Creating Competitive Communities: Pastor's Conference on Effective Community Planning Held at South Dakota State University, Brookings, January 23, 24, & 25, 1967

South Dakota Agricultural Experiment Station
Department of Economics, South Dakota State University

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CREATING COMPETITIVE COMMUNITIES

Pastors' Conference

on

Effective Community Planning

held at

South Dakota State University

Brookings

January 23, 24, & 25, 1967

Economics Department
Agricultural Experiment Station
South Dakota State University
Brookings
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Introduction

The second Pastors' Conference on Effective Community Planning was held January 23, 24 and 25, 1967 on the South Dakota State University Campus. Its theme was "Creating Competitive Communities."

Although we attempted to tape record each talk, we were not able to get a usable manuscript for each one to include in this pamphlet. Perhaps with several more months delay something could have been obtained from each speaker. The fault in no case is with the speaker. They were not asked to provide us with a paper.

Rather than delay any longer getting distributed the papers we have, it was decided to omit those speakers for whom we could not prepare at this time a usable version of their talk. Those omitted include the talks by Dean Ine Hinsvark, Prof. Stanley Marshall, Mr. Dale Roth, Mr. Robert Aldern, and the wrap up presented by Msgr. Louis J. Miller. The substance of the talk by Mr. Robert Antonides is available in his publication: "Some Guidelines for Organizing Economic Development Efforts in South Dakota Along Trade Area Lines," Extension Circular 651, South Dakota Extension Service, S.D.S.U., Brookings. Because this publication was distributed at the Conference it was not felt necessary to include his talk in this pamphlet.

While the Economics Department does not necessarily endorse all the ideas presented in these talks, it is felt that they will contribute to the stimulation of thought and ideas on the subject of community planning and development. We are pleased to make them available in this form.

The Planning Committee for the Conference consisted of the following:

Conference Chairman:
Orville Berkland, Assistant to the South Dakota District President, The American Lutheran Church.
Conference Vice-Chairman:

Conference Secretary:

Conference Treasurer:

Committee Members representing South Dakota State University:
Dr. Loyd Glover, Professor and Head, Economics Department; College of Agriculture and Biological Sciences.
Prof. Howard M. Sauer, Professor and Head Rural Sociology Department, College of Agriculture and Biological Sciences.
Dr. John E. Thompson. Extension Economist, Rural Economic Development, College of Agriculture and Biological Sciences.
As I directed my attention to this paper I found myself needing a more precise definition of the word "community". It became immediately apparent that the community is a widely discussed and deeply analyzed entity in American life. The sociologists have devoted much time and many pages to the discussion. However, it also became immediately apparent that there is not agreement on the definition of the word community.

Perhaps the most interesting comment on the community was that of Don Martindale as quoted in "The Formation and Destruction of Communities".* Martindale's comment on the community is as follows. "The essence of the community has always been found in its character as a set of institutions composing a total way of life. In the past when communication and transportation facilities were primitive, such total ways of life were usually confined to relatively restricted areas. It was convenient under such circumstances to view communities as territorially based systems of common life. Systems of common life still arise, but they are relatively free most of the time of any narrow dependence on a restricted territory. Perhaps it is not asking too much to expect the theory of the community to discover the industrial revolution."

*As quoted in paper by Dr. Ronald Powers presented at the Rural Sociological Society Meeting Aug. 1965, "The Utility of the Social System Concept in Area Development".
Although there might be definitional disagreement among analysts, there are also areas of general agreement. There is general agreement that the rural community is not the same community as it was 50 years ago. There is also general agreement that the rural community is still changing rapidly. Most people will also agree that the social and economic conditions in the rural community need improvement. Furthermore, most informed people will agree that our nation will be a better nation when this rural improvement has been accomplished.

In other words, I am sure we can find general agreement among the objectives relating to the rural community — the objective of improvement. I am sure that we can also find general agreement in the desire to accomplish this improvement in the rural community. However, I am also certain that there is a significant difference of opinion regarding the means, methods and techniques in accomplishing rural improvement.

This morning I would like to convince you that there is an untried method that offers great potential — a great potential for improving the rural way of life. "To convince" is perhaps too ambitious, but it is with that hope that I have accepted this assignment.

I know that many of our foremost rural, political and institutional leaders have given impassioned pleas for:

1. Keeping the small farm.
2. Maintaining our farm population.
3. Keeping the rural values and attitudes and extending them to everyone.

If I interpret the statements of these rural leaders correctly, I understand them to be expressions of a sincere desire to move the clock of history back
at least 50 years. Some of these rural leaders are personal friends of mine, and I believe them to be entirely sincere, but I also believe them to be wrong. They are pleading for an alternative that does not exist, and they have permitted fantasy to gain over realism.

The butterfly must emerge from its chrysalis or it will not survive. Rural America is also undergoing a metamorphosis. Standing still or turning back is not a viable alternative. First, it simply cannot be done. Second, should it be possible, rural America, like the butterfly, would experience an undesirable condition unanticipated by those who prescribe this course.

There are two alternatives rural America must recognize and face. One, adjust to the changing social and economic environment or, two, condemn itself to poverty, ill health, illiteracy, low levels of income such as we have never known before. We must recognize that these are the only two alternatives facing us and the choice between them should not be difficult to make.

Let us undertake an aggressive program to improve rural America. This program should include improvement in the economic levels, improvement in the educational levels, improvement in the cultural levels and let us maintain the best of the rural American democratic ideals, the moral values, the idea of an honest day's work for an honest day's pay. In brief, let us devise a program to develop rural America, both economically, socially and "realistically". Let us do it by looking forward, not backward. Let us do it by aggressively planning ahead and not by wistfully wishing for the return of the good old days.

Before we can plan a realistic program, we must be fully cognizant of
some of the hard, cold facts with which we are dealing. Some of us might wish these facts would go away, but they have always been with us and will be for some time to come. One of these facts is as follows. Every community must have an economic reason for existence. In some communities the economic reason is commercial recreation in others, manufacturing in others, space exploration. But in most of rural America the economic reason for existence of a community is to serve the farming industry.

Should the economic reason for a community's existence disappear, then the community will also disappear. Reflect for a moment on the ghost towns in the west, the most dramatic example. When gold was discovered, mining became the economic reason for a community's existence. Boom towns blossomed in the gold mining areas. But as soon as the vein of gold became depleted, the community made a dramatic metamorphosis from a boom town to a ghost town. The economic reason for existence had disappeared.

What is happening to the economic reason for communities in rural America? Technological developments, particularly mechanization, have made it possible for fewer farmers to farm the land better than ever before. Transportation and communication technology have made it possible for rural people to travel further more conveniently than ever before. The economic reason for the existence of rural communities has not disappeared, but the economic reason supporting some of our rural communities has changed significantly in the last 50 years. And it is because of this change in the economic reason for a community's existence that we are expressing our concern for the rural communities.

But I am sure that most of us are familiar with that story so I will not
spend much time looking back. Let us look ahead! What kind of rural America would we like to see? And again, among informed people, I find very little disagreement.

1. Agriculture is the economic base of rural America. Serving the farming industry is the economic reason for a rural community's existence. Therefore, it logically follows that if we are to have strong viable rural communities, we must have a structurally strong farming industry. A structurally strong farming industry is a family farm industry with each farm large enough to fully employ a farm family and to provide an income comparable to that of the rest of society. If we are to achieve a structurally strong farming industry, somehow the vast amount of underemployment on small farms must be corrected.

The present truth is that half of our farms are now too small to provide a farm family with a fully employed job. Let me emphasize that I am not saying that we should move farmers off the farm. If the farm industry can minimize "entry mistakes" in the next 20 years, the natural rate of retirement of farmers can move farming rapidly toward a structural strength.

2. We must have structurally strong rural institutions.
   A. School vocational training community colleges must have an economic base large enough to provide the highest possible quality at the lowest possible cost.
   B. Churches must be in the appropriate number and location to provide a quality and character of service and witness which is not severely curtailed by economic considerations.
   C. Local government functions must be designed to serve present and future needs, but designed to serve an adequate tax base.

3. We must have structurally strong service sectors.
   A. Retail establishment must be of the kind, number and size to balance with the economic base in order to insure quality service to the customer and reasonable income to the retailer.
   B. Professional services, doctors, lawyers, etc., must be balanced in kind, number and quality with the economic base. If this were true, no rural community would have difficulty securing the qualified medical services within reasonable time-distance.

4. Community environmental facilities must be modernized. The transportation, communication, water, power, recreation, and other community facilities should be available to every rural resident.
Most people would agree that this is the kind of rural America they would like to see. Therefore, it is the kind of rural America we should plan toward.

As we reflect on a rural America possessing these characteristics, one inescapable conclusion emerges. Not even the most devout fundamentalist would admit that it is possible to achieve these characteristics in every presently existing rural community. Such a possibility is outside the bounds of economic reality.

What then? Is it impossible to have the kind of rural America I have described, the kind that offers rural people equal income equal facilities equal service, equal amenities with other people? I think it is entirely possible, but it will take the kind of future planning by informed, aggressive leadership that is not making itself apparent in rural America today. The leadership in rural America must fully recognize that the small town in Martindale's words no longer contains a set of "institutions composing a total way of life." The small town does not have an economic base large enough to support the set of institutions to achieve the characteristics previously described.

