

THE TEXAS OFFICE OF RURAL COMMUNITY AFFAIRS: WILL STATE AGENCY REORGANIZATION IMPROVE RURAL HEALTH CARE IN TEXAS?

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ABSTRACT

This article examines the potential impact of state agency reorganization on the future of rural health care in Texas. Recent surveys of rural residents and their community leaders suggest that rural health care leaders and local government executives have different priorities for rural development. These different perceptions potentially create obstacles for the Texas Office of Rural Community Affairs (ORCA) to construct a rural development agenda that strongly emphasizes rural health care and fully uses agency resources in support of rural health.

Key words: agency reorganization, ORCA, rural health, Texas. (Texas Journal of Rural Health 2003; 21(2): 20-30)

INTRODUCTION

Prior to the 77th legislative session, the House Select Committee on Rural Development (2000) submitted its Interim Report, which called for the creation of a “central administrative agency whose sole purpose is rural affairs.” In May of 2001, this proposal became reality with the passage of HB 7, which created the Office of Rural Community Affairs, otherwise known as ORCA. This

agency now contains the operations previously assigned to the Center for Rural Health Initiatives (CRHI), the Texas Community Development Program (TCDP), and local government services; the Texas Department of Housing and Community Affairs (TDHCA) housed the TCDP and Local Government Services units before reorganization. The self-identified mission of the agency is: "...to serve as a focal agency for the state's health, economic development, and community development programs targeting rural Texas communities (www.orca.state.tx.us)."

In short, ORCA is a rural community development agency that deals with a variety of issues, including rural health care.

Since ORCA now administers or jointly administers about 20 rural health programs and has been commissioned to develop others, the key question from a health vantage point is whether state agency reorganization will translate into better health care programs and policies for rural Texas. Although it is too early to formally assess the impact of this state agency reorganization on rural health care in Texas, we can highlight important challenges that will influence whether rural communities will benefit from reorganization. This article argues that the benefits of reorganization are contingent upon the development of effective partnerships between ORCA and rural constituents, which include both the public and community leaders in health care administration and local government administration.

Using surveys of rural residents and community leaders conducted in July and August, 2002, we find that ORCA faces significant challenges in the development and implementation of more effective rural health policy. The first challenge is differing perceptions of rural health care problems among the public, rural health care leaders, and local

government administrators. Such differences carry with them the potential to frustrate ORCA's ability to develop a rural development agenda that strongly emphasizes rural health care issues or ORCA's ability to use agency resources in support of rural health care. Geographic barriers between the agency and rural Texas are a second challenge that can make effective policy development and programmatic implementation more difficult. These conditions do not preclude effective and creative problem-solving, but they underscore significant policy development and management challenges that will confront the new agency. Each of these issues is discussed below.

ORCA AND RURAL HEALTH CARE

The Texas legislature created ORCA to address rural policy fragmentation and the insufficient resources that have undermined governmental efforts to improve the quality of life in rural Texas (House Rural Development Report, 2000). Hence, ORCA has the legislative mandate to be the central agency for developing, coordinating, and implementing rural policies and programs in such areas as health care, economic development, and leadership development.

The logic behind this reorganization is two-fold. First, a centralized agency should bring coherence to rural policy by bringing rural economic development, leadership, and health care under a single agency, and hence eliminating the costs of coordinating rural policy among many state agencies. Moreover, a focal-point agency for rural development should not subordinate issues important to rural Texas or use policy solutions developed primarily for urban areas. Centralizing these program functions creates a rural develop-

ment agency that focuses solely on rural issues, but does so from a broad rural development perspective. This speaks to the utility of bringing diverse issue-areas under the purview of a single agency. As part of this rural development perspective, ORCA's enabling legislation requires the agency to develop, implement, and update a rural health plan that includes:

- Mission, goals, and objectives of how the office will work to assist rural communities in meeting rural health care needs;
- Ways for the state to effectively and creatively address the unmet health care needs of rural communities; and
- Ways to coordinate the administration and delivery of rural health care service with federal, state, and local public and private programs that provide similar services.

