

# The RURAL MONITOR

*A Publication of the Rural Assistance Center*

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## Putting Rural Services on the Map

By Thomas D. Rowley

Presentation matters.

With people increasingly glued to televisions, computers and video games, a picture is worth not just a thousand words, it's worth a whole spreadsheet of numbers.

In the health and social sciences arenas, maps can make population numbers and other data easier to comprehend.

"When you can take a map and throw it down there and somebody can see it, it's very impressive," said Ray Stowers, D.O., Director of the Oklahoma Rural Health Policy and Research Center. "You can talk all day, but when you lay that map down it makes a difference."

What's the difference?

By some estimates, 80 percent of all data has a spatial component. In other words, the data are tied to a particular place—address, census tract, neighborhood, zip code, city, county, state or country, to name a few. A map, because it shows the data's connection to place, helps immensely in visualizing and understanding what the data have to say.

On the health care front, a map can show what areas have the highest rates of diabetes, whether those areas have

high rates of obesity and what health care services are available.

On the human services front, a map can show, for example, poverty rates, alongside educational attainment rates,



*Participants at a community gathering in Salmon, Idaho in May 2004 hear about mapping health and human services.*

unemployment rates and child care facilities.

Best of all, a map can link all of that information together to help make the connections between poverty, disease and their various causes (as well as the services to address them). In short, mapping can not only show how various measurements play out in space, it can also show how they interrelate. Think list of ingredients (flour, eggs, sugar) versus a picture of a cake.

"With mapping, we have something worth its weight in gold as a tool," said Hartzell Cobbs, Executive Director of

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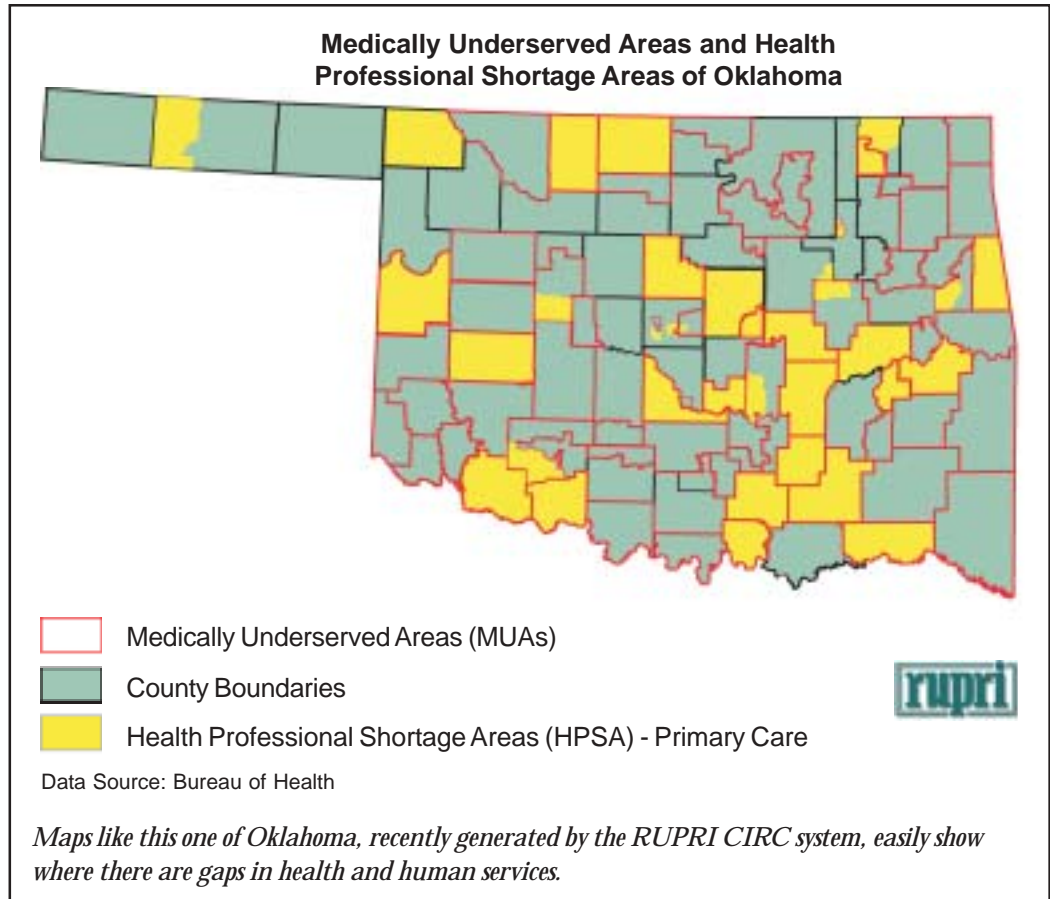
**Internet:** <http://www.raconline.org>

Mountain States Group Inc., an Idaho-based non-profit organization working in rural health and human services. “The tool is not a program, however. It is just a tool. It can inform policy and allow for better decision making.”

