease and Injury Research, Education, and Prevention

To date, there are ten NIOSH Ag Centers around the country conducting research, education, and prevention projects to improve farm health and safety. Each focuses on the agricultural health and safety issues unique to its own region.



- **Pacific Northwest Agricultural Safety and Health Center** at the University of Washington, <http://depts.washington.edu/pnash/>

- **The Western Center for Agricultural Health and Safety** at the University of California, Davis, <http://agcenter.ucdavis.edu/>

- **High Plains Intermountain Center for Agricultural Health and Safety** at Colorado State University, <http://www.hicahs.colostate.edu/>

- **Southwest Center for Agricultural Health, Injury Prevention and Education** at the University of Texas Health Center at Tyler, <http://swcenter.uthct.edu/>

- **The Great Plains Center for Agricultural Health** at the University of Iowa, <http://www.public-health-uiowa.edu/GPCAH>

- **The Midwest Center for Agricultural Disease and Injury Research, Education and Prevention** at the Marshfield Clinic, <http://www.marshfieldclinic.org/nfmc/projects/>

- **The Southeast Center for Agricultural Health and Injury Prevention** at the University of Kentucky, <http://www.mc.uky.edu/scahip/>

- **The Northeast Center for Agricultural and Occupational Health** at the New York Center for Agricultural Medicine and Health, <http://www.nycamh.com/>

- **The Great Lakes Center for Agricultural Safety and Health** at Ohio State University, <http://www.ag.ohio-state.edu/~agsafety/>

- **The Southern Coastal Agromedicine Center** at the North Carolina Agromedicine Center, <http://www.ncagromedicine.org/scac.htm>

For more information on the NIOSH Agricultural Health and Safety centers, and agricultural health and safety in general, see: <http://agcenter.ucdavis.edu/niosh/niosh.htm>

safety. But, he adds, their focus on research and education can be somewhat limited.

“If you have something causing illness or injury in your community, you don’t just warn people, you reduce it or eliminate it,” says Meyers. “Too much of what we do is aimed at education and information: telling people this is dangerous; be careful.”

Other experts on the subject agree.

“Farm safety and health problems are incredibly complex,” writes Dr. John Shutske of the University of Minnesota in a farm safety newsletter. “Complex problems deserve equally complex solutions.” Shutske, an Extension Agricultural Safety and Health Specialist, gives a simple, but heart-wrenching example. “If a child is riding on the fender of a tractor and falls off and is run over, the solution isn’t to simply tell other children ‘no extra riders!’”

In discussing the limitations of education, Dr. Dennis Murphy, Professor of Agricultural and Biological Engineering at Penn State, notes in his book, *Looking Beneath the Surface of Agricultural Safety and Health*, that farmers know they are at risk, but such knowledge does little to change their behavior. They continue to put themselves, and even their children, at risk.

Murphy labels this incongruence and disconnect the “farm safety-risk paradox.” If—despite knowing the hazards—farmers still engage in risky

behavior, the value of more education, without supporting efforts, is limited.

Going Beyond Education

While the bulk of federal efforts in farm safety focus on education, there are efforts around the country that go beyond education and take a more comprehensive approach to reducing farm accidents and illnesses.

AgriSafe Network

Kelley Donham, a professor at the University of Iowa and Director of Iowa’s Center for Agricultural Safety and Health (I-CASH), looked overseas for help. During a trip to Sweden in 1987, he visited a network of clinics set up to serve the agricultural workers of Sweden—a country that has shown remarkable progress in improving farm safety. Impressed by the effort, Donham returned home and began creating a similar network.

Today, the Iowa Agricultural Health and Safety (AgriSafe) Network has 22 clinics around the state providing farm families with services that can help reduce injuries and illness. It bills itself as the only network of clinics in the country providing preventive health and safety services specifically tailored to the needs of farmers. There are three basic components to the network’s offerings.