However, the functional economic area embraces an economic base that can permit the development of higher quality institutions than rural America has ever enjoyed. And modern transportation insures that these institutions can be within the reasonable time-distance of every rural family. A short precise definition of a functional economic area does not exist because it appears on no maps. It corresponds to no survey lines and its geographical dimensions can vary from one region to another. Furthermore, it is not always called a
"functional economic area". The same area could be called a "labor market area," "an expanded rural city," a "functional sociological area," or a "multicounty community". In any case it is not only a recognition that the "rural communities" of the past are no longer adequate, but it is also an attempt to identify the relevant rural community to synthesize today's advanced technological accomplishments with today's rural living.

The significance of a functional economic area becomes apparent if we visualize a large city with more than 100,000 population spread over an extensive land area of several rural counties. The functional economic area has a sufficient economic base to provide commercial and institutional services at high quality and lowest cost. The residents at the perimeter of the FEA have access to any or all of the commercial or institutional services within an hour's driving time.

It is also necessary that residents of the area feel that they are an integral part of the "large community". This inclusion is due to the availability of social and economic activities within the area as well as transportation and communication patterns which have developed over time.

In geographical terms the FEA of rural America consists of a central city (wholesale center) of 25,000 or more population. It also includes several retail centers (county seat towns) and numerous villages and farms of approximately 10 counties. The exact geographical area will be determined by population density and transportation conditions. In general terms 1 hour of driving time from the central city approaches the boundaries of FEA.

The area is so constituted that social and economic gains at any point within the area will have beneficial effects upon the area as a unit. The
different functional areas in a given state have many similarities such as total population, economic resources, college graduates, labor commuting patterns and available services. Given all the similarities it is definitely possible to consider programs of one area within the capacity of other areas. The functional economic area can serve more adequately as a basic unit for social and economic planning than the presently existing rural geographical units. Therefore, I am suggesting that we must look forward and plan the future development of rural America on the basis of the "larger community"—the functional economic area. Rural development will include future planning in all aspects of rural living on a multi-county base. Aspects of this planning will include:

1. Planning for area transportation and communication
2. Planning for recreation, parks and tourist development
3. Planning for industrial parks, zoning, water, power, etc.
4. Planning for schools, colleges, vocational training with units in number and size and location to fit the tax base.
5. Planning for churches and other institutions with units in number and location to fit the population base.

These are the more obvious aspects of planning but aggressive imaginative planning for rural America's future will also include the more difficult but necessary considerations

1. It will include planning for consolidation and location of local government units and functions in accordance with the population and the tax base.
2. It will include planning for graceful retirement of many of our small town "convenience center" communities which have served us well in the past but are no longer needed.
3. It will include planning for the removal of abandoned farmsteads abandoned main street buildings and perhaps eventually the removal of entire small towns that no longer have an economic reason for existence.
4. It will include planning to abandon the maintenance on rural roads that are no longer needed and could even include the planning for relocation of farmsteads along maintained all-weather roads.
Emerging from this long-run plan would be efficient production of goods and services, high-quality retail, governmental, and institutional services available to all the area residents at the lowest possible cost. Emerging from this plan would be the larger community with a central city containing airline services, radio-TV stations, community college, vocational training, and other services which require a large economic base. Also emerging from this long-run plan would be several retail centers with modern and well-equipped retail and service facilities comparable in size to the existing county seat towns today.

In addition, there would be several "convenience centers" specializing in providing inputs in the farming industry. These convenience centers would be the strong, viable small town of the future. I have not said the small town will disappear; I do not believe it will. I think the convenience center in rural America still serves an economic purpose but rural America has far too many of them today than it can possibly support.

With courage and aggressive planning, rural America can develop and enjoy living satisfactions exceeding any previously demonstrated.

But there are those who say that this type of planning is unnecessary. They say that the expanding and exploding metropolitan centers will of necessity have to use the more dispersed population areas eventually. Perhaps this is true. We can speculate that future national policies will subsidize industry to locate in the more sparsely populated areas. We might see deliberate government investment or deliberate government policy to locate governmental activities such as space exploration in the sparsely populated areas. Should this be true, and it is indeed possible, it will not only increase the importance of the kind of planning on the larger community basis that I have
suggested. Should the complications of a rapidly expanding industrial base be thrust upon the problems of the adjusting rural community long-range multi-county planning will become even more necessary.

There are those who say that this type of planning is totally unacceptable to rural people. As of now, 1966 perhaps this also is true. But it has been my experience in working with community leaders that if they have the information at their disposal and are fully aware of the alternatives before them they are fully capable of making the right decision.

The larger rural community cannot be thrust upon rural America. Planning without implementation is sterile. The only alternative is an informational educational program for both rural and urban America which will present the alternative courses to pursue. If and when this is done I have great confidence that rural America will choose aggressive planning on a larger community basis, but this will not happen automatically. It will not happen unless rural American leadership emerges to lead the way. It is my opinion that the rural problem has been adequately identified—the answer is available to us. Now we need informed leaders with the courage to pursue our only realistic course of action.
This is a substitute in that Mr. Kelsey was on the program and was to be here this afternoon and was unable to make it. He has been working directly in the programs of planning communities and the things they can do in finding the better type of income from resources, and entertainment from activities which communities can support and are willing to support and help them in becoming knowledgeable enough to make the decisions they would like to make.

I am going to have to limit my remarks to a discussion of the services of the particular area in which I am somewhat founded at the present time. I will discuss general extension services which are available to the people of South Dakota and some of the things were becoming involved in and will become more involved in.

One of the things I am sure many of you are interested in is the planning and programing in connection with federal programs. There is a tremendous amount of concern and effort directed towards plans, community orientation to the problems and changes of the next 30-40 years of the 20th century. The conference theme "Creating Competitive Communities" seems to imply that we know what the competitive communities is or must be and that we would like to think the answer lies in education, that people become informed to the point that they make the decision that will provide them what they would like to have. I have been asked to review some of the things that are aides for community planning from our particular office. I will confine my remarks to this area.

It was mentioned that this office was identified just recently as being an office of services in the general extension area. The idea being that we have done many things in production, management and marketing and have become
very competitive through the cooperative extension program and homemaking role, in our youth program and in 4-H. At the present time we are requesting that the broadening of these services include all areas of the state and even though we have a rural state and we have few urban and suburban problems, in light of the programing being done at national level. We have reversed problems in that the rural problems, as far as population, distance and travel and the ability to establish state institutions is as great to us, as is the congestion of the urban and suburban area. The population shift is taking place and while we are not leaving our economy we are leaving production areas and going into Agri-business or related areas and we do have problems. Extension is attempting to serve all these segments.

The specific services I am going to start out with in reference to our government programs, are these services distinguished as a separate from agricultural production. For example, the State Technical Service Act which was established to provide technical and consulting services for business and industry was established under legislation by the Federal congress which makes available through a board within our state to provide programs and assistance to those parts of our economy which are saging or which are not competitive, which are related to business and industry. Under the State Technical Service Act we have become involved in providing an extension service in the field of engineering.

I suppose all of us are so familiar with the county agent role as a factor in all our counties and communities that when we say an extension engineering service, it is easy for us to equate this to the present communication system that now exists. So here on this campus in connection with our engineering program, we have established a consultant extension service connected with the engineering division under Dean Stone, who is also known to many of you as the
director of the cooperative extension program and is also Dean of all extensions on this Campus.

The State Technical Service Act is programmed services to enable business and industrial establishment to acquire new scientific and engineering information effectively, through the preparation and dissemination of reports and abstracts of materials such as computer tapes, referral and consulting services. In some cases problems are solved directly by the State University where the technique and the assistance is available. In some cases, of course, referral is made to Technical Engineering Consultant Services. Iowa's CIRAS is a highly sophisticated program of this nature while this is our first move in this area.

I presume that I should say that many of the things that we now are identifying as new programs have been carried on to a degree, though the existing structure of extension was never identified necessarily as such. The teaching of new knowledge throughout the field has been carried out where requested and where called on by the extension service, as it now existing. We want people more aware that there is an overall service to continuing adult education in all phases not just in the field of agricultural. The State Technical Service Act has developed a directory of technical assistance, people, and subject matter field, available for business and industry is the same manner as the referral services in the agricultural field. Under the Technical Service Act we are sponsoring work shops and training programs, field visits, conference and seminars. Federal funds being available have been the thing that started it moving when we felt we had no local resources.

In connection with the State Technical Service Act, we are also prepared to give specialized training in the field of management, training for key personal and in this title the writers of this particular proposal included small
businesses. Large business set up and have the ability to preform services for management, provide training for key personal by small businesses and small firms do not go to consulting organization. A directory of products needed by industry in the state, that purchase from outside the state, is being prepared with IDEA. This is venture which IDEA (Industrial Development Organization) has had a firm hand in. So in these three areas, management training, marketing directory, and the engineering field service we have broadened the concept of extension.