## Mapping for Rural Communities

So how many communities are using mapping technologies to inform policy and improve their decision making? According to a recent survey of local governments, many are, but far fewer than would like to—especially among small and rural communities.

The *2003 Survey on the Use of GIS Technology in Local Governments*, conducted by Public Technology, Inc., the International City/County Management Association, the National League of Cities and the National Association of Counties, asked questions of more than 10,000 local governments—counties, cities, towns, townships, villages and boroughs. Answers from the just over 10 percent that responded show that 64 percent are interested in Geographic Information Systems (GIS) but lack the resources to effectively utilize mapping; 42 percent said they do not have the necessary technical expertise.



## Helping Overcome Those Obstacles

To help smaller, rural communities and those who make decisions on their behalf gain access to GIS, the Rural Policy Research Institute (RUPRI) created the Community Information Resources Center (CIRC) in 2001. Among other things, CIRC provides an interactive Internet mapping tool that allows users to build their own maps using a wide range of datasets.

“As the federal government continues to push responsibilities down to the states, and states push these responsibilities down to localities, those places with inadequate infrastructure become increasingly disad-

vantaged,” RUPRI Director Charles Fluharty said. “In our continually devolving federal system, this is one of the greatest disadvantages rural America faces. We created CIRC to try to level this playing field.”

The idea was to make sure rural wasn’t left out of the picture.

“We take the technology, which, out-of-the-box, is cumbersome and challenging to use, and modify it so it’s more practical in its application to the realities of issues at the community level,” said Ann Peton, CIRC Director and former state GIS coordinator in both Missouri and Iowa.

CIRC does that by offering a step-by-step tutorial, but also by doing all of the data processing on its

## Mapping Rural Health and Human Services

GIS offers rural communities a way to evaluate, plan, and improve a wide range of services:

- Health Care
- Human Services
- Law Enforcement
- Education
- Economic Development
- Transportation
- Natural Resources

According to Ann Peton, Director of the Rural Policy Research Institute's Community Information Resources Center (CIRC), Internet mapping enables users to do all of that far more cost effectively for reasons including:

- No GIS software is required. Users only need a browser such as Netscape or Internet Explorer to interact with the Internet-based GIS.
- No data distribution is required. All data and GIS functionality is updated via a centralized server or clustered network.

computer, so that people with slower, less powerful machines can use the mapping tools. According to Peton, other mapping applications typically don't allow that. CIRC also specifically designed its mapping application to work with 56k line speeds, since so many rural areas are still

without broadband service.

"Most applications out there are built by kids just out of school who learned to build applications using T1 lines," Peton said. "They don't understand how to consider our rural stakeholders' resource limitations. Everything we do is built with the limited capacity of rural in mind."

In addition to offering a service that works with limited rural capacity, CIRC offers data that are unavailable in other Internet mapping services—things like the Health Professional Shortage Area designations, which measure health care shortage areas, and the Rural-Urban Commuting Area codes, which are census-tract based measures of rurality.

Having built a better mouse trap, CIRC is finding that rural organizations around the country are beating a path to its doorstep, giving it a long list of customers, partners and users.

### Idaho

In Idaho, efforts are underway to map the locations of a wide range of health and human services as part of that state's 211 program.

The 211 program—first developed and implemented in 1997 by the United Way of Atlanta—designates the phone number, 211, as a place to call for information and assistance with non-emergency health and human service needs. Like its cousin, 911, it provides an easy-to-remember, one-stop place for help. States and communities around the nation are working to get the system

up and running for their jurisdictions. Idaho is among the leaders in the effort.

Unlike other states, Idaho is combining its 211 efforts with Internet mapping. Currently, through its Idaho CareLine component, people can call for information or check the Internet for information on services and volunteer opportunities by geographic area, keyword and program name. Eventually, decision makers and others will also be able to map those services to see where they are and are not. The information will help them evaluate the data and establish priorities for future program development.

Among the many partners behind the effort are Mountain States Group Inc.; CIRC; Serve Idaho, the Governor's Commission on Service and Volunteerism, which oversees the state's AmeriCorps program; United Way; the Junior League; the Idaho Department of Health and Welfare; and St. Alphonsus Hospital. Initial funding came from the Murdock Charitable Trust.

"We're a large and rural state that has a lot of challenges with access," said Kelly Houston, Executive Director of Serve Idaho. "Sometimes it's hard for communities to know what's going on and for us to know where resources are in the state."

The program, she said, will allow the commission to do more things. For example, the Commission can more clearly see what areas have high drop-out rates, what services are or are not available in those areas and then determine if those are places to develop partnerships and

place AmeriCorps mentors and tutors.