The first component is an in-depth occupational health screening and series of health tests. The tests include pulmonary function, cholinesterase (for pesticide exposure), cholesterol, blood pressure, hearing, vision, height, weight and skin cancer screening. The initial series of tests is used to establish a baseline for the farmer’s overall health and to monitor any significant changes in the farmer’s health over time. The results of these tests are also used to help determine what kind of safety equipment would be most beneficial to the farmer and what areas of his or her health are at the highest risk. The tests are provided on a fee-for-service basis, but at a below-market rate.

The second component is an on-site farm visit and evaluation of the farmer’s working environment. This leads to recommendations for health and safety practices specifically tailored to a farmer’s working area. The evaluation also helps the farmer and clinic personnel recommend and select the most effective and proper protective gear to be worn in the course of the farmer’s working day.

The final component is education and outreach aimed at the entire farm family so that family members exposed to the various work conditions may also practice safe and healthy work habits. As part of this component, AgriSafe clinic staff visit county fairs, agribusiness meetings, and other places farmers gather and do business. In addition, staff members refer people to other sources of assistance—from Medicare and Medicaid to mental health service and food stamps.

According to Carolyn Sheridan, who coordinates the program, the number of farmers taking advantage of AgriSafe's offerings is rising. At the Spencer site, the program sees 150 to 200 farmers per year.

Still, she says, the program offers only a start.

"It's very hard to convince people to take a look at their total health picture," she says. "We touch a lot of lives, but few of them take advantage of the full offering."

Certified Safe Farm

The Certified Safe Farm (CSF) program, run by the University of Iowa's I-CASH, is another effort to improve safety on farms. The program, which began in 1996, offers certification as a "safe farm" to farmers who complete an occupational health screening, receive safety education tailored to their own health and farming situation, and pass an on-farm safety review.

The hope is to someday be able to provide certified farms with discounts on insurance premiums and other benefits.

"We try to offer a full array of assistance, from health screening to protective devices to on-farm safety review to referral for mental health issues," says Sara Schneiders, Coordinator of the Certified Safe Farm Project.

A key aspect of the CSF program is that it offers an alternative to safety regulations and enforcement. Voluntary certification—especially when

rewarded with financial compensation—is typically more appealing to farmers than is compliance with regulatory requirements, experts note.



A farmer gets fitted for personal respiratory protection at an AgriSafe network clinic.

To gauge the effectiveness of the program, the Universities of Iowa and Nebraska are conducting a study, funded initially by the National Institute of Occupational Safety and Health. Additional funding has been provided by the Iowa Pork Producers Association, the National Pork Producers Council, Pioneer Hi-Bred International, Inc., and the Wellmark Foundation.

The Iowa program compares health outcomes on 125 certified farms and 125 control farms in a nine-county area in northwestern Iowa. AgriSafe at the Spencer Hospital provides local leadership for the study and offers the clinical

services and education. Three trained local farmers conduct the on-farm safety reviews.

Staff is also working with the farm service industry to expand the CSF program throughout the state.

Their hope is to get 600 farmers to participate and then compare the insurance claims of those farmers against those not in the program. The question they seek to answer is whether participation reduces claims due to illness and injury.

According to Schneiders, preliminary findings of studies on the program's effectiveness are mixed. On the one hand, the health screenings make farmers more aware of their health and prompt them to see the doctor more often. In addition, farmers are using respiratory protection equipment more often and seeing a

reduction in certain respiratory symptoms as a result. On the other hand, injury rates between farmers in the program and those in the control group, she says, "are not that much different."

Despite the initial mixed results, officials from both programs say they've seen enough positive impact that they are hoping to continue and expand their efforts.

"The farmers say they've learned a lot, they like it, and will continue to use what they've learned," says Schneiders. "To me, that makes it successful."