A second justification for reorganization stems from an expectation that administrative centralization should enable ORCA to use and to coordinate financial resources of disparate programs to more effectively target the issues facing rural Texas. The House Select Committee on Rural Development (2000) identifies the TCDP as the key financial resource for rural development. The TCDP is the largest non-entitlement Community Development Block Grant (CDBG) program in the United States at \$88.6 million in FY2001 expenditures. Historically, grants are predominantly awarded for water and sewer infrastructure and traditional economic development projects throughout Texas (Collins and Gerber, 2002a).

The emphasis upon administrative centralization is balanced, however, by legislative language requiring that agency operations should be located outside of the capital closer to rural constituents if such

relocation were found to be cost-effective (HB 7, Section 15). Although the politics of locating state jobs outside of the capital certainly colors this legislation, the legislature recognizes the benefits associated with locating agencies near their primary constituents. As a general proposition, effective policy development and implementation are contingent upon localized "time and place" information that is best obtained by being more proximate to a policy's target population and geography (Tang, 1991; Ostrom, Schroeder, & Wynne, 1993; Lindblom, 1990). In this context, the legislature recognizes that geographic proximity to rural Texas should significantly enhance ORCA's "time and place" information regarding the diverse challenges of rural development in Texas. In short, even though rural development policy is to be centralized within ORCA, the agency itself is bound by a statutory expectation that its operations should be more geographically decentralized to better serve rural constituents (Collins & Gerber, 2002a).

Whether this state agency reorganization will help address the unmet health care needs of rural communities is largely contingent upon ORCA's ability to fulfill legislative intent that is grounded in fundamental theories of policy development and implementation. The following three issues are of particular importance:

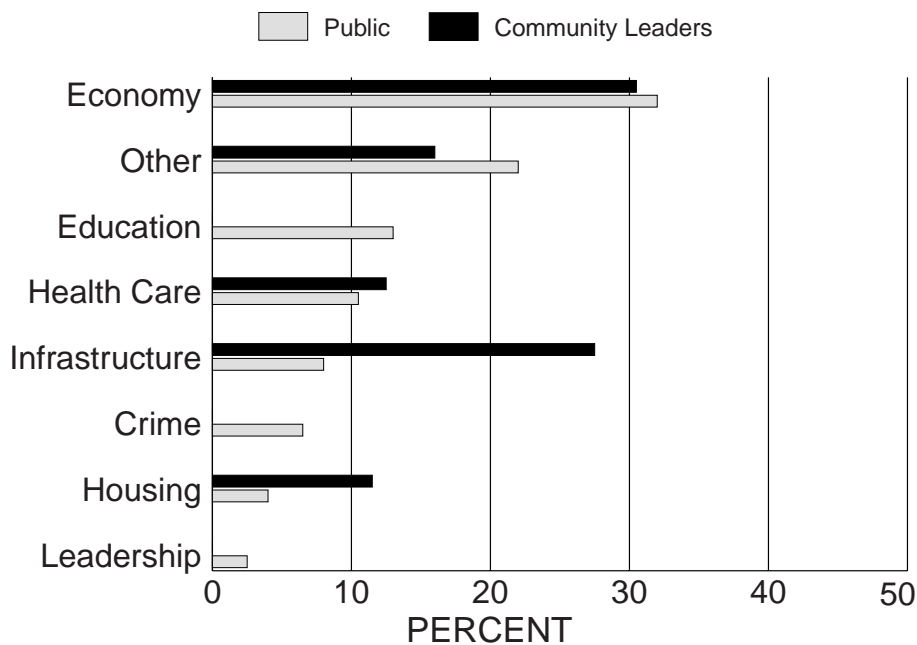
1. Can ORCA construct a rural development agenda that strongly emphasizes rural health care needs?
2. Can ORCA use financial resources in innovative ways to further support rural health care?
3. Can ORCA improve the flow of information to and from their constituents?