A second area that has developed rather rapidly is Title I of the Higher Education Act. Under this act there have been many things done with libraries and school facilities. The governor appointed a commission to work out a state plan by which assistance could be given to the people in the solution of community problems such as housing, government, recreation, employment, youth opportunities, transportation, land use, and zoning. Our state organization which is the same as the Higher Facilities Act Commission assume the responsibility for establishing a five year plan, incorporating in it the things that could be done for people in South Dakota, and in this particular area we establish proposals, covering an adult educational program for training and assisting leaders.

The college of pharmacy conducted a series of conferences over the state that served 30 percent of all registered pharmacist working in the state of South Dakota. Another program provides administrative management programs for local business and industrial firms which we think is extremely important. We are aware of the fact that our health services people working in many of our communities need to be brought up to date on some of the things that are being done in health services and nursing programs. They are tied closely to effective community planning. In planning you must have things organized so you know where you are going to go, what you are going to do in the meeting, and how it may come out. The best plans have to be revised from time to time and
This broad approach to community planning and training aides in community planning is the government's attempt to move into what they feel is a void that has been a gap in local planning which has not been taken care of. I am sure that many times we wait until something from the outside makes us aware of the critical situation that we are living with and accept. When decisions are made, all the people have the right to participate and if all the people in participating fail to have enough knowledge to make the right decisions, the right to make decisions can soon be lost.

One of the areas that is going to give us a boost in communicating with people over the state and increasing our teaching effectiveness certainly is in the field of educational TV. There is a board handling education TV programs for the schools of the state. These are 108 schools participating on ITV (Instructional TV) which is a commission within the educational TV board. Blocked time is saved for the normal elementary secondary school programming time, but the channels for Educational TV can be opened from early morning to late night, depending upon the amount of programming and will give us a chance to do adult continuing education programs before and after the school day. The educational TV program of South Dakota is off and running, giving us another communication system in a state with problems as far as sparse population and great distance. We have a job to do in telling people, educated people, that their decisions determine which direction we move, how fast we move and how far.

We want a community with size enough and a tax base adequate to support the institution necessary to provide the kind of a place that a man and his family can live happily. Some of you know that I lived in cities and I don't like cities—I like to live in small towns, and I like to live where everybody know what you do and then reads the weekly newspaper to find out who got caught.

I'm going to wind this up by saying that there are programs in many areas
designated to aid and assist in creating the competitive communities that were outlined for you by your keynote speaker in the early part of this afternoon. I am sorry that Mr. Kelsey couldn't be here. It's been a privilege for me to be here.
I guess it is customary to start out with a joke. I really don't have too much time to learn new jokes any more, but I'll tell an old joke that might help me get started here. The meaning of this joke I think has changed quite a bit in the last few years. It is a joke about an Indian reclining under a tree by a stream and doing some fishing. Along comes, believe it or not, an enthusiastic young minister who spies him and says, "What are you doing under the tree?"

"Well, I'm fishing," he says.

"Well it is the middle of the afternoon, why are you fishing?"

"Well, what should I be doing?"

"Why don't you go to work and get a job?"

"Well, what for?"

"Well if you get a job then you will have some money coming in. You could budget your money and you could put some of it away gradually."

"What for?"

"Well, when you get enough put away and you get it invested and your money grows, eventually you will have quite a pile there."

"Yeah, so what?"

"So well then when you get old enough you can retire and you won't have to work anymore and you can go fishing."

"I'm fishing now."

That joke was originally supposed to illustrate what a happy-go-lucky, lazy bunch of people we are, and supposed to show how far we are out of the main stream of American thinking and American life. I suppose it is still true, but it is interesting that in the last ten years or so some people in various parts of the country have been thinking about the future of America, how it is going to be in 50 years or 100 years from now, and one of the problems that has really got them hung up is what do you do with all this leisure time when everything gets automated. How do people get over the feeling that they are not really contributing members of society unless they are putting in 40 hours a week? We have electricians in New York City working 30 hours a week and trying to get down to 25 and the real advanced thinkers are worried about what these people will do with their spare time. How do we get them to use their time productively? On behalf of my people, I suggest fishing.

As was explained in the introduction I am working with the Indian Community Action Project, which is a project of the Institute of Indian Studies at the University of South Dakota. We are concerned with providing certain
services in the Indian Reservations in eight states in this area from the Dakota's south to Kansas and east to Michigan and this is under title 2 of the Economic Opportunity Act.

But before I describe what is going on in the Community Action Program, I would like to give you a little background of what has been going on in the reservations in the last 50 to 100 years. The original ideas for solving the Indian problem had to do with breaking up the sense of community—the sense of identity of the people. Then they used the divide and conquer the approach to diplomacy with the tribes: finding the people who would agree with you and naming them leaders and thereby splitting the group. In order to prevent the threat of war, people were reduced to complete dependency on the government for groceries, as you probably know. Through the reservation system attempt was made to completely reduce them into submission so that they would not make their own plans (which would usually conflict with the plans of their neighbors) so that they wouldn't try to form a real opinion about anything and, so that they wouldn't assume responsibility for their own affairs because this responsibility usually went contrary to government policy. I am sure you are familiar with this through your knowledge of history. This worked fairly well and it can be argued that is was the only alternative the government had because the desires of the two groups of people were so contrary. Unfortunately, over a number of years of living on reservations the people developed certain habits of action which led them to believe, led them to adopt the attitude, that the only action possible for them, the only effective action, was negative action. So when a new policy came out, they would protest. Or as you saw in South Dakota several years ago when legislation was proposed which they didn't like, they would protest. Sometimes they have been effective and sometimes not.

The keystone of the policy of the tribes in the past and into the future has been and will be the protection of a land base as a home for the people, so that they can still make some attempt to retain a sense of identity and sense of community. In many ways this has been contrary to government policies.

In 1934, in response to a study that was done, the Marion report it is called, the Indian Organization Act was passed which attempted to provide some sort of self-government for the tribes. The problem was that this was a form of government patterned somewhat after the American government. It was a representative government of the type many of the tribes weren't used to, so that the way that they received it and the way they put it into action was not the way John Collier, the architect of the act expected. He was an anthropologist and he thought if you give them self-government, maybe they will be able to pull themselves up by their own bootstraps. Unfortunately this system was superimposed on them and they didn't quite know how to handle it and they couldn't fit it into the existing social pattern. Also, the attempts they did make to use this system of government were thwarted by the federal government because it was never really allowed to function. They were never really allowed to make a mistake. These policies all operated to stifle self-government and self-determination.

In the last few years there has been an awakening on many reservations, partly as a result of the new policy that began to come in towards the end of the Eisenhower administration and that was brought in fully by President Kennedy. This was a policy supposedly to help the reservation to develop physical and human resources, develop a sense of community, and gain a little more say over their own affairs. Many of the larger tribes began to plan several years
ago for their own future. They began to use their own initiative, to use
their own resources and generally have a say in what happens to them. The
result of this has been that they have found many alternatives to the Bureau
of Indian Affairs, which has been their little private cul-de-sac in the
Federal government. They have begun reaching out to other resources, mainly
public. Private resources have been limited largely because of the lack of
experience and knowledge of the tribal leaders about where to look for private
resources.

The smaller tribes in general did not take this opportunity to begin
planning their own affairs. They did not gain this initiative because of their
size and because they didn't have the tribal resources to hire people or to
sustain an effort. So then in 1964 the Economic Opportunity Act was passed
providing for the Community Action Program and in response to the recommendation
of the task force on the Indians an Indian desk was set up in Washington to
make grants directly to the tribes. This avoided the regional office stopover
and allowed the tribes to develop and conduct programs on their own reservations
for all the poor people on the reservation. It was planned by them with the
initiative by them and administered by them. This is one of the first times
that an Indian tribe has had the opportunity to participate in a program under
the same rules as everybody else, going through pretty much the same procedures
and being expected to do the same things. This has caused somewhat of a re-
volution in Indian thinking. The tribes have taken the initiative over-
whelmingly as many of you know.

In South Dakota many of the tribal people were instrumental in helping
some nonreservation communities apply for Community Action Programs because the
tribes had been operating programs for a year, or a year and a half, before
the other communities even considered it, or at least got to the point where
they were ready to apply. One of the reasons is that the tribes for years had
been organized, in the sense that they had been making plans, they had been
wishing and dreaming. And the tribal councils represent, for the most part,
poor people. There is very little divided interest. The tribe is responsive
directly to the poor people. In the nonreservation communities of course, the
poor people have not had the opportunity to organize themselves or be organized
and this is one reason for the lag throughout most of the country in community
action programs getting starter--the poor people weren't organized.