Sowing the Seeds of Hope in Iowa

Diane Patton is Program Coordinator of Sowing the Seeds of Hope in Iowa. She works for the Ecumenical Ministries of Iowa (EMI), the state council of churches with members from ten protestant denominations. EMI's interest in, and subsequent agreement to act as fiscal agent for, the program stems from its concern for rural ministry and the overlap between mental health and faith. According to Patton, each has a way to help people be healthy and whole persons.

"We think prayer is a powerful thing," she says, "but we also think there are cases where people need medication and counseling, and that counselors should

recognize the power of people's faith and help them build on that."

As part of the program, Patton does outreach to rural congregations, connecting pastors and their flocks with members of the mental health community and establishing peer support groups.

Patton and her husband Jim, Extension Education Director for Webster County, facilitate one such support group in Fort Dodge, Iowa. The group—seven people, all farmers—comes from a 40 to 50 mile radius and meets every four to six weeks in the county extension office. According to Patton, the group is an opportunity for farmers and their

spouses to meet and discuss situations that concern them and share experiences and ideas. Topics range from relationships to finances to the skills needed to find off-farm employment. In addition to the discussion, people bring in helpful information they have found on farming issues, community college offerings, or the name of a good doctor.

"It's a way of building that network of resources that are available and helpful to a community," says Patton.

It is also a way of expressing support for one another, as evidenced by the group's closing prayers for one another.

Sowing the Seeds of Hope

Just as important to a farmer's safety as his or her environment is his or her mental state. When operating heavy machinery, dealing with toxic chemicals, or climbing a grain bin several stories high, undivided focus on the task at hand is critical. Indeed, studies indicate that in times of economic stress—a major cause of anxiety and loss of focus—the incidence of farm injuries and fatalities increases two to three times.

Recognizing the importance of mental health in reducing accidents and increasing the overall well-being of farmers, the Wisconsin Office of

Rural Health and the Wisconsin Primary Health Care Association started the Sowing the Seeds of Hope program in 1999. Initial funding came from the Health Resources and Services Administration's Office of Rural Health Policy and the Bureau of Primary Health Care. Today, the program operates in seven states—Iowa, Kansas, Minnesota, Nebraska, North Dakota, South Dakota and Wisconsin—and operates under the umbrella of AgriWellness, Inc., a nonprofit corporation founded in July, 2001.

Though the programs vary from state to state, each offers several core services:

- Identification of persons in need of services;
- Training and education of behavioral health care providers, community health workers, the faith community, and others who serve the agricultural population;
- Education about agricultural behavioral health issues;
- Information clearinghouses;
- Crisis hotlines;
- Vouchers for counseling services; and
- Retreats and support group activities for farm couples and families.

Dr. Mike Rosmann, a psychologist and a farmer, runs AgriWellness and believes the behavioral aspects of farm safety are a critical element that needs to be addressed.

“Farmers are under tremendous pressure, says Rosmann. “They constantly ask themselves things like ‘Am I doing my job well enough?’, ‘How would Dad have done it?’, ‘What will the neighbors think?’ and ‘How much will I lose if I don’t get this done?’.”

These pressures, thoughts, and emotions can distract a farmer, resulting in accidents, injuries, and fatalities. They can also lead to suicide. According to Rosmann, the incidence of suicide in the agricultural community is twice as high as the national average. During the foot and mouth epidemic in Great Britain, the suicide rate among farmers increased to ten times that country’s national average.

On a happier note, and as evidence of the success of Sowing the Seeds of Hope, Rosmann points out that during the current drought in Nebraska, suicides among farmers have not gone up.

“I’m almost convinced that these networks really work,” he says.

Political Will Needed

As helpful as these efforts are, experts agree that more needs to be done. And that will not be easy.

“We know what it will take to make farming safe,” says Dr. Mark Purschwitz, Associate Professor and Extension Agricultural Safety and Health Specialist at the University of

Wisconsin. “The question is do we have the political will to do it?”

Ultimately, he says, agricultural safety is more a political issue than anything else.

