THE IMPACT OF SOCIAL CAPITAL ON UNUSUAL HEALTH OUTCOMES IN

DALLAS AND SUMTER COUNTIES IN ALABAMA: AN EXPLORATION

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David Russell Buys, son of Russell Gene and Vickie (Rhodes) Buys, was born July 7, 1983, in Jackson, Mississippi. He graduated from the East Rankin Academy as Senior Class President in 2001. Immediately following graduation, he began undergraduate studies at Mississippi College in Clinton, Mississippi, where he graduated in December, 2004, cum laude with a Bachelor of Science degree in Sociology, having also minored in Philosophy and Business Administration. In January, 2005, he moved to Auburn, Alabama, to begin studies for the Master of Science degree in Sociology at Auburn University.

THESIS ABSTRACT

THE IMPACT OF SOCIAL CAPITAL ON UNUSUAL HEALTH OUTCOMES IN DALLAS AND SUMTER COUNTIES IN ALABAMA: AN EXPLORATION

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Access to health care and the quality of that care is persistently a problem in communities both the United States and abroad. There are basic demographic factors generally used to predict health quality in all communities. Such factors were found to not reliably predict better health outcomes in Dallas County over Sumter County, Alabama, however. This study uses the concept of social capital to make sense of the unusual outcomes by examining the quality of relationships that health care practitioners have with their patients and the general perceptions about the health care structures in participants' respective counties. Findings indicate that health quality is significantly impacted by the investment of health care practitioners (social capital) in the communities where they practice.

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I. INTRODUCTION

Health care is consistently a major source of debate and contention in governments at federal, state and local levels. However, it seems that people continue to engage in useless rhetoric when health care issues emerge. What is apparent in discussions about the health care system is that the philosophical shift away from an emphasis of social contract to a stronger emphasis on individualism has resulted in (or from) our government only allocating enough funds to meet minimal social responsibilities rather than providing enough funds and implementing a structure of health care that ensures all citizens have their needs adequately met (Bogenschneider 2006). Unfortunately, gross inequality in health care exists, and ideally, researchers, sociologists and policy makers alike would pose some plan to eliminate all of the inequality, however that is not realistic. What is realistic is promotion of a cultural climate that embraces social justice, attainment of economic efficiency, and the preservation of individual liberty (LeGrand 1986).

Political efforts to address health care needs are divided based on polarized ideologies that center on what the focus of corporate or joint efforts should be. In a very general sense, conservatives advocate for the focus governmental powers on recruiting businesses and lowering taxes for citizens in order to empower individuals to access education and healthcare from the private sector. The other political extreme, typically identified as “liberal,” calls for provisions of education, health care, and other services by

the government for anyone who cannot obtain such for themselves. Because health care is the topic at hand, in that regard, the basic difference in the two political camps is that conservative policies require individual responsibility and liberal policies make provision of those services by imposing higher taxes on its citizens. Those advocating for the conservative perspective, then believe that with individuals educated and empowered with access to good health care and ability to maintain a healthy lifestyle, they can work to contribute to society with economic input to the tax structure. This would in turn pay for their own and others' health care, education, and other needs provided by the government (Bogenschneider 2006).

Even though the debates about these important issues will likely continue in policy and law-making assemblies for decades to come, a consensus is needed to address the imminent needs of the members of the American population who are without health care. Regardless of the political ideology one holds, individuals should admit that health care, both in terms of quality and access, is crucial to the strength and success of a society. Although some in both the liberal and conservative camps suggest that education or other issues should take precedent over health care on the agendas of policy makers, that idea is likely a mistaken one. Without a healthy society, the nation can not have a strong national defense, a good educational system or a positive economic structure. However, without a healthy populous, education is useless. Further though, without education, national defense, and a good economy, health care will be inaccessible. The interrelated nature of health care to other areas of society is indicative of a cyclical problem. While education would potentially provide one an escape from poverty to better jobs, poorer communities traditionally lack a quality education system.

Additionally, while job opportunities provided to poverty-stricken communities could improve the lifestyles of the residents, no business wants to locate in the midst of an uneducated workforce. And while the amount of violence, lack of access to positive recreational environments and inability to obtain quality food to maintain a healthy diet is great in impoverished communities, those communities are often inescapable because few residents can afford housing outside of their current circumstances (Flora, Flora and Fey 2004).

Clearly, an answer to the question of what a society's priority regarding health care should be is perplexing. The fact is though that a healthy society is not necessarily a productive society, but a productive society must be a healthy one. Maslow's pyramid of needs (1954) is often cited across disciplines as an important tool in addressing individuals' needs and their ability to contribute to society or some organization in society. The most basic level in the pyramid calls for food and shelter. The point is that without those needs met, an individual will have no ability to exhibit skills that would contribute to a larger group of people or community. Maslow assumes that the individual is basically healthy; there is nowhere in his model for assessing the needs of one's health, so it is implied that to even start making a contribution to society, one must be healthy. That should be a significant indicator to individuals making decisions about health policy: that because health care is implicitly at the bottom of the pyramid of the needs of every human being, health care provisions should be at the top of the priority list of every policy maker. This is so because individuals who comprise society must be able to contribute to it in some way, but if they are ill, they will not be able to do so.

Current health policy needs a major overhaul because the United States and local regions within the United States do not fare well compared to other industrialized nations. At the most basic level—the individual—health is often not considered until it begins to digress to a poor state, and at that time, health care becomes very important. It could be that is the case in policy as well—that until the health care structure is completely in shambles, the overhaul needed will not be introduced or considered. Both the