I suppose most of you are familiar with the Community Action Program as
it applies to the whole country. There are a few things I would like to point
out about it. As you know the Community Action Program makes grants to com-
munities for programs that they develop themselves, ideas that they develop
themselves, that are supposed to alleviate the conditions of poverty in that
community. One of the requirements has been that the poor people are involved
to the maximum feasible extent in the administration of the program and in
the hiring. This is a new idea and there has been some controversy about it.
Columist, Art Buchwald, said that asking the poor people how to win the war on
poverty is like asking the Japanese how to win World War II. In a sense he
is right but you can be sure that we didn't win World War II by sitting over
here talking about our country and how our country is made up and what our
armed services are like and what we think should be done. We spent a good
deal of time wondering what kind of country was Japan, how they think, what
they want, what are they after. If we hadn't done that we probably wouldn't
have won World War II either. So the principle, if you are going to deal with
someone, you best know what they are thinking and the kind of people they are,
still holds.
I think that this is a rare case of Mr. Buchwald's lack of insight or maybe inability to resist a good joke. I think the reason that community action programs have been the success that they have, is largely because there had been a leadership gap, not only on reservation but in the whole country. The people, the voluntary associations, the public services, the private enterprise that should have been doing many of these things, did not act, and I am afraid this is an old story. But obviously the job wasn't being done. Obviously, as you well know, there were alot of people trying to help poor people get out of whatever bad situation they were in, but it wasn't really being done. I think the reason was that rather than trying to help the people as people, they were trying to make carbon copies of themselves out of these people.

And involvement was lacking. I think the concept of involvement probably wasn't understood. I have heard this from other people. The concept of involvement of the poor people was not understood by the majority of congress or by the president when this act was passed. I think this is obvious because when the poor people really began to involve themselves there were alot of surprised politicians around. The very idea sort of leads you into an inescapable conclusion that there are going to be alot of political changes or at least sparks flying if the people really got involved and really say what they want and really go after it to try to get it.

So it has been a surprise to a lot of people, and I think it has been a surprise to a lot of people associated with Indians. In the same way as has been done throughout the country the Indians CAP's are giving the people a voice in what is going to happen to them. They are making the plans. Regardless of what the experts say from the B.I.A. or from their schools and churches, the people are the ones who say, "this is what we want." But to keep things in perspective, the people are also learning the problems of administering several million dollars worth of programs. They are learning that you just don't say, "this is what we want to do and you go do it." There are many problems connected with it and this gives them better insight into the problems faced by the agencies that are trying to serve them.

Also the concept of the non-professional has been a big hit on reservations. It has been a great addition to reservation life. Now the tribes can hire their own people as non-professionals—sometimes people with a pretty bad record from societies point of view—but the tribe has decided it will give them a chance. They have received some training from our office and have been put out in the field to help the professionals administer a program.

As you know there are a lot of little jobs that a professional does, a social worker, a minister, a policeman, anybody, that do not require a professional to do—file vouchers, all these little things that you don't have to be trained with three or four degrees to do. The non-professional can help in these ways, and in the process learn something about what the agency is doing. Also this helps to overcome the gap between the professional and the people he is supposed to serve. The non-professional is out in the community talking to the people who are supposed to be served and finding out why the service is not effective as it could be, and he can come back and tell the professionals. There is a language gap, not just Indian and English language, but a language gap when any profession develops its own little symbolic language which is way up where other people can't understand. The professional forgets this, and he starts throwing around these terms that people don't
understand. If he's got a non-professional there he can tap him on the shoulder and say, "hey, wait a minute." This is a good thing. It has worked very well on reservations and as a matter of fact I would recommend the concept of the non-professional to churches. I think this is something you might use.

The CAP's have provided the tribes with a staff for the first time in the history of many of them, to help them plan, to help them define very strictly what the problems are, what the goals are, and how to reach them. This is something that has never been done by a tribe before--it has always been done for them. Someone has come along and thrown a ten year plan on their desk and said "O.K. Tribe, now by next week you decide whether you want this or not because we have to send it into Washington". The tribe will say, "Ya, I guess we want it, because I don't know what else we are going to do." They don't have to do that anymore. They have their staff. It has also helped the people as individuals. It is their program. If they have a problem they can go to their Community Action Program. They don't have to go to some impersonal agency that has an answer some place but always says it in terms we don't understand.

Now the way we fit into this at the University is two-fold or fourfold or some fold. We have two grants, technical assistance and training. The technically assistance grant provides funds to hire people to work with the reservations on planning. This would be defining problems and finding resources to meet whatever needs the people define. We have a full time staff with 6 or 7. We also have money for consultants.

We are trying to bring the best knowledge available in certain fields to the reservations and to use them in such a way that they can sit down across the table, and the reservation can say, "this is our problem." Then the professionals can say,"here is one way to solve it", and the reservation replies,"we don't want that, give us another one." They can keep doing this until they arrive at something. So this is not a one shot affair and the tribes don't have to take it or leave it.

We also have a training grant in which we organize training sessions for the staff that is hired on Community Action Programs and in some cases for other people on the reservations. For instance, we are trying to develop at the request of the tribes some ways of training the tribal council to understand a little better the form of government that they are working with, and how it relates to society. They learn how with this tribal council, district councils, and the superintendent of the B.I.A. they can meet the needs of the people and what is each man's responsibility. The tribes are wondering these things, and I think just the fact that they are wondering this shows that they are doing some very deep thinking about their responsibilities, about their role in the community, and they are doing this in response to questions that are being asked in the communities. I think that this shows a lot of activity going on out there. We are trying as well as we can to bring the resources of the university to bear on these problems as defined by the tribes.

We are also trying two other factors involved in our services. We are trying to meet the immediate needs of the Community Action Programs by helping them with forms, helping them satisfy all the requirements and also meet the long range needs by trying to uncover more resources for them to use, and not just public resources. The tribes for a long time have been tied to the federal government as the only resource. We believe that this is wrong and the tribes believe that this is wrong. We want to bring every possible
resource to bear in solving the economic and social problems on the reservations. Of course this will take time to find out who they are and who is interested, but this is what the tribes want and this is what we are trying to do. Also for long range planning in general, let's face it, they are determined to stay there on the reservation because that is where they live; those are their homes. The people who want to leave can leave, but many of the Indian people are determined to stay.

What we are trying to do with the tribes is to help them decide what the reservation would be like if all the problems were solved, what would it be like physically and economically, and what would they like to have there.

There we have some very rough community planning, which is what we are supposed to be talking about. This is very crude, but we have to start some place. This is the people deciding where they want to start, where they want to go, and laboriously working out ways to get there. There are many problems that we have and the tribes have. I think the major one has been time Congress has been in the habit of thinking that if a job can be done with X number of dollars in ten years and you would appropriate 2X number of dollars you could cut the time down to 5 years. It doesn't always work that way and Congress has trouble understanding this. People fall into certain habits that aren't cured over night. We are not going to get results overnight. There are bound to be people who, whether they can see 50 years in advance or not, would still rather fish than work. This is a problem. There are a lot of people, however, who would rather work right now. Congress expects results too fast, that is one problem.

The commitment of society has not been as total as the legislation reads. As I said, few people understood the real implications of this program, and when they see some real community action on the part of the poor people they begin to think "well maybe that wasn't such a good idea." This supplies as well to the tribes. In the cases of poor people, often the first ones they turn on are certain people on the council. They say "you haven't been doing a very good job the last ten years you have been on the council, maybe you ought to leave." This makes community action a bit less attractive than it was before. But this principle goes for everybody. I think some of the, perhaps, cynics who had an intellectual understanding of the possible consequences of this act, underestimated what the poor people could do with it. They thought it could happen this way but it probably wouldn't. Again, the resources are limited under Title II of the Economic Opportunity Act right now, but if there is a total commitment which is needed, is demanded, in order to solve these problems, then we have to find these other resources.

The tribes, many of them, lack experience in administering programs, in looking at a long range point of view, because it was never before necessary for them to do anything but look at the day before them or to the end of that day. It takes awhile for a tribe or a group of people or one person to develop the habit of looking at the long range, making a compromise here in order to get to the next step. Also, there has been a rather sad lack of cooperation on the part of local resources. This applies to just about every agency serving poor people in communities. Instead many of them have adopted a "wait and see" attitude, or worse, adopted the attitude "they can't do it--they don't know how to do these things." This we have got to find some way around. I think it can be done. It will be done. I know that most of the tribes in the two years I have been working on this program have changed 180 degrees. Before they asked for things that they had a right to get. They asked for our
services and they took them anyway they could get them. They asked for re-
sources. Now they are very direct, they say "this is what we want. Tell us
how to get it." They seize the initiative, which I think is the first step
towards getting anyplace.

People have asked about the cut back in funds that Congress made last year
and is threatening for next year. This will be inconvenient for us and for
the tribes. But I think in general it doesn't really make any difference what
they do with their funds, because the tribes are on the move now and they will
find the help, they will find the resources wherever they can get it. Its
going to be more convenient with some money to help them right now but they
are going to get it anyway.

I think for people in non-reservation communities there are many ways you
can be of help to the tribes. You have resources within your community, human
resources, that should be put to work and could be put to work. You have people
who would be willing to give of their time and give of their skills to assist
the tribes in developing certain programs. I think if you spearheaded such an
idea, each community that you represent could help these tribes in their efforts
to improve their reservations economically. Also I think that if you would
develop something like this in your community, it would be of benefit to your
community, because you would see what you have to offer yourselves as well as
others. It is sort of a "people to people" arrangement. Also I think one of
the things we are going to do is to help the tribes communicate about themselves
to other people, and I think, by the same token, you and your people could learn
a lot more about what is going on here.