Meyers concurs, citing tractor rollovers as an example. Across the country, tractor rollover is the number one farm hazard and the leading cause of death. In Sweden, where the government made rollover protection systems (ROPs) mandatory two decades ago, rollover injury and death rates decreased dramatically. In the United States, ROPs are not mandatory. As a result, only half of the farm tractors in use have them. Indeed, because tractors last so long—30 years or more compared with the six-to-ten-year life of most cars—many tractors in use today were manufactured before ROPs were even available. And retrofitting older tractors with safety equipment can be quite expensive.

“We continue to debate it in this country,” says Meyers. “People say farmers can’t afford a new tractor. They can’t afford to be dead either.”

As another example, he cites kids working on farms.

“There are physical reasons why kids should not be on [hazardous equipment],” says Meyers. “We ought to make it a law. It’s about time those fools in Washington did something about it.”

Despite the logic and the passion of such arguments, there is no groundswell of support among farmers for safety regulations and the burden such regulations would put on their pocketbooks, time, and attention. Indeed, as Purschwitz points

out: “A lot of farmers don’t see elimination of risk as their highest goal.”

A Glimmer of Hope

In spite of limited political will to do much more than providing education to improve farm safety, Mary Miller sees a glimmer of hope. In May, 2002, NIOSH released a report outlining recommended changes in federal child labor laws to “eliminate outdated [hazardous] orders, strengthen inadequate orders, and develop additional orders to address new and emerging technologies and working conditions.” The recommendations deal with such things as operating tractors and other hazardous equipment, working in storage facilities, and handling pesticides, explosives, and toxic materials.

According to Miller, an occupational health nurse with the Washington State Department of Labor and Industries, the changes—if made—will help make agriculture safer for kids.

“I don’t believe there should be double standards for agriculture and other industries,” says Miller. “This is truly a landmark and will go a long way in the right direction.”

That said, Miller admits that it could take years for some of the recommendations to make it through the maze of legislative and regulatory processes and hurdles that stand in their way—confirmation of Purschwitz’s statement that whatever else farm safety is, it is mostly a political issue.

Montana

Combining Faith, Health, and Social Services

When President Bush rolled out his administration's Compassion Capital Fund Grant program last year, folks in Montana were standing in line ready to go to work.

The Montana Office of Rural Health and the Montana Association of Churches developed the Montana Faith-Health Demonstration Project, which received a Compassion Capital Fund Grant of \$615,000 from the Administration for Children and Families at the U.S. Department of Health and Human Services. With that money, the project will support:

- A parish nurse center to train parish nurses and congregational health ministers (volunteers who help with social service delivery and outreach);
- A prisoner community reentry program that enlists people from faith communities to help former prisoners successfully rejoin their communities and avoid returning to jail; and
- Some 20 small churches and community-based organizations working to improve the well-being of local people and communities.

The federal government requires that grant recipients pony up one dollar for every two dollars it puts in. To get the \$615,000, the Montana group had to come up with a little more than \$300,000. According to Young, the lion's share of that match

came from Blue Cross/Blue Shield, which obviously sees merit in the program.

"Faith institutions are really a strong foundation in rural communities," he says. "The first building built in most rural places was usually the church."

For more information, see <http://faithhealthcoop.montana.edu> or contact Dave Young at (406) 994-5553 or dyoung@montana.edu.

South Dakota

Improving the Health Care Workforce in Rural South Dakota

With just \$17,000, the South Dakota Office of Rural Health has created a mini-grant program to help develop the health care workforce in rural areas of the state.

The money—provided by the federal Office of Rural Health Policy—enabled the state to support rural facilities in activities not covered by other recruitment programs. Eligible projects included those that support recruitment or retention of health care professionals and those that provide for staff education or training. In addition, only facilities that are not-for-profit, certified by Medicare or Medicaid, and located in a community of 5,000 or fewer were eligible to apply.