We will use two surveys of ORCA

constituents to address these questions about the impact of state agency reorganization on rural health care. The surveys were conducted in July and August of 2002. The survey of rural residents questioned 410 randomly sampled residents of rural counties in Texas to obtain their opinions about issues facing rural Texas. The sampling frame for the survey of rural Texas citizens consisted of all adults living in the 196 rural counties of Texas. The rural designation follows the United States Office of Management and Budget's designation of rural counties as "nonmetropolitan." The goal was to complete an interview with 400 such citizens. All interviews were conducted from the centralized telephone interviewing facility of Texas Tech's Earl Survey Research Laboratory. Calls were placed between 10:00 a.m. and 5:00

p.m., Sunday through Friday, and 10:00 a.m. and 2:00 p.m. on Saturday beginning on July 1 and continuing through August 6 by trained interviewing staff. Telephone numbers were generated at random, and respondents were selected at random. This results in a random sample from which projections can be made to the state's rural population. There was no maximum number of attempts placed on the sample, so phone numbers remained in the active pool until they received a final disposition or the end of the study period was reached. The cooperation rate, which measures the proportion of eligible adults participating in the study to the number of eligible adults contacted, was 46.3%. The response rate, which measures the proportion of eligible adults participating in the study to all households in the sampling frame

**Figure 1. Single Most Important Issue Facing Community Today:
Public versus Community Leaders.**

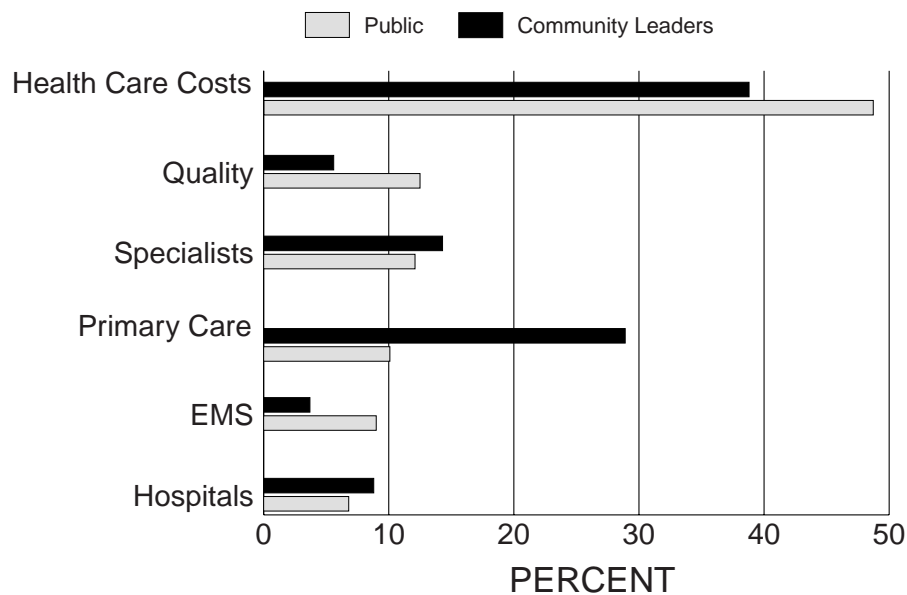


(including numbers that were assumed to be households even though no one was actually contacted), was 33.5%. Both of these rates are typical of a statewide survey of randomly selected individuals.