Organizers say the program will identify areas of high need that are not getting services.

“We want to use it for policymaking decisions and looking at where we invest our resources,” Houston said.

While the program will eventually cover all of the state, Houston notes its special importance to rural Idaho.

“In the rural areas, the main advantage will be to allow us to identify where resources do and do not exist without having to physically travel there,” she said.

Mountain States Director Cobbs, who secured early funding for the program, agreed.

“The whole rural angle is that there is isolation in a lot of rural communities,” Cobbs said. “This puts them on the map. It levels the playing field. It provides rural communities with a sense that others care about them. There’s a psychological value in knowing what your community does is important to others outside the community.”

## Nebraska

Denny Berens is both the Director of the Nebraska State Office of Rural Health and the President of the National Organization of State Offices of Rural Health (NOSORH). He is excited about mapping’s potential for helping rural areas get better health care.

Consequently, the Nebraska office is beginning a partnership with the University of Nebraska Medical Center to tie GIS to a health professions

### The National Neighborhood Indicators Partnership

On the urban front, the National Neighborhood Indicators Partnership (NNIP)—a collaborative effort by the Urban Institute and local partners—is developing and using neighborhood information systems in local policymaking and community building to help distressed urban neighborhoods. Like the Rural Policy Research Institute’s Community Information Resources Center, NNIP partners seek to “democratize information” by facilitating the direct practical use of data by city and community leaders, rather than preparing independent research reports on their own.

In a 1998 Working Paper, *Neighborhood Indicators: Taking Advantage of the New Potential*, G. Thomas Kingsley highlights lessons learned over the course of NNIP’s eight-year history.

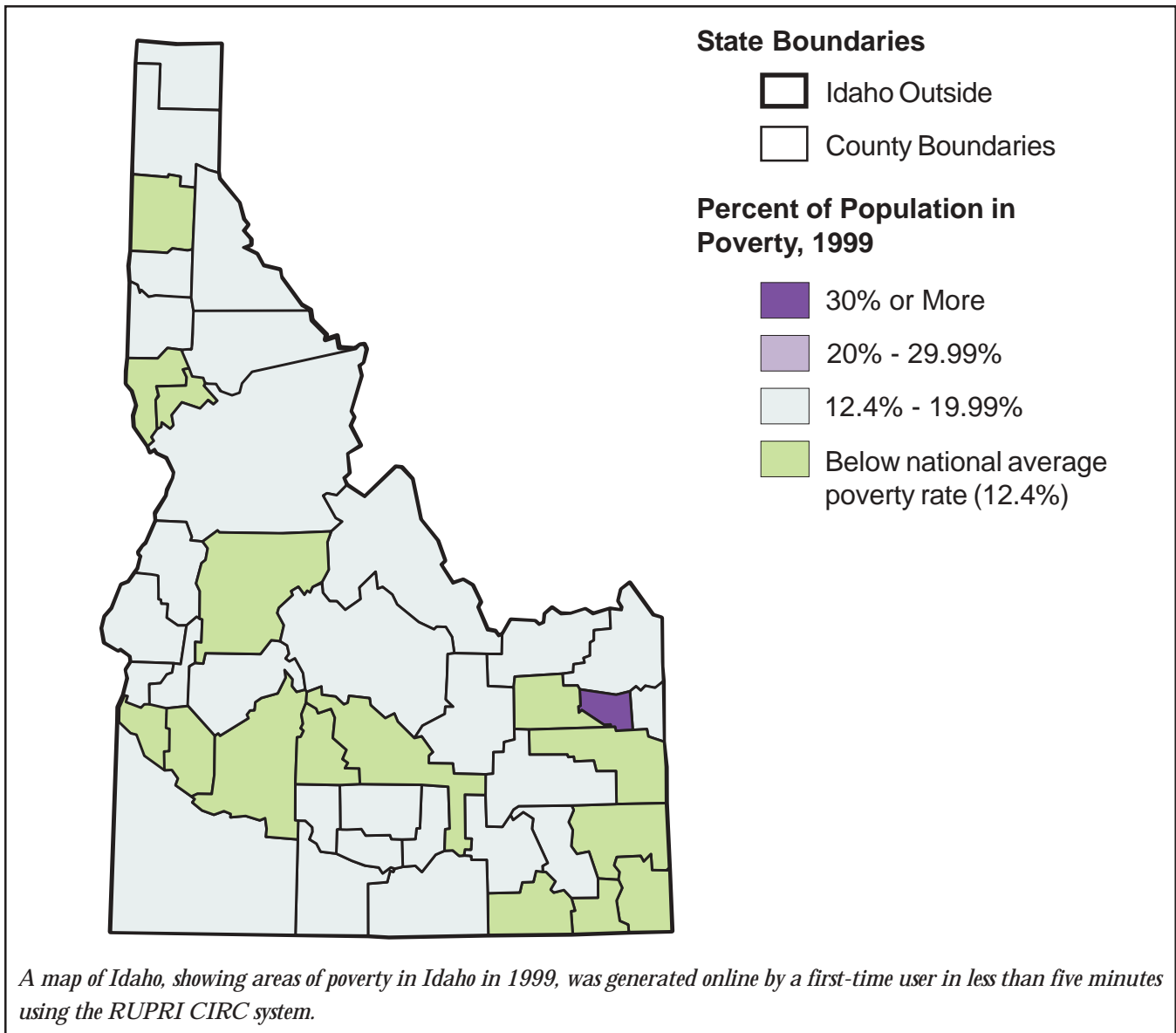
1. Design indicator systems for the explicit purpose of changing things—not just to monitor trends.
2. Develop a single integrated system that can support one-stop shopping.
3. Develop indicators at the neighborhood level—not just for the city as a whole.
4. Build a data “warehouse” from which indicator reports can be derived—not just a set of files on indicators.
5. Serve multiple users but emphasize using information to build capacity in poor communities.
6. Democratize information—help stakeholders use information directly themselves.
7. Help stakeholders use data to tackle individual issues, but do so in a way that leads toward more comprehensive strategies.
8. Use information as a bridge to promote local collaboration.
9. Use available indicators but recognize their inadequacies—particularly the lack of sufficient data on community assets.
10. Assure integrity in the data and the institution that provides them.