Many of the problems and many of the things in these communities are similar
to your communities, your rural communities. Many things are different. I think
you can learn from each other. I think that too often well meaning non-Indians
decide that the way to solve the Indian problem is to make Indians like them,
because they don't seem to have any problems. The way to do that is to en-
courage them to move off the reservation so they will be dispersed around.
Then everything will be all right. This is not going to work, and they are not
going to do it. I think that what can be done is for everybody to stay right
where he is but so that we can still communicate. We can visit back and forth;
lets do it that way.

I call upon you to become interested in these people because they are there.
I can assure you within the next 10 to 15 years this country and this area here
is going to know what vital and living communities are out there and the progress
they have made. As long as we can help them, we are going to try, and when we
can no longer help them. I hope we can get out of the way before they run over
us.
A few decades ago, American society seemed to be divided into two clear-cut segments: rural and urban. Today, increased mobility of our people and advances in communication media have lessened the contrasts between rural and urban population. Nevertheless, differences still exist in availability of resources and facilities for human services in rural communities of America as compared with large metropolitan centers. This is particularly true in health services and facilities.

Health, as all of us except the very young have had occasion to know, has a great deal to do with the quality of our lives. It is both an end and a means in the quest of quality. It is desirable for its own sake, of course, but it is also fundamental if people are to live creatively and constructively.

Some Rural Health Concerns

An increasing number of rural health problems arise from our changing environment as follows:

1) **Mushrooming suburban developments** extending into rural areas have already posed some serious menaces to public health;

2) **Inadequate sewerage disposal facilities** will almost inevitably lead to outbreaks of communicable disease unless proper provisions are made;

3) Assurance of an **ample supply of uncontaminated water** for family and farm use is an increasing problem;

4) Problems arise in **land use**, as well as in **planning and zoning decisions**;

5) Farming requires an **increasing use of chemicals in insecticides and other pesticides and fertilizers**;
6) Rural safety is a problem of national concern, since farming is the third most dangerous occupation. Farmers suffer an abnormally high rate of work-connected disabling and fatal accidents;

7) Access to hospital facilities and distribution of health manpower continue to be problems in the more sparsely populated sections of our country;

8) Mental health problems are of particular concern today. We see it in the fact that at least half of the patients who seek medical care have an emotional component connected with their illness;

9) More than 100 different animal diseases are transmissible to man;

10) Health care for migrant farm workers poses certain difficulties;

11) Expansion of outdoor recreation facilities and recreation enterprises in rural areas and on farms has many health implications, and

12) The enrollment of rural people in voluntary prepayment sickness and hospital insurance plans presents special problems. Many people, unfortunately, insure against minor expenses that they could pay themselves while failing to secure coverage for major surgery and hospital bills.

Health Is a Community Affair

During the past four years a large group of professional persons from the various fields of health care services, known as the National Commission on Community Health Services, has been administering community self-studies, operating specialized task forces, holding regional and national forums, and finally has produced a report entitled "Health Is A Community Affair."

In describing the goals of comprehensive personal health services, the Commission indicated that the range of services available and accessible in the community must promote positive good health, apply established preventive measures, seek early detection of disease, and promote prompt and effective treatment.

The specific health services involved in the achievement of these goals will necessarily vary from community to community as local needs, preferences, customs, and capacity determine. However, the range and quality of services
toward which communities strive are increasingly clear. Because of the very nature and rapidity of change, the Commission realizes that what it says now will not apply for all times and its report calls forcefully for increased research and demonstration efforts to develop improved methods of organization and delivery of health care and to enhance the quality of services.

**Physician-patient Relationship**

Every individual should have a personal physician who is the central point for integration and continuity of all medical and medically related services to his patient. Such a physician will emphasize the practice of preventive medicine, through his own efforts and in partnership with the health and social resources of the community.

The physician should be aware of the many and varied social, emotional, and environmental factors that influence the health of his patient and his patient's family. He will either render, or direct the patient to, whatever services best suit his needs. His concern will be for the patient as a whole and his relationship with the patient must be a continuing one.

It is critically important to make full use of available medical manpower. The physician is neither nurse, social worker, nor physical therapist. He is a physician. His training and talents as a physician must not be dissipated by employing them--except in crisis situations--in any nonmedical discipline. Because it is necessary to face up to this fact squarely, and make the most efficient use of limited physician manpower, health care functions not requiring medical training should be delegated by the physician to other members of the health care team to the maximum extent practical.
Community Health Planning

Physicians and health workers have long recognized the need for community health planning to prevent fragmentation of services, needless duplication of services, and waste of money, not to mention the need for efficient utilization of the services of health manpower and facilities.

Planning is essential for developing comprehensive personal health services in a community. A community is used to describe a geographic area within which a health problem can be defined and dealt with, and within which the community or communities can draw every service needed.

By combining resources and efforts in larger and more functioning groupings, rural and small urban communities--comprising a population base large enough to support a full range of efficient and high-quality health services and facilities--can achieve the conditions necessary for effective community health planning.

The dimensions of an area within which residents should join to carry out integrated planning are likely to be already marked by the trading or community patterns that have been drawn by rural and city residents together--as they drive to work, to shop, to college, to visit, to recreation and cultural facilities.

In most such communities, the total population will be large enough, with enough potential users of each essential service, to justify employing competent full-time resident specialists in medical services. In some communities, where town of 10,000 are scarce, it may be more practical to provide major services to people at the outer limits through mobile facilities.

The school structure is often the central focus in community planning. To be a true community center, the school should serve as a magnet to draw people together and to give them collective identity. Studies show that the sense of belonging to a community is important to the family, as it must belong to some
unit in which issues and problems can be debated and where social activities and social controls can take place.

By using the school system as the primary indicator for community structure, other social structures can be clustered about it which often may encompass several communities to provide a suitable population base. These social structures include centers for recreation, cultural activities, spiritual enrichment, health, family and household needs, location of industry, and social interaction.

For example, the Missouri Growth Center Concept is an attempt to do comprehensive planning for all the basic needs of people who reside in a certain geographic area. Two principle criteria have been used to designate the centers as follows:

1) It is preferred to have a center of service within one hour's driving time of every citizen. In the center it is envisioned to have at least a junior college and major medical facility in the form of a hospital with some degree of specialization to meet not only emergencies but normal medical needs of the area.

2) The area served by the center should have a minimum population of at least 40,000.

Naturally, there are vast differences between Missouri and South Dakota. But the general principles involved in community development should have application in most every state.

Planning is defined as designing for action. Planning is therefore a means to an end, in this instance action to change community health services so that they meet present needs. Unfortunately, too many of us fail to recognize that a "plan" is not a plan unless it contains all the elements necessary to bring about action. Our shelves are filled with surveys and recommendations, so-called plans, representing huge expenditures of citizen effort, which in reality were only wishful thinking by well-meaning people.

We have long given lipservice to the need for citizen involvement in planning: prominent citizens are found who endorse a study; an impressive
letterhead carries an extensive list of sponsors; agency executives and presidents of boards are interviewed; a public meeting is called to receive the report and there is anonymous applause.

We must accept the basic rule that the essential foundation of a community plan is the active participation of citizens who lend to the study committee all significant shades of opinion of the various interests in the community and exert, for the committee, leadership in securing acceptance of the plan by their respective interest groups. What then are the steps we must take to conform to this rule?

Let us look at a number of specific factors which tend to make programs in health planning successful:

1) Although readiness of a community to plan and act is dependent on many factors, a seemingly important factor is presence of a planning structure;

2) Effectiveness of planning is dependent on aggressive skillful leadership which succeeds in involving and influencing economic, political, and professional sectors of community life;

3) Health is not isolated unto itself, but is intertwined with numerous other community factors;

4) Awareness of health as an urgent community problem is usually held in lower priority than many other community concerns and may be relatively low on the overall value scale;

5) Health action is dependent not on professional health workers alone but on effective involvement of the sectors which make up the community;

6) Regional planning across political boundaries is not easy. It requires realistic, skillful facing up to traditional vested interests -- professional, economic, and political -- resolving the conflicts and controversies that are bound to emerge, and developing the kind of collaborative relationships which allow decision making and action programs to evolve; and

7) Self-study is one technique which can be used effectively to bring together disparate community groups for the educational, political processes of action-planning for health. It can form the setting for community health action in widely differing kinds of communities from the sparsely populated rural areas to large multi-jurisdictional metropolitan regions.
Feedback from community study leaders in the 21 community action study groups of the National Commission on Community Health Services provides us with some useful information. If there is one thing learned in these studies, it is that there is no single blueprint for study and solution of problems that is applicable to all communities in all situations. Self-study is a process of action. We may call it **action planning**.

One of the 21 communities mentioned previously was a rural, agricultural area where the health study was started largely through efforts of the home demonstration clubs in the outlying towns. Although the major town (the county seat) had some environmental health services, they were limited to the city limits, and no services extended into rural areas. In response to this need, the county medical society and the Chamber of Commerce decided to spearhead efforts to obtain countywide health services.

They organized a study group with strong representation from such groups as the home demonstration clubs, the county commissioners, city council, city health department, medical society, Chamber of Commerce, voluntary health agencies, schools, etc. The group decided to develop a countywide health departments as a first step and decided to retain the study steering committee as a permanent citizen's advisory group to the county board of health.