The program began in September, 2002 with a request for applications. The procedure was kept simple to avoid the need for professional grant writers—a luxury few rural

facilities can afford. Thirty-eight applications requesting a total of \$136,000 came in. "That's a pretty good response," said Kenny Doppenberg, Special Projects Coordinator for the South Dakota Office of Rural Health.

From that pool of applicants, five projects were selected for funding, some focused on recruitment and retention, others on training. Two projects sought help in filling slots for radiology technicians—in short supply in rural South Dakota. One of the projects received funds to create a tuition reimbursement mechanism; the other to train a current employee to become a radiology technician.

According to Bernie Osberg, Director of the South Dakota Office of Rural Health, the program helps the office better understand the types of need that exist in rural areas. Although the program is too new to fully evaluate, he says, they have learned much already about what is needed and how best to meet those needs.

For more information, contact Kenny Doppenberg or Bernie Osberg at (605) 773-4031 or by e-mail at: kenneth.doppenberg@state.sd.us.

New Hampshire

Drugs by Phone

For residents of Mt. Mooselauke, New Hampshire, a tiny town 25 miles from the nearest retail drug store, getting prescription drugs filled is quite a challenge. That will soon change, however, thanks to

technology and the work of Ammonoosuc Community Health Center (ACHC) and its partners.

The health center—a federally qualified community health center—operates a remote site in Mt. Mooselauke and participates in the federal 340b drug program, getting and selling prescription drugs at a discount to its clientele. It also serves other residents of the community on a sliding fee scale. With no pharmacy in Mt. Mooselauke, however, it was difficult to get prescriptions, discount or no. According to Norrine Williams, Executive Director Ammonoosuc Community Health Center (ACHC), the solution is “telepharmacy.”

With a grant from the state of New Hampshire and help from the New Hampshire Board of Pharmacy, the State Offices of Rural Health, Primary Care, and Planning and Medicaid, ACHC has purchased a \$35,000 remote prescription dispensing machine and contracted with a pharmacist in Littleton, a town an hour away. From Littleton, the pharmacist will be able to authorize and dispense prescription drugs at the center in Mt. Mooselauke using his computer, existing phone lines, and the dispensing machine.

A trained staff member in Mt. Mooselauke will remove the pills from the machine, put them into a bottle, place a label on the bottle which has been typed by the machine, and give them to the patient. Should the patient need to consult with the pharmacist, that can also be done via the phone lines and live two-way video.

While it may sound simple enough, Williams says it has been challenging making the technology work, sorting out the logistics, and getting the necessary arrangements in place. It took a year to get authority to conduct the demonstration project, and the machine was purchased back in November.

Despite the challenges, Williams is optimistic.

“I’m excited about the potential for solving pharmacy problems in remote rural communities,” she says. “In a very remote community, patients will be able to immediately have their pharmacy needs met. It’s going to be an improvement in their care.”

Williams hopes to have the program up and running—and prescriptions being filled—by early April.

For more information, contact Norrine Williams at (603) 444-2464 or norrine@nchin.org.

Nebraska

Tapping the Universal Service Fund

For remote rural areas, advanced telecommunications offer a way to access health care but the costs are often prohibitive. An ongoing effort in Nebraska seeks to break down the economic barriers.

A group comprised of the Nebraska Office of Rural Health, the state hospital association, rural health advocates and the telephone industry

is asking the Nebraska Public Service Commission to help offset some of the cost.

The proposal would piggyback on the Federal Universal Service Fund to buy down the cost of telecommunications for rural hospitals, making it affordable for even cash-strapped facilities.

“Now that rural health care providers finally have the ability to be reimbursed by Medicare for telehealth, what is lacking is affordable telecommunications infrastructure,” said Denny Berens, Director of the Nebraska Office of Rural Health. “In Nebraska, the cost of connectivity is so high. Even though there is reimbursement for services provided, we can’t afford the connectivity.”