For more information, see [www.urban.org/nnip/](http://www.urban.org/nnip/).

tracking system. When it’s finished, health and human services researchers and policymakers will be able to click on any place in Nebraska and see, for example, what, if any, doctors are practicing there, how many hours they work in that area, how many hospital beds are there, the demographic profile of its residents, inci-

dence of disease and a whole host of other important variables. The purpose: to find areas with service gaps and help fill them.

“It’s going to be very helpful to us,” said Berens, who, as President of NOSORH, has asked all state offices of rural health to evaluate this new



tool. “It will basically build the case for what needs to be done. From a policy standpoint, this is a wonderful tool, whether at the local, state or regional level. It makes a whole bundle of information readily understandable to local residents and to policymakers.”

## Oklahoma

Further south in Oklahoma, the technology was instrumental in getting funding recently from Congress for the Oklahoma Telemedicine and Distance Learning Center at Oklahoma State University. According to Dr. Stowers, maps proved invaluable in showing policymakers what services are in their districts, the demographics and health care needs of constituents and how telemedicine would

help meet those needs.

Stowers and his colleagues also have used maps to show state legislators the need for a statewide telemedicine network.

“We would have two sets of maps,” Stowers said. “One showing the existing network and a second showing what the state would look like if we get funding. [The network] really would put us as one of the tops in telemedicine in the country.”

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## Nation

At the national level, maps are being used to show the success of the Rural Hospital Flexibility Grant Program. The program strengthens rural health care through the support of Critical Access Hospitals (CAH), among other things. Rural health leaders—with help from the Technical Assistance Service Center of the Rural Health Resource Center (TASC) and CIRC—have been circulating maps showing how the Flex program has impacted the countryside.

Specifically, maps showing the location of CAHs, their service areas and how many people they served were generated for key policymakers.

“Mapping really can help people who are not involved in the program see...what the actual impact is, how much of their state is covered,” says

Tami Lichtenberg, TASC Program Manager. “It really helps them see (for example) that three-quarters of their state is covered.”

## And More

The list of applications for GIS goes on and on—from refining Medicare reimbursement for rural ambulance service to building a better early childhood development system. As Dr. Cathy Grace, Director of the National Center for Rural Early Childhood Learning Initiatives, put it, “The questions and the answers are limitless.”

As with all tools, however, a word of caution is in order.

As one of the pioneers in using maps to further rural health policy, Dr. Tom Ricketts, Professor of Health Policy and Administration at the University of North Carolina-

Chapel Hill, knows how valuable they can be.

“Everybody’s doing it and should,” he said. Still, he and other GIS experts say it is important to also understand mapping’s limitations.

“A map doesn’t solve your problems,” Ricketts said. “It’s just a picture. To do real analysis, you have to do more than just make a map.”

He also warns that maps, like all graphic representations, can distort reality—intentionally or unintentionally.

“What you see,” Ricketts said, “may not be what you get.”

That caution noted, Denny Berens is still high on the possibilities.

“You can begin to dream,” he said.