There is need in many communities for:

1) Planning to provide continuity of care and free flow of patients into the appropriate facility at the right time, the hospital, nursing home, rehabilitation center, and others;

2) Programs of home care: food service, homemaker services, and nursing care;

3) Day care centers for the care of children of working mothers;

4) Greater utilization of inactive professional and subprofessional health workers to work on a part-time basis: registered nurses, practical nurses, laboratory technicians, and others;
5) Hospital-based rehabilitation services for outpatient clinics for ambulatory and home-bound patients;

6) Improvement of ambulance service;

7) More adequate space in school health service area in schools; and

8) More health education at the time when people are most responsive to it, in the hospital, the physician's office, the home, at school, and at work.

Planning for Emergency Medical Care and First Aid Training

The AMA Council on Rural Health, at its meeting on January 28-29, 1966 in Chicago, reviewed the problem of emergency medical care for rural communities in America. The council agreed that availability of effective emergency medical care and of safe transportation to the nearest physician or hospital for treatment are absolute necessities for every citizen.

A recent study of rural and urban traffic fatalities in California showed that one and one-half times as many people were injured per 1,000 population in traffic accidents in rural counties (under 50,000 population) as contrasted with urban counties (over 500,000 population) and that people injured in rural counties were almost four times as likely to die of their injuries as those injured in urban counties, despite the occurrence of less severe accidents and more survivable injuries.

The higher case fatality ratio in rural areas seemed to be related to the inability to provide adequate first aid procedures and to get the person to a hospital within a reasonable period of time.

Emergency medical transportation and first aid arrangements are also important to farm families because 740,000 farm people are disabled every year in accidents on the farm. Only those who work in mines or on construction jobs have a higher accident death rate.

Recognizing that the following measures will improve the effectiveness of
emergency medical care in rural communities, the Council strongly urges that:

1) Rural communities coordinate their efforts with adjacent towns in analyzing existing patterns of response to medical emergencies. This must be done by each community individually, since urban and rural areas will have different problems. Bottlenecks and poor communication patterns may occur in different places. Particular isolated stretches of roadway or waterfront may have so many accidents that it is worth installing telephones or first aid supplies or providing first aid training for residents or workers in these areas.

2) Adjacent rural and urban communities, where feasible, institute a medical service area program for emergency medical transportation facilities and health personnel to include initiation of programs to evaluate automotive and helicopter services in sparsely populated areas.

3) Rural communities in cooperation with town or urban centers of population, where possible, adopt the model ambulance ordinance to give the public a greater voice in the quality of ambulance care. This ordinance proposes standards for ambulance equipment, personnel and operation, liability insurance requirements, maintenance of records, duties of regulatory agencies, and penalties to be imposed if the ordinance is disobeyed.

4) Rural and urban communities provide a program of advanced first aid instruction for the non-medical people most frequently called in rural emergencies -- especially police, sheriffs, and ambulance crews; and

5) Rural and urban communities develop a continuing campaign directed toward first aid instruction for rural families and particularly young people through the schools, 4-H Clubs, Future Farmers chapters, and other educational channels. The long-term goal is to have at least one member of every rural family trained in basic first aid procedures.

To implement the latter goal these points should be followed:

1) A campaign geared to grass-roots development by committees at the county or district levels.

2) Step-by-step action plans made available by these committees.

3) The inclusion of first aid instruction as part of the regular programs of participating organizations.

4) The provision by rural news media of effective communication aid.

5) The involvement of rural organizations, and particularly rural youth.

6) Emphasis on the concept of first aid instruction as an aid to accident prevention through promotion of accident-consciousness and improvement of attitude toward safety.
7) Greater effort at providing materials and methods to reach low income families including migrant workers.

One of the most shocking findings of recent studies of emergency care has been the number of hospitals and communities that have not made even the most simple preparations for emergencies. In many areas there are no road signs to indicate where the hospital is located. Once having found the hospital there are no signs to direct one to the emergency room. Emergency planning must include questions about communications, care at the scene, transfer to the hospital, and treatment after arrival. Lives can be lost by neglecting any of these.

Health Education Helps Meet the Challenge

One of the effects of rapid technological and social change is the increasing need for more education and, in particular, more health education.

Every person, to the extent of his knowledge, must assume responsibility for his continuing good health. The key words here, however, are "to the extent of his knowledge." If in our American society, we assume that the people have a right to know, where can they go for education about health?

Effective health education must be available to the individual of all ages, the family, and the entire community. Health education must begin and must continue to reach people where they are -- at their current level of awareness of personal and community health matters. Such education, to be effective, must teach basic health knowledge, attitudes, and practices, and the teaching must cause the student to act -- either to do something because it will promote his health or to refrain from doing something that will be hazardous to him or to those around him.

Education for health is a fundamental aspect of community health services and is basic to every health program. It should stimulate each individual to
assume responsibility for maintaining personal health through life and to par-
ticipate in community health activities. The community has a responsibility
for developing an organized and continuing educational program concerning health
resources for its residents. Each individual has a personal responsibility for
making full use of available resources.

Health education can and should be provided in varying degree by many kinds
of people. The health educator can provide special services to many sectors of
the community. The physician can explain the nature of illness and treatment
to his patients and he can also explain preventive measures. The housewife can
teach her family and recommend a course of action to her neighbor. The teacher
can teach the rules of personal and public health to students. Voluntary health
agencies can further develop public education programs relating to the agency's
field of interest. Special interest groups within a community can identify
their specific objectives in health education and coordinate their work with
the work of others.

None of these concepts is new. What is new is that communities are now
becoming aware of the fact that knowledge about health, like knowledge in any
other field, must be taught so as to motivate the person receiving the informa-
tion to relate it to himself and to his own life.

The objectives for health education, then, are to interest each individual
in his own health and the means to improve it; to teach him where health services
are available; to motivate him to use them; and to enable him to discriminate
between scientific health care and quackery.

We need an increased educational program in the potential of health careers
for young people at the junior and senior high school level. Ways must be found
to attract potential medical students with a rural background who will be willing
to return to rural communities after graduation and enter general or family
practice. Here is an opportunity for our schools and youth organizations like 4-H and FFA to render an outstanding service for our young people and the nation.

The health services industry employed about one million people in 1940. Today its ranks are approaching three million. It is the nation's fastest growing employment field, ranking third in employment behind agriculture and construction. If present trends continue, it may be No. 1 by the early 1970's. However, the health services industry is generally concentrated in the larger metropolitan complexes where the large centers of population live. It is the distribution of health manpower and facilities which pose problems for people living in rural areas of our nation. For example, the physician-population ratio in 1960 for the nation was one physician for every 737 people and in 1965 one physician for every 681 people. In general, this ratio is higher in rural areas, that is, there are more people per physician. The trend is for even greater concentration of physicians in urban centers.

Looking Ahead

As we look into the future in the changing rural community, we can visualize the team approach for providing health services and facilities. In order to utilize the services of the physician most efficiently, a nucleus of professional people in the community can provide valuable assistance. The dentist, pharmacist, public health personnel, nutritionist, nurse, health educator, staff of voluntary health agencies, clergy, sanitarian, physical therapist, safety engineer, veterinarian, and school health personnel -- all allies of the family physician -- would certainly be included on the health team.

Medical practice will change. There will be greater emphasis on keeping people healthy. In the years to come, health education and disease prevention will be of paramount importance. Early recognition of disease will be stressed. The prevention of disease -- through development of a more healthful environment,
through immunizations, through better understanding of food and nutrition, through fitness programs for youth and adults -- will increase in importance.

Finally, we can say that the way for each of you to attain the goal of this Conference lies within your community and its resources. Ultimately, the power is found within the people themselves. As Thomas Jefferson said, "I know no safe depository of the ultimate powers of society by the people themselves; and, if we think them not enlightened enough to exercise their control with a wholesome discretion, the remedy is not to take it from them but to inform their discretion by education."

alk
1/19/67
"A SMALL TOWN MEDICAL CARE EXPERIMENT"

Dr. Thomas C. Points

It has been stated that health is a community affair, and the community is a patient. The individual going his daily rounds sets the boundaries of his community. The dynamic character of the population affects the pattern of medical care and hospital facilities as much as it does any other public or private enterprise. A great number of people have moved from the rural areas in the last two decades but more would have, had it not been for new machinery which enabled them to do their work more efficiently, and for farm reorganization which gave them a new basis for management and production. Had it not been for these innovations, the agricultural picture would be very much sadder indeed.

Teachers, tradesmen, and physicians have also left the rural areas in disproportionate numbers and they will continue to leave unless there is the equivalent of new machinery by which they can do their work, plants which enable them to operate successfully and the assurance of a fairly consistent income.

Twenty to twenty-five years ago almost every small rural town had access to a family physician who was revered as an individual. Then came along astonishing medical and scientific advances, specialization and industrialization, better roads and transportation, the mobile population, or the itch to see the larger bright lights with the shift from the rural to urban living.