According to Berens, a T-1 line—a high-speed, high-capacity phone line necessary for the audio and video transmission required to provide some health services—would cost a rural hospital in Nebraska as much as \$1,600 per month. Few rural providers can afford that. As a result, the majority of Nebraska’s 60 some rural hospitals are not using the technology.

The existing federal subsidy brings the cost of a T-1 line down to about \$550 per month for a rural hospital—still out of reach for most. The proposal before the Public Service Commission calls for an annual subsidy of \$900,000 to help buy down that cost further, to about \$200 a month for each of the state’s rural hospitals. According to Berens, the hospitals have said they can

afford, and are willing to pay, that much. The subsidy would come from an existing 6.95 percent surcharge that Nebraskans pay on retail intrastate phone service.

For more information, contact Dennis Berens at (402) 471-0142 or dennis.berens@hss.state.ne.us.

Kentucky

A Holistic Approach to Services

The Southeast Kentucky Community Access Program (SKYCAP) exemplifies the growing awareness that a person's health depends not just on medical care, but on a variety of other factors—from housing to transportation to information. The group is using a grant from the Health Resources and Services Administration to address the broad challenges faced by some Appalachian counties.

For some people, however, especially those in poverty, many of those factors—including medical care—can be difficult if not impossible to obtain. SKYCAP helps overcome those obstacles and works with eligible residents of four Kentucky counties to obtain the services they need to live healthier and more productive lives.

Created in 2000 with funding from the federal Community Access Program, SKYCAP is a joint endeavor of the University of Kentucky Center for Rural Health, Harlan

Countians for a Healthier Community, and Hazard/Perry County Community Ministries.

The program trains and employs people from the local community as Family Health Navigators (FHNs) to work with local service providers to provide holistic care that includes mental wellness services, physical health care, and environmental services to uninsured and underinsured residents. They also help clients with transportation, appointment arrangements, housing issues, and heating and sustenance needs. Clients also are educated about their illnesses and taught how to properly access appropriate health care resources. SKYCAP's approach has led to successful placement of more than 300 clients in case management services. More than 7,000 people have been referred to SKYCAP.

According to Fran Feltner, who directs the SKYCAP program, the approach improves quality of life while saving health care dollars. The key is the FHNs.

"The FHNs are a valuable extension of the provider into the community," says Feltner, a Registered Nurse and Director of the Lay Health Worker Division at the University of Kentucky Center for Rural Health. "People won't tell a doctor that they don't have running water at home. They will tell an FHN. They're from their communities."

Supporters of the program say its success is evidenced by the tremendous savings generated from the decrease in hospitalization and

emergency room visits. As a result of those savings, the program is being heralded as a national model.

For more information, see <http://www.mc.uky.edu/ruralhealth/LayHealth/SkyCap.htm> or contact Fran Feltner by e-mail at fjfeltn@uky.edu.

Call for Input

Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at: info@raconline.org (Attn: **Tom Rowley**)

Innovative State Policy Options to Promote Rural Economic Development

P. Kalomiris, National Governors' Association, February, 2003.

This issue brief from the National Governors' Association's Economic and Technology Policy Studies group describes the challenges faced by America's rural areas and small towns in the 21st-century economy: poverty, geographic isolation, infrastructure deficiencies, poor links with metropolitan and global markets, weak community infrastructure for business development and growth, and the flight of skilled human capital to metropolitan regions. It then examines three strategies for governors interested in "rural economic dynamism:"

- Adapt cluster-based principles. States can support clusters by encouraging the development of industry networks that help businesses work together. To meet the need of cluster businesses for highly skilled workers, states have deployed colleges and universities as training centers. States can ensure that cluster businesses in remote, rural communities have access to the same capital and technical resources as their more advantageously located competitors.

- Promote entrepreneurship outside the agricultural sector. States can best serve entrepreneurs by providing access to seed capital; by

developing local ability to identify, encourage, and train entrepreneurs; and by using online networks and other technology to connect entrepreneurs with critical information and financial resources.

- Reinvigorate the agricultural sector through diversification and value-added agriculture practices.