## GET CONNECTED

For more information on the people and sources described in the previous article, see the following web sites:

### **RUPRI Community Information Resource Center (CIRC)**

<http://circ.rupri.org/>

### **Public Technology Enterprise GIS Forum**

<http://www.pti.org/gos/>

This site has a copy of PTT's *2003 Survey on the Use of GIS Technology in Local Governments* as well as a web-based interactive reporting tool that allows users to compare their GIS operations with other local governments and an On-Line Analytical Processing Database (OLAP).

### **Idaho CareLine**

<http://www.idahocareline.org/>

### **Oklahoma Telemedicine and Distance Learning Center**

<http://www.healthsciences.okstate.edu/telemedicine/>

The center is part of the Oklahoma State University Telemedicine and Distance Learning Department.

# Rethinking Human Services

by Tom Corbett, Ph.D.

## Human Services in Rural Communities: Envisioning the Future

Almost two generations ago, the specter of want and isolation in places like rural Appalachia and the Mississippi Delta motivated John Kennedy and Lyndon Johnson to call for an unconditional War-On-Poverty. But attention soon wandered to urban areas where key media outlets vividly documented the consequences of economic and social inequality as well as racial anger.

Though long neglected, the need for effective systems of social supports for rural America remains a pressing challenge. Persistent, high-poverty counties (i.e., those with aggregate poverty rates in excess of 20 percent in each decennial census since 1960) are disproportionately likely to be rural.

Given this, issues touching on the availability of public services and how they are delivered in rural communities are of great concern to the policy community. What is the best way to design and deliver high quality human services in areas where the need is so great and where both the institutional infrastructure and financing are likely to be deficient?

I, and a number of colleagues, have been studying the challenge of how best to design and deliver human services, particularly to families with multiple needs. As we see it, social programs too often are delivered through a confusing array of categorical programs organized around specific target groups (at-risk children) or narrowly defined service technologies (e.g., in-kind benefits

like Food Stamps or substance abuse counseling). Disadvantaged families in the real world, on the other hand, often experience multiple challenges at the same time.

A group of senior welfare officials, in a 2002 report from the Welfare Peer Assistance Network, put it this way:

“Arguably, the Federal government thinks about policy in terms of specific programs and categorical funding streams (each as it were, an independent ‘silo’). States, on the other hand, increasingly think about how a coherent and seamless service delivery system might better assist disadvantaged families.”

In the 1930s, when the federal government became a major player in the delivery of services during the Great Depression, there were few public programs dedicated to poor families. Over time, new social challenges were identified. New groups were designated as worthy of public help. And new strategies were suggested for solving this growing list of societal issues.

While each new public program was defensible in its own right, the array of separate programs grew unabated, each developing its own congressional supporters and advocacy groups. With separate oversight committees, with different rules for spending money and determining success, it became increasingly difficult at the local level to help families in ways that made sense to them. As early as the 1970s, then Secretary of Health and Human Services Elliot

Richardson noted that services in the United States suffered from a “hardening of the categories.”

A medical analogy is often used to describe why this is a problem. A given patient has five medical issues, but the hospital has expertise in only four of them. They treat those four very well, and assert that each procedure was a complete success. And the patient dies of the fifth condition, which, of course, is someone else’s responsibility.

When the welfare reform act (the Personal Responsibilities and Work Opportunities Act of 1996) was up for renewal in 2002, the Bush administration proposed a so-called “superwaiver” provision. This would have allowed states and local governments to seek waivers of federal rules across a broad set of programs and executive agencies for the purpose of better aligning programs and more effectively delivering integrated services. Though the welfare re-authorization bill has not been enacted to date, interest in service integration remains high nevertheless.

Over the past two years, I’ve worked with my colleagues to convene a number of meetings that have brought together what I call “lighthouse” sites, localities that have experienced some success in advancing the service integration agenda. I’ve visited many of these sites and I’ve attended meetings where we convene stakeholders and experts to discuss how best to advance this agenda. This initiative has also worked with states through the National Governor’s Association Policy Academy initiative.

*(continued on page10)*



## Look What's Coming

by Wayne Myers, M.D.

### Rural Tail Wags Dog

In the Spring issue of *The Rural Monitor*, I argued that American health care has two great problems: (1) health care is outgrowing our capacity to pay for it and (2) the quality of the care we get, and give, is unreliable. In this column I'll suggest some ways that rural communities can help themselves and the rest of the country out of this mess.

The National Academy of Sciences' Institute of Medicine (IOM) has been hard at work on the quality issues. In the year 2000 its Committee on Quality of Health Care in America issued the sentinel study, *To Err is Human*, pointing out how many people are hurt by their health care, and recommending the development of safeguards. The following year the Committee released a much broader report, *Crossing the Quality Chasm*. This report went beyond patient safety to tackle the whole subject of health care quality.