The second survey questioned 242 rural community leaders about various issues of concern and ORCA's role in addressing those issues. The stratified sample of leaders sought a composition of 50% from government executives, 20% from health care leaders (rural health leaders were selected from membership roles of TACHC, TARHC, TORCH, and TRHA), 20% from economic development leaders, and 10% from housing officials. Survey participants were randomly selected from those groups. The sampling frame for the survey of rural community leaders consisted of public officials in the

areas of economic development, health care, housing, and governing executives (city managers, mayors and county judges). From this frame, the goal was to complete an interview with a total of 250 officials. All interviews were conducted from the centralized telephone interviewing facility of Texas Tech's Earl Survey Research Laboratory. Calls were placed between 9:00 a.m. and 5:00 p.m., Monday through Friday, beginning on July 25 and continuing through August 7 by trained interviewing staff. Respondents who were not available to be interviewed at the time of any particular call were rescheduled for additional attempts until the case received a final disposition or the end of the study period was reached. Because of time constraints, interviews were concluded with 242 leaders instead of the original goal of 250.

Figure 2. Most Important Health Care Issue Facing Community Today: Public versus Community Leaders.



The cooperation rate for the survey was 92.7%, meaning that an interview was completed with about 9 out of 10 of the officials in the sample that were contacted. A total of 198 officials could not be reached throughout the study period, resulting in a response rate of 52.7% (response rates take into account all valid members of the sample, not just those that were contacted). One additional note about the response rate: about one in every five of contacted leaders declined to participate in the survey because they stated they did not know anything about ORCA (54 individuals or 17.1% of those contacted from our sample frame). This is notable in that the sample frame was created of local officials and community leaders who specifically should have an interest in the programs ORCA administers. See Collins and Gerber (2000b) for additional information.

RURAL HEALTH CARE ON THE RURAL DEVELOPMENT AGENDA

Although centralizing rural policy within ORCA eliminates the need to coordinate rural policy development across many state agencies, policy fragmentation is also likely to arise when agencies face constituent groups holding different opinions about the priorities of rural development and rural health issues in particular. Hence, the impact of state agency reorganization on rural health care will be contingent, in part, on ORCA's ability to construct a rural development agenda that balances differing preferences and perceptions about rural development priorities and rural health care issues.

Findings from a recent survey suggest that rural health care is important to the public and community leaders, but it is in competition with other rural development issues. For example, about 53% of the rural public believes that health care services have

Table 1. Most Important Issue Facing the Community (%): Health Care Leaders versus Government Executives.

Issue	Health Care Leaders N=47	Government Executives N=119	Total N=166	Sig
Economy	31.9	29.4	30.1	
Health Care	53.2	3.4	17.5	
Housing	0.0	10.1	7.2	
Infrastructure	0.0	38.7	27.7	
Other	14.9	18.5	17.5	
Total*	100.0	100.1	100.0	P<0.001†

* Numbers may not sum to 100% because of rounding.

† $\chi^2_{(4)} = 71.1$

Source: Collins and Gerber, 2002b.

improved in recent years, but Figure 1 shows that the public and community leaders still identify health care as one of their top concerns. However, both the public and community leaders seem more concerned about economic development, and community leaders focus on infrastructure provision much more than the public.

The emphasis that community leaders place on economic and infrastructure issues provides some insight about the future focus of a rural development agenda. The relatively large number of governing executives in the sample explains the strong emphasis upon economic issues and infrastructure provision, but this finding is also consistent with the agency's operational emphasis on economic development and infrastructure provision. For example, 47.3% of ORCA's staff are dedicated to work on issues related to economic development and infrastructure provision (CDBG and Audit unit), whereas 17.6% of

ORCA's staff are dedicated to work on issues related to rural health care. (This calculation is based upon data reported to investigators on August 7, 2003). As presented at an August 2002 Executive Committee meeting, the baseline operational and grant funding for the CDBG unit in FY2003 constitutes about 93.5% of ORCA's budget, whereas the Rural Health Unit's baseline operational and grant funding constitute about 4.2% of the agency's baseline budget for FY2003. The upshot of the agency's organizational structure and perceptions of the public and community leaders is pressure to construct a rural development agenda that emphasizes economic development and infrastructure provision. This does not suggest that rural health care is now or will be excluded or marginalized from a rural development agenda, but the winds of organizational dynamics and elite opinion are not strongly supportive of a greater emphasis on rural health.