Farmers can earn more by growing different types of crops, by raising nontraditional species of livestock, or by processing their crops into finished products that they market themselves. To support farmers in these efforts, states can provide the capital and technical assistance.

The issue brief is available at <http://www.nga.org/cda/files/0203RURALDEV.pdf>.

Why Rural Matters 2003: The Continuing Need for Every State to Take Action on Rural Education

E. Beeson and M. Strange, Rural School and Community Trust, February, 2003.

In an update of previous work, this report by the Rural School and Community Trust presents and analyzes descriptive data about the schools that serve the 21 percent of U.S. students who go to school in communities of under 2,500. The authors argue that these children, their schools, and their communities

matter and deserve more consideration than they get in the national debate over education policy.

The report uses two gauges to rank the 50 states: "importance" and "urgency." The importance gauge encompasses seven statistical indicators of the relative scale and scope of rural education in the state. The urgency gauge encompasses 12 indicators of the conditions faced by students, teachers, leaders, and others in rural schools and communities, plus the percentage of rural population. A cumulative ranking on each gauge is calculated and states are then divided into quartiles. An overall ranking for each state, a "Rural Education Priority Gauge," is also calculated by combining the two gauges.

In addition to the rankings, the report cites several developments that have occurred since the previous study was published in 2002, which indicate that "rural education is a little less marginalized." That conclusion notwithstanding, the report notes that many of the children attending school in the nation's most rural communities are "at risk of failing to get a quality education." According to the authors, poverty is a central reason why.

The report is available at http://www.ruraledu.org/streport/pdf/WRM_2003.pdf.

Rural and Urban Health: Health Care Service Use Differs

Center on an Aging Society, Georgetown University, January, 2003.

This data profile by the Center on an Aging Society compares urban residents and rural residents on various health and health care indicators. Its findings come as no surprise to those familiar with rural health issues: the rural population is somewhat less healthy than the urban population; chronic conditions are somewhat more common among adults in rural areas; risky behaviors are somewhat more common among adults in rural areas; and rural residents are more likely to lack insurance and access to a range of health care services.

The profile is available at <http://ihcrp.georgetown.edu/agingsociety/rural/rural.pdf>.

Rural Hunger

America's Second Harvest, March, 2003.

This issue brief by America's Second Harvest tells the story of two rural Americans struggling to get enough to eat: an elderly woman in Louisiana and a third-grader in New Mexico. In between their stories, the brief gives statistics on hunger and food insecurity in rural areas, explains their causes, and recommends ways to alleviate the problem.

While food insecurity is less prevalent in rural areas than in central cities, the rate is higher than it is in the suburbs. However, 20.6 percent of nonmetropolitan children lived in food insecure households in 2000, compared with 17.4 percent of metropolitan children. Regionally, food insecurity is highest in the rural West (15.5 percent of households) and lowest in the rural Midwest (8.9 percent of households).

As for causes of food insecurity in rural America, the report cites high rates of poverty and unemployment, transportation barriers, distance to markets, rising housing costs, and the large percentage of older residents.

Among the recommendations the report makes are promoting access to food stamps, providing equitable tax deductions, and continuing commodity spending.

The brief is available at http://www.secondharvest.org/newsroom/feature/issue_rural.pdf.

Rural Populations and Health Care Providers: A Map Book

R. Randolph, K. Gaul, and R. Slifkin, North Carolina Rural Health Research and Policy Analysis Center, University of North Carolina, September, 2002.

This map book by the North Carolina Rural Health Research and Policy Analysis Center uses data from the 2000 Census to reassess and

provide a visual picture of where rural people live, how the racial and ethnic nature of rural populations is changing, and whether the distribution of health care providers matches the population distribution.

The report is available by calling (919) 966-5541.



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The Rural Assistance Center
PO Box 9037
Grand Forks, ND 58202
Phone: (800) 270-1898
Fax: (800) 270-1913