The title, "...Chasm," was selected to point out the enormous gap between the care we are giving/getting, and the care that people rightfully expect. The report endorses a recommendation that care should be safe, timely, effective, efficient, equitable and patient-centered. The mnemonic, "**STEEEP**," helps me remember the six aims. If it helps you, realize that the road to health care with those six characteristics is going to be steep.

Several of these six characteristics of quality care have potential for helping with the cost problem. For example, quality care is **SAFE** and **EFFICIENT**. One reason our health

care costs so much is that it is fragmented. Hoards of independent providers generate duplicate management costs, redundant lab and clinical work, scattered records and lack of information management.

In 1998 no airline passengers died in accidents. Would that impressive safety record have been possible if every aircraft mechanic kept his own records to himself, and worked for a separate contractor? In *Crossing the Chasm* the IOM makes the point that "Trying harder (to avoid making mistakes) won't work." Catching and preventing errors requires systems we don't have, and can't have because of our fragmentation. Pulling pieces of health care together under common management and information systems can make care safer and reduce costs.

Quality health care is **EFFECTIVE**. That means practice based on current clinical evidence rather than personal bias, idiosyncratic experience or intuition. It is generally more economical, and safer, to work through a problem methodically than erratically, though the researchers will have to scramble to keep up with the clinicians.

Quality care is **TIMELY**. Saving money while improving timeliness will take ingenuity. Certainly treating the diabetic early rather than when his foot is ulcerating will help. Getting the lab report today rather than next week may be very important. But some advances in timeliness must rest on pure human decency. A woman with a breast lump should not have to wait weeks to find out whether she has cancer. A **TIMELY**,

**PATIENT-CENTERED** system would answer that question today.

**EQUITABLE** care treats everyone alike regardless of race or wealth.

What has this to do with rural care? Rural systems may be more amenable to innovation and constructive change than cumbersome urban systems. They are smaller and have fewer players than urban systems. Local movers and shakers already know each other. It may be relatively easy to spread the word about new ways of doing things. Rural clinicians are relatively likely to know their patients' socioeconomic situation.

I know of some rural innovations that move health care toward lower costs and the six IOM aims, such as:

- Moving toward a culture of error reporting, analysis and prevention, rather than concealment.
- Starting case management in the critical access hospital and extending it into the community when the patient goes home, reducing emergency visits and readmissions.
- Pulling together local care entities (e.g. hospital, clinic, ambulance) into a single organization for purposes of administration, billing and records.
- Reducing paper and increasing electronic clinical record keeping, facilitating error detection and timely access to accurate essential information.
- Supporting evidence-based care.

(continued on page 10)

# Around the Country

by Deanna Durrett

## Nebraska

### Community Assists in Creation of CAH

Folks in Crete, Nebraska, were part of their new Critical Access Hospital long before its doors opened.

The Crete Area Medical Center opened on June 3, 2003 with a state-of-the-art design, advanced technology and extended services. But its creation began more than six years before that, with input from the community.

In 1996, Joseph Lohrman, the administrator of Crete's previous public-owned hospital, began discussions with the hospital's Board of Directors about the limitations of the old facility and the need for expanded services. Many of Crete's residents were forced to travel to Lincoln to receive the care they needed.

Lohrman arranged a partnership between the hospital and BryanLGH Health System, a Lincoln-based non-profit health care company, which agreed to construct and own the facility. An oversight committee was then established that included medical staff, members of the chamber of commerce, county commissioners and other community representatives. From there, it was time to engage the community.

"I took the show on the road," Lohrman said. "I met with all the major service organizations and a lot of community members."

The change of ownership from public to private created some initial hesitation among residents, but Lohrman addressed this issue and

other concerns at public hearings.

The architect of the new facility, Doug Elting, also attended several public meetings and worked with residents in designing the facility.

The new \$15.8 million medical center integrated the hospital and medical clinic and contains 25 patient rooms, two surgery suites and an emergency department and trauma area. The facility also touts a physical therapy and cardiac rehabilitation area, a healing garden and a helicopter pad.

"You would be hard pressed to find anyone who has not touched the project in some way or form," Lohrman said.

*For more information, contact Joe Lohrman, President of Crete Area Medical Center, at (402) 826-6800.*



*The new state-of-the-art exterior (above) and lobby (below) of the Crete Area Medical Center*



## Texas

### New Distance Learning Program for Migrant Health

A new center will offer specialized training to nurses and other professionals who work with migrant and seasonal laborers.

The Milagros Center of Excellence in Migrant Health, a collaboration between Georgetown

University's School of Nursing and Health Studies and South Texas College's Division of Nursing and Allied Health, will educate nurses, early childhood specialists, paraprofessionals and child advocates who work with migrant families in their home-base and during the seasonal migration.

The center was created in September of 2003 with funding from the Office of Minority Health in the Department of Health and Human Services.