Table 2. Most Important Issue Facing the Community (%): Health Care Leaders versus Government Executives.

Issue	Health Care Leaders N=35	Government Executives N=31	Total N=66*	Sig
Quality	2.9	6.5	4.6	
Primary Care	34.3	22.6	28.8	
Specialists	25.7	3.2	15.2	
Costs	22.9	54.8	37.9	
Hospital access	11.4	6.5	9.1	
EMS	2.9	6.5	4.6	
Total	100.1*	100.1	100.2	P=0.034

* The survey asked this question only to each respondent identifying health care as the most important issue facing the community and those who answered "Other" in Table 1.

* Numbers may not sum to 100% because of rounding.

ORCA can better balance these competing concerns by first developing a focused rural health agenda. Figure 2 suggests that both the public and community leaders identify health care costs as the most important issue, but this does not address the issues of more immediate and particular concern to rural Texas. For example, Figure 2 also suggests that rural community leaders are also concerned about primary care, but the public has no obvious secondary concern. Without well-defined agenda preferences from the grassroots, the agency can take advantage of its statutory mandate to identify those key issues and develop policy responses to them.

With clearly defined rural health care objectives, it will be easier for the agency to highlight the common ground between rural health care, economic development, and infrastructure provision. There are ongoing, significant discussions about linking rural health care with other rural development issues that can pave the way for bridging these issues (Gamm, 2002). If ORCA can effectively demonstrate the linkages between rural health care, economic development, and infrastructure provision, the construction of a rural development agenda is likely to be more balanced and supportive of rural health care.

INNOVATIVE FINANCIAL SUPPORT FOR RURAL HEALTH CARE

ORCA can demonstrate the linkages between rural health and a broader development agenda by using non-entitlement CDBG funds to support rural health care.

Since non-entitlement CDBG funds flow through ORCA and county or municipal governments, both the agency and local government executives are key gatekeepers of these funds that are supposed to support

rural development in Texas. If the agency and local government executives can work together to use non-entitlement CDBG funds for rural health care, they will by their actions make a positive statement about the importance of linking rural health care to the broader development agenda.

ORCA may find it difficult to use non-entitlement CDBG funds, however, given the substantively and statistically significant differences between health care leaders and local government executives' perceptions of the most important issues facing rural communities. According to Table 1, government executives find infrastructure provision, economic development, and housing issues more important than health care, which stands in sharp contrast to rural health care leaders. The differences between health care leaders and government executives are not unexpected, but such a significant divergence highlights a tension between infrastructure provision, economic development, and rural health. Since most non-entitlement CDBG funding supports infrastructure provision for small cities and counties, however, local government executives may be reticent to seek innovative ways to use those funds in support of rural health care.

A further divergence of opinion is seen in how each group defines the most important health care issue in the community. Table 2 offers evidence that the concerns of health care leaders and local government executives are different. This is most clearly demonstrated in comparing the relative concern about health care costs. Local government executives' primary concern is the cost of health care, which is consistent with the public's concern about health care costs as evinced in Figure 2. Because this is a smaller sample, the statistically significant differences between health care leaders and government

executives are probably driven by the group differences regarding health care costs. One explanation for this divergence is that health care leaders have more information and thus have more narrowly defined rural health care concerns relative to government executives. For example, health care leaders may be more informed about limited access to specialists than government executives, but both groups seem to agree that health care costs and primary care concerns are top concerns.

Taken together, Table 1 and Table 2 paint a picture of key rural groups with different preferences about rural development agenda items. These differences will make it difficult for ORCA to find innovative ways to use non-entitlement CDBG funds and thus demonstrate the linkages between rural health and the broader development agenda. Local government executives are one of ORCA's most influential constituencies regarding non-entitlement CDBG funding, and they do not find rural health care a pressing issue. Unless ORCA can promote a better understanding of rural health care and its relation to the broader development agenda, it will be difficult to realize the financial synergies hoped to be

gained through state agency reorganization. Consequently, the issue of improving information flows between state agencies and rural Texas becomes even more important.