All too often, and in too many communities, a sort of dreaded disease is set in on them. People said, "it was what is happening to small towns, and it was the fate of every small town to die away." They then would let the empty buildings deteriorate, let empty houses become ghost houses. In fact the town would decline in accord with the philosophical attitude, "Small towns are dead, and this one is no different. I don't have the gumption to try to stem the tide so I'll just sit here, eek out a living as long as I can and die with it".

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Is this your attitude or your town's attitude? I doubt that this really is your attitude. Otherwise you would not be taking the time to come to this conference. If you just wanted to get away from it all, you would registered here at the conference and then messed around town or some other place. But you are here taking part, thereby showing your interest.

I for one am a firm believer that some small towns will come back. They can grow, they can become centers, but they won't accomplish this by feeling sorry for themselves. It is a reported fact that industry, whether 10 employes or 10,000 employes, look at communities from many angles, but three of these are: (1) schools (2) churches and (3) medical coverage. These three factors are greatly interwoven. School boards report they have difficulty recruiting new teachers and keeping their good ones if there is an absence of medical coverage. The same holds true for rural and small town churches, I expect. On the other hand, I know physicians who will not go where there are not good schools for their children. Nor will they go where there is not good basic religions under pinnings for the community.

The Jewish Talmud itself stated "No Jew may live in a city that lacks a good physician." Emerson said, "The first wealth is health." In all surveys that have been conducted as to why physicians don't go to small communities, economic or income dissatisfaction is usually the very last on the list. There are many, many others that take precedent.

In the United States there are many more rural communities than there are urban and there is a great need for the provision of health care for these areas--services to all areas. At least one-third of the population of the United States lives in rural areas. Although families in rural areas want, need, and expect to have health coverage available and within a reasonable measure of time and distance, it is too often unavailable. On the other hand, where do those city
go for recreation? They go to the rural areas for hunting, fishing, boating, picnicking. For a good many years I have heard of South Dakota as the mecca or the ultimate for pheasant hunting and then there are the Black Hills and other tourist attractions.

It is reported that 70 percent of all auto accident deaths occur near sparsely populated communities. Could it be that the lack of medical staff facilities and equipment contribute more to the high death rate than the fact that distances are so much greater? Distance in itself is a relative term. Driving 100 miles to view — to freeze — while watching a football game is not nearly as far as 20 to 30 miles for a mother with a small child who has a bleeding cut near the eye. There is one thing I remember from years past from one of my ministers — and he says this is the only thing I really remember from him. In one of his sermons he spoke of this business of time, and said that there is a great deal of difference between three minutes of a lover talking to his girl long distance and the same time for a prize fighter in the ring. This is the way of time and distance.

Now for the people who seek their recreation in Oklahoma and who just drive through, there are areas of the state either completely lacking or shamefully short of medical coverage. There are 77 counties in Oklahoma with a total area of 68,887 square miles and a population of 2,328,284 with 1,834 practicing physicians. In only six counties, generally located in the northeast corner of the state, there are 1,172 of these practicing physicians for 1,063,503 people, Approximately one-half of the population, covering 4,000 square miles or only 5.8 percent of the total area of the state. Conversely, only one-third of the practicing physicians are available to serve the remainder of the state, encompassing 71 counties, 94.2 of the total land area, and one-half of the population. Now we do not wish to dictate the kind of practice or the place of practice of physicians. They will go where they are attracted. Hence, rural practice must be
made attractive to physicians and other health personnel if the rural health services are to be met.

Many communities have felt, and still feel, that all they must do is build a clinic or small hospital and this will attract the physicians. In reality, the basic depths of rural health services are those of health personnel. From reviews and experience have come the growing conviction that perhaps too many small hospitals may have been constructed in communities where the real need may not have been for so many in hospital beds, surgery and sophisticated equipment, as for well equipped and staffed diagnostic and emergency facilities. The construction of hospitals in the absence of medical and technical personnel has been seen as an economic waste.

Too many of these were and are affected by the same problem that is, low occupancy and low utilization. The expenses of a practically irreducible staff are ordinarily spread over a few patient-days which sky rockets the per-day cost to the point where the community is faced with a big red deficit which has to be made up each year.

Obviously, a community attaches much importance to a new medical facility. It is proud of the hospital and frequently regards it as the show place of the community. Very often the facility tends to generate a high degree of community pride. Praise for the facility becomes praise for the community and for all the individuals in the community. Similarly though, criticism for the hospital is regarded as an attack up on the community and upon its citizens, and they cannot dodge the brick-a-bat—because they insisted that such a facility be built.

Now recognizing the seriousness of this problem in Oklahoma, the medical profession through the Oklahoma State Medical Association and other related medical groups, in cooperation with the medical school, accepted this as our medical-social responsibility. We seek answers by studying the situation. Now
we don't propose any mass health program based on a rigid pre-conceived bureaucracy but rather pilot programs in which we hope to learn some facts as we assist communities to solve their own problems. The medical school is not going to set up another practice of medicine, but we want to learn how to use our health personnel and to develop project responsibility.

Now what is project responsibility? First, in cooperation with the various organizations and groups within Oklahoma, we are doing a complete health survey of all the health personnel in the state, where they are, what they are doing, their education, their training, their background. We are doing this for facilities, and we are doing it for the area economics. We call this our "Health Intelligence Facility". We are trying to find out where all our health personnel are, where they are not, and who needs what.

The second phase is that we are trying to project into the future what our health needs really are, what they are going to be, and to project these from the findings of this needs study, from expectations of the public and from the universities and the social forces.

Phase three is the re-evaluation of our curriculum at the School— not only in hopes that we can shorten it but also re-evaluate it to put out more family physicians. We have established within the Department of Preventative Medicine a division of Family Practice. We have established a Family Practice Clinic, completely divorced from the medical school physically, where these boys can see family practice. Also we are putting in a school of Allied Health Sciences to produce our other personnel.

Now we are well along on these first three phases, so what is phase four? Phase four is the provision for a pilot study in the packaging of medical service in a "have-not" rural area. It has these objectives: to develop this center geared to the modern concept of family medicine, to utilize this center for the development of a university-approved program in family medical care, to study
the methods for increased efficiency and economy of effort in providing this
care for rural areas, to put in exemplary medical care in these areas, to attract
family physicians to rural areas, and to stimulate rural communities to par-
ticipate in improving their own cultural environment. We publicized this through
the papers and the problem developed that we had 23 communities express an in-
terest to the dean that they wanted to be considered for the plot project. Well,
we didn't go to any community that didn't come to us, because if we felt that
they weren't interested enough to come to us, we weren't going to go push some-
thing down their throats.

From this 23, we reduced the number to 17, because these were the ones who
really wanted an on-the-spot investigation. The other six didn't qualify for
many reasons. One was that they might have already had medical coverage there
and, as you ministers know, there are going to be a few people in the con-
gregation who are dissatisfied and want a change. They got in touch with us
saying, "Well, we have medical coverage but he is no good" or "he is too busy"
or something. But we didn't go into this for we are not in competition.

I gathered all the facts I could possibly gather on each community before
I went to it. Then I would go to the community and I would always arrive some
30 minutes to an hour before I was due to arrive in this town. At the time I
drove up and down the streets, I looked at their buildings, whether they were
in good repair or delapidated. I went to the cemetery. Now I didn't go there
to see if a physician were in town, how busy he would have been, but I went there
to see how they took care of their cemetery. If it was well kept, I know that
there was community responsibility and pride. Next I would go driving around
town and I would look up and down the alleys and if the alleys and adjoining
lots were fairly well taken care of, and the lots adjoining were in good con-
dition, than I felt that these people -- a majority of them -- would have
individual pride and responsibility. I learned this from industry. One time I took an industry man with me on a trip and he stopped me at the edge of town and he said, "I'll meet you down at the end of the block." I said, "What are you going to do?" He said, "I'm going to walk through the alley." I thought he was the craziest person on earth and then he told me why he did this.

Now many of these towns really went all out to try to give a good impression in order to get medical coverage. Usually I had a town meeting with many of the people there or with just a few. We picked a town, finally, for our first one of these pilot projects. We picked this town of Wakita, Oklahoma. This is a town of only 450 people, but there are some 8,500 living within a 20-mile radius and no medical physician nor facility or available within less than 40 to 45 miles. It is 135 miles from Oklahoma City.

What about this town. The Lions Club of Wakita read about the project one morning. They had a meeting at noon. They appointed a committee and this committee was in the Dean's office early the very next morning when he arrived. They invited us up for a dinner meeting to be held in the Methodist Church, it was the largest place to serve the dinner. They could serve 168 people. They sent out 168 invitations. 168 people showed up. Before the meeting eight of the leaders chauffered me around town, and bent my ear extolling the virtues of Wakita. Every yard of grass had been mowed, every house had been cleaned up on the outside, and some even had new coats of paint. I could talk my whole allotted time about the town of Wakita, but there are many more towns available if they have the chance. It only takes one key community leader or sport club to accomplish a tremendous job. Unwavering pressure of a few determined dreamers can stimulate the community to push the project to completion in spite of fears and financial problems.