According to the National Center for Farmworker Health, there are more than three million migrant and seasonal farmworkers in the United States today, and this population has different health needs and receives different care than the general public.

Mayra Fernandez, the administrative assistant at the Center and daughter of once-migrant farmworkers, described their unique circumstances.

"They toil in the sun, enduring occupational dangers, environmental health risks from pesticides and poor housing to harvest our fruits and vegetables," Fernandez said.

She added that they receive too few health and social services due to several factors, including high costs of health insurance, lack of transportation to health facilities and the inability to take off work to attend to their health concerns.

"Right now, there is not enough to meet their increasing need," she said.

The Milagros Center has tested two online pilot courses this year, "Mental Health & the Migrant Family" and "Growing Up on the Border." The courses will become part of a targeted program that will use distance-learning technology. Students for the courses will be accepted from states in the Northeastern and Midwestern migrant streams, with Georgetown managing the former and Texas the latter. Program administrators hope to eventually expand the program to places like California.

The program, which will first offer Certification in Migrant Health or service learning credits, is projected to be completed and available for enrollment in January of 2005.

*For more information, please contact Mayra Fernandez at (202) 687-1309 or visit <http://elearn.stcc.cc.tx.us/milagros/> or <http://snhs.georgetown.edu/content.cfm?objectID=2045>.*

***(Myers, cont. from page 8)***

Would you please tell me about your examples of rural innovations through an e-mail to me c/o the Rural Assistance Center ([editor@raconline.org](mailto:editor@raconline.org))? Have you had any success in getting payers to share the benefits of better, more efficient care?

How can such modest local innovations be of any national significance? As employers and states determine that they can no longer meet their medical bills we will enter a period of rapid and striking change. Practical experience with better ways of organizing care will be of great interest to policymakers. In the next issue of *The Rural Monitor* I'll outline one possible scenario for that period.

*Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.*

***(Corbett, cont. from page 7)***

In future articles, I'll share some of the insights and lessons learned about how to design and deliver integrated and comprehensive services effectively. And I'll discuss ways to think through how these lessons might apply to the unique and complex circumstances found in rural America.

*Tom Corbett has emeritus status at the University of Wisconsin-Madison and is an active affiliate with the Institute for Research on Poverty*

*where he served as Associate Director. Over the years, he has worked on welfare reform issues at all levels of government, including a year as senior policy advisor at the U.S. Department of Health and Human Services. He continues to work with a number of states through networks of senior state welfare officials in the Midwest and West Coasts and on issues of program and systems integration to deliver better services to challenged families.*

# Spotlight on Rural Research

by Thomas D. Rowley

## New Ideas for Rural Development

Over the past year, several institutions have taken a fresh look at rural development and proposed major policy changes to promote it.

At a March meeting convened by the international Organization for Economic Cooperation and Development, the Federal Reserve Bank of Kansas City, the United Kingdom's Countryside Agency and the Rural Policy Research Institute, some 120 senior policy officials and experts from 15 countries gathered near Washington, D.C. to discuss the future of rural policy. The consensus: rural policy in developed countries must change if rural communities are to prosper.

"Existing subsidies tie regions to the status quo....," said Thomas Hoening, President of the Federal Reserve Bank of Kansas City. "Holding a steady course in rural policy is likely to be expensive and less than effective."

In his keynote address, Federal Reserve Chairman Alan Greenspan pronounced that the key to improving the well-being of rural people and places lies in giving them the flexibility to innovate and adapt to changing global conditions. He went on to warn that flexibility is stymied and rural development hindered by the de facto rural policy of agricultural subsidies, which distort market forces, restrain trade and trap resources that could be better utilized in other endeavors.

According to these and other experts, new and effective rural policies would do three key things:

- Replace agricultural subsidies that preserve the status quo with investments that enable innovation;
- Help rural entrepreneurs find and exploit niches in the global market in which they already have or can build competitive advantages; and
- Allow a wide range of individuals and institutions—public and private—from all levels—local, regional, and national—to work together to initiate and administer them.

In *Competitiveness in Rural U.S. Regions: Learning and Research Agenda*, Harvard Business School professor and author, Michael Porter, also makes the case for new rural policy. Commissioned by the Department of Commerce's Economic Development Administration, Porter provides a useful synthesis of the rural economic situation and some ideas for improving it.

The highlights of Porter's report:

- The pain felt by some rural areas notwithstanding, Porter notes that most of the job losses have been concentrated in a few industries such as textile, apparel and footwear that now account for a small part of rural employment and are concentrated in a few regions. These industries, he says, are not representative of the whole rural economy.

"The performance of rural economies is far from dismal, and is actually promising in many fields," Porter writes in his article. "This suggests that there may well be more opportunities for economic

growth in rural areas than are generally perceived."