IMPROVING INFORMATION FLOWS

ORCA's enabling legislation specifies a strategy to improve flows of information between the agency and constituents—locating agency operations outside Travis County closer to rural areas (Collins and Gerber, 2000a). According to survey respondents, both health care leaders and government executives agree with the strategy espoused in the enabling legislation. Several survey questions asked the respondent to evaluate how three major regional offices or ORCA contacts in their area would change their service delivery and ability to obtain grants. Each of these options included a provision that the agency would maintain an office at the state capital. The scale for responses ranged from one to five, with one meaning that more decentralized agency operations would have a very negative impact

Table 3. Mean Scores for Impact of Geographic Decentralization by Groups of Community Leaders

	Service Delivery		Obtaining Grants
	Three Regional Offices	Contacts in Area	Regional or Contacts in Area
Health Care	3.66* n=45	3.74* n=46	3.86* n=42
Government Executives	3.70* n=117	3.88* n=121	3.99* n=114
All Others	3.82* n=185	3.94* n=191	4.09* n=180

* This symbol indicates a p-value < 0.001 for the H₀: Mean=3 (no impact) and the H_a: Mean>3 (positive impact on service delivery or obtaining grants).

on service delivery or obtaining grants, and five meaning more decentralized agency operations would have a very positive impact on service delivery or obtaining grants. A score of three indicates no impact.

Table 3 reports the mean scores for the impact of more decentralized agency operations on service delivery and the ability to obtain grants. Community leaders thought decentralized operations would improve service delivery and ability to obtain grants. In addition to these findings, the statutorily required report on the cost-effectiveness of agency relocation also found that a variety of relocation models would be more cost-effective than the status quo (Collins & Gerber, 2003a).

These findings do not suggest that ORCA is inadequately assisting community leaders in the delivery of local services or obtaining grants. Other survey responses indicate a high level of satisfaction among community leaders (Collins & Gerber, 2002b). Instead, these results highlight the premium that community leaders place on having greater access to the agency as obtained through more geographically decentralized operations.

Although agency reorganization focused specifically upon improving agency-constituent information flows, improving information flows among constituents is also important. As one reviewer noted, ORCA could support peer groups of communities and offer travel support for local leaders to visit model communities or use pre-existing agricultural extension offices to facilitate communication. There are certainly many ways to improve information flows between the agency and constituents and among constituent groups. However, only the geographic decentralization strategy is directly tied to agency reorganization, and as part of the statute, it will be reviewed during the sunset process

in 2007.

In response to these findings and legislative expectations about locating the agency closer to its constituents, ORCA has developed a long-term plan to investigate relocation further. This plan calls for the creation of two small regional offices over the next three years and the placement of ORCA contacts in some agricultural extension offices. However, in the short-term, ORCA operations will remain in the capital complex and other strategies to improve information flows will be employed.

CONCLUSIONS

In conclusion, the state-level agency reorganization giving rise to ORCA's administration of rural health care policies presents enormous opportunities and significant challenges to addressing the unmet health care needs of rural Texas. ORCA is most likely to have a positive impact on rural health care if the agency, rural health leaders, and government executives work together to exploit all of the agency's resources, including the financial, to develop and to implement effective rural health programs as an important component of a broad-based rural development strategy

As the agency begins its third year of operation, it is critical for the agency, rural health leaders and local government executives to find common ground about how rural health fits into the broader set of rural development issues and which rural health care issues are most pressing. Diverse perceptions and limited information flows between the agency and constituents make this task more difficult but not impossible, especially if the agency, health care leaders, and government executives are individually

willing to take the initiative to pursue and to promote linkages between economic development, infrastructure provision, and rural health care. Although each of these groups will likely need to make concessions in this process, there are potentially significant benefits for rural development broadly speaking and rural health care in particular.

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