We had them down to the Medical Center when it was announced that they
were going to have pilot project. We happened to have a dining area like the Needle in Seattle World's Fair that goes round in a circle. So, we took them up there for lunch. We were sitting around and one of them looked at it and he said, "Tom, you know what? We could put one of these up on top of the elevator."

Now, this community has by various methods underwritten, subscribed, donated, and raised by various other legal means, $250,000, and have arranged from private financing additional moneys to provide the facilities for the Community Health Center. They have purchased a 23-acre tract of land. This bunch thinks big. In addition to the community Health Center their long range plans are for a community house, a park, swimming pool, a fishing lake, housing for older citizens (both apartments and houses) a heliport and even a motel. These are not out of the realm of possibility. The Community Health Center will encompass professional offices and treatment rooms for a minimum of 3 physicians, appropriate space for supporting forces of para medical workers, including at least one medical social worker, public health nurse, other nurses, technicians, and aides.

The supporting services will include clinical laboratory, X-ray, emergency minor surgery room and a delivery room. Contiguous with these will be a 35 to 50-bed extended-care facility with 7 to 10 beds of it designated and equipped for acute patient care. The number of beds necessary for acute care will be a sliding scale, as need and utilization are indicated. Now, this rural Community Center will care for acute emergencies, uncomplicated deliveries, and patients with less serious illness. For the sever cases or major emergencies, the Community Health Center will be utilized to stabilize the patients and, then, transport them to other areas.
Patients with the more unusual and serious problems will be transported to the nearest approved completely equipped and staffed medical and hospital center which is now approximately fifty miles away. For the more esoteric problems, helicopter and ambulance service to the University of Oklahoma Medical Center will be provided. You may remember that after World War II the airlines really got going, because there was such a surplus of planes and pilots. I think if communities should remember this when the Viet Nam war ends, there is going to be tremendous surplus of helicopters and helicopter pilots and this can be really taken advantage of.

The Health Center will be staffed by permanent physicians who will live in and become a part of the community life and, hence in touch with the segment of the population with whom they will identify and who they will serve and influence. Comprehensiveness and continuity of medical care are important. Physicians and their patients will be encouraged to create a realistic relationship that takes into consideration the continuing life of the individual and the community. In this way many of the clinical problems can be handled. It is anticipated in this pilot project that the clinic will be staffed by an internist, a pediatrician, and a trained general practitioner. They all perform as family physicians and each will learn from the other. Ultimately all should become the complete family doctor of the future. This will be considered an integral part of the University of Oklahoma Medical Center's teaching program.

Now, how are we going to do this? These three physicians will be required and assigned three days each month at the Medical Center in Oklahoma City where they will teach and be taught. They will teach what happens in their community, what diseases they see, how to treat them. They will be taught the very latest
advancements and very latest techniques for medicine. In addition, we are going to be assigning our part-time or practicing physician faculty and our full-time physician faculty to go to Wakita on scheduled visits where they will spend the day, not to consult on a particular case, but to consult on problems. Hopefully too, this way our full-time faculty will learn a little bit about what is going on out in the world, rather than stay in the ivory tower.

In addition to physicians, the center would be staffed with registered nurses and aides. A public health nurse, whose duties would be similar to a visiting nurse for pre- and post-care, as directed and supervised by the physician, would maintain a file on various families and patients, and even follow up on those that should have been in. They will have a professional medical social worker, who will, under the doctor's supervision, listen to and assist with individuals and their family problems, evaluate the family's ability to pay a partial or full fee or other things that are problems bothering them. When indicated, they will refer them to the appropriate agency. Also included in the staff will be a registered pharmacist, who will own the Pharmacy, and he, also, will have a clinical teaching appointment at the University of Oklahoma School of Pharmacy. In addition, we will have intern pharmacists from the Pharmacy School serving there, so that they can learn how to become a part of a Medical Center in a rural area.

Our Residents in Family Medicine will be assigned six months at this clinic to work with the physician, so that they can see family medicine in a rural area and what it offers. There will be visiting professors and students of social work, pharmacy, nursing, laboratory technicians, public health workers and others from the medical center. That's why they are thinking of a motel at Wakita! They are not only for teaching, but also hopefully we can stimulate them to want to go to rural areas. Also, we are going definitely to be working
in exploration and utilization of new kinds of health personnel.

The physicians will charge standard fees for their services. They will not be full-time faculty men, paid by the University. They are going to be like any physician going into any community. They will charge standard fees, as will all the other portions of the clinic, the extended care facility and all. The physician's fee schedule will be one that is acceptable to the Oklahoma State Medical Association. There is always a certain time lag, from the opening of an office until a living income is established. This facility we don't expect to be any different. Because most of the people or all of the people in the community, have been under the care of some physician somewhere—though not as much as they should have been—it will take them a while to realize this is a good, exemplary type of medical care, and to sever their previous patient-physician relationship.

For these reasons, and to assist in the initial recruitment of qualified physicians and the other health personnel, the personnel will be guaranteed a minimum annual income. If the collections do not equal the guaranteed income, the difference will be paid to them from trust funds to be developed by the University of Oklahoma Medical Center. If more than a minimum is earned, it belongs to the Wakita Health Center. This, we think, provides the incentive for free enterprise practicing of medicine along with the security of a known basic income. As you know, in Oklahoma, we're conservatively conservative and so, we are very strong on the free enterprise practice of medicine.

The average medical school with its teaching hospital is oriented strongly in favor of clinical research, student teaching, and challenging problems of patient complications. The socio economic elements of medicine are given little attention in a crowded curriculum. Most medical schools find it difficult keeping up with the march of medical science, let alone consideration of medical
With such a plan of action as we have outlined, the Oklahoma Medical Center in cooperation with the Oklahoma State Medical Association is providing a prototype pilot project for the provision of rural medical services, both therapeutic and preventive, by a group of physicians and other medical personnel, in an environment conducive to the improvement, distribution and utilization of health-manpower and services. The exemplary medical standards, economic and educational satisfaction combine to provide rural medicine with an attractiveness not now normally available.

Hopefully, the project will contribute to a resolution of many unmet problems in rural health care for this Nation. It will bring warmth and homelike atmosphere of the Center; the physicians and the staff are at home with folks they know in and out of the office; and it brings care closer to the people who promote the Center. It provides the physician with a broader base of operations than he would ordinarily find in just his office. It stabilizes physician-supply. It results in channeling needed referrals to qualified physicians and hospitals. The health center will be a prime local resource. It will provide jobs, buy services and goods, and, in general, strengthen the economy of the area. However, this is only the stepping stone, but a necessary one to improve the whole area in attracting industry and young people, and upgrading or reversing the downfall of the small community.
THE ABERDEEN AREA MINISTRY

Rev. James Patten

Many things have been happening in the rural scene in the upper Great Plains that are significant. Changes have appeared in the landscape as dams have been built and farm to market roads and the interstate highways have laced the countryside. High voltage power lines crisscross the prairies and microwave and television and radio towers reach for the sky, and local telephone lines lie beneath the sod, and we touch tone our distant friends without the operator.

The School, the Urban Center, yes, and even the church takes on a new look in physical appearance. What is most significant and less apparent, is the movement within the Church toward a better understanding and appreciation of other denominations and persuasions of the Christian Family.

A new venture in faith is the Aberdeen Area Ministry, a voluntary association of six denominations banded together for a more effective ministry to all the people in the rural greater Aberdeen community, comprising seven counties, seventy-five churches, fifty-seven ministers concerned for the religious welfare of some fifteen thousand people.

The major phases of the Aberdeen Area Ministry are:

1. An immediate serving of the vacant pulpits of Area churches by a staff of ministers who are presently engaged in associated professions or vocations and are available for Sunday preaching services and other pastoral counsel.

2. An extensive religious and Sociological survey and study in four dimensions,
   A. Survey of Church Conditions
   B. A community attitude scale for clergymen
   C. Community economic and sociological pattern for Laymen
   D. Community attitude scale for Laymen.
3. To move toward realignment and grouping of churches across denominational lines to provide an adequate challenge and workload for a pastor or staff. To follow the social, economic patterns of community and school re-organization, and provide an economic base for support.

4. To provide more effective program planning and implementation of continuing Pastor in service training, and the cultivation of Lay Leadership.

5. Provide for a better stewardship of Pastoral time and service in chosen fields of emphasis and training across a broader segment of the church.

6. Make available through conferences and seminars, and workshops, leadership counsel and guidance on a professional level, in a variety of areas of need; such as:

   A. Church Music
   B. Church Youth Work
   C. Church Adult work
   D. Family Counseling
   E. Urbanization of the Rural Vocational opportunities for Displaced Rural people, Rural Changes affecting the Rural Church etc.

7. It will also be necessary to provide progress reports to participating denominations to cultivate a continuing support and resource personnel from general boards of all churches.

8. Make available information and guidelines for those interested in a similar, Area Ministry of the Great Plains variety.

   The church is challenged to be relevant and speak the prophetic word in a time of rural crises—indeed world crises.

   The church is on trial Christianity must provide the elements of saviorhood and justify its worthiness to lead the procession in new and better ways of Stewardship in God's world.

   A constitution has been formulated that spells out the aims and purpose of the Area Ministry, its functions and structure.