- The essence of rural areas is their differences, not their similarities. Efforts to improve rural economic performance must be region-specific. One size does not fit all.

Furthermore, the efforts must be truly regional—encompassing both rural and urban areas.

"There is little or no structure in place to forge the strategic linkages between rural and nearby urban areas that will be critically important in moving to the next level of economic development," the author notes.

- Productivity is the key. "A region's standard of living," writes Porter, "is determined by the productivity of its economy. Productivity is measured by the value of goods and services produced per unit of labor, capital and the natural resources employed. Productivity sets the wages that can be sustained and the returns to investment in the region—the two principal components of per capita income."

Porter's article argues that the way to increase productivity is to create and commercialize innovations. And the way to promote that is to see to it that rural areas have the research, training and investment capital needed to support entrepreneurship.

Porter believes a rural policy framework is needed that recognizes and addresses the differences in rural regions and focuses on building their competitive advantages rather than

---

simply reducing their disadvantages.

In *Reversing Rural America's Economic Decline: The Case for a National Balanced Growth Strategy*, The Progressive Policy Institute's Robert Atkinson lays out his plan for revitalizing the rural economy. In it, he writes "our de-facto federal rural policy—providing massive subsidies to a shrinking number of farmers—does little to help develop competitive rural economies or boost opportunity for rural residents."

Atkinson's three-pronged approach:

1. Convert farm subsidies to investments in place-based rural economic development. Citing the billions of dollars that the U.S. (and Japan and the European Union) spend propping up agricultural producers, Atkinson calls for a multilateral disarmament in agricultural subsidies over a 15-year period by developed nations. The money saved would be used to help rural communities plan and gear up to compete in the New Economy. (In 2001, rural development programs in the U.S. got only \$1.2 billion, a fraction of the sum given to farm payments.)

2. Move rural programs out of the federal bureaucracy and consolidate them in a single quasi-governmental agency. Hundreds of federal programs exist to help rural America. Clearly, that bewildering array isn't getting the job done and, in fact, gives community leaders fits trying to figure out where to go for help and how to get it. Atkinson wants Congress to create a new Rural Prosperity Corporation—directed by folks from business, labor, state and local government, and by rural

experts—and give it the flexibility and entrepreneurial drive to make things happen.

Specifically, he wants the corporation to manage grants to states (with financial contributions by the states) that enlist them in helping communities develop. He also wants funds targeted to so-called growth poles, rather than spread all over the map.

"In order to effectively create the most jobs in rural areas," Atkinson writes, "efforts should be targeted to a small number of centers with the potential to be the regional anchors for growth that surrounding rural residents can commute to for employment."

3. Move government facilities and jobs out of congested, high-cost urban areas that don't need them and into un-congested, low-cost rural areas that do. He cites Social Security Administration claims processing centers and teleservice centers as prime candidates of "routine back office government functions" that could be relocated to rural growth poles—reducing costs, maintaining service and helping rural areas.

## Whither Farming?

In all these ideas, agricultural subsidies are reduced drastically, if not eliminated. What, then, will be done for farmers?

While agriculture can no longer be the driving force behind rural policy, farmers and ranchers cannot be forgotten. Rural development policies must be crafted to enhance

their well-being too. Indeed, the link between the two is obvious, if sometimes ignored or presented cart before horse.

Most U.S. farm households rely on non-farm employment for the majority of their income. Rural development provides jobs, income and benefits (32 percent of the country's farmers have no health insurance) for farmers and their families. And just like everyone else, farmers need the hospitals, schools and other services that rural development helps provide. Farmers today depend more upon the rural economy for economic survival than vice versa.

As Secretary-General of the Organization for Economic Cooperation and Development Donald Johnston put it, "Agriculture must find itself within a new, broader, synergistic policy, not outside of it."

### Reports are available at:

*New Approaches to Rural Policy: Lessons from Around the World*

[http://www.kansascityfed.org/RuralCenter/mainstreet/MSE\\_0604.pdf](http://www.kansascityfed.org/RuralCenter/mainstreet/MSE_0604.pdf)

*Competitiveness in Rural U.S. Regions: Learning and Research Agenda*

[http://www.eda.gov/ImageCache/EDAPublic/documents/pdfdocs/eda\\_5frural\\_5fregions\\_2epdf/v1/eda\\_5frural\\_5fregions.pdf](http://www.eda.gov/ImageCache/EDAPublic/documents/pdfdocs/eda_5frural_5fregions_2epdf/v1/eda_5frural_5fregions.pdf)

*Reversing Rural America's Economic Decline: The Case for a National Balanced Growth Strategy*

[http://www.pponline.org/documents/rural\\_economy\\_0204.pdf](http://www.pponline.org/documents/rural_economy_0204.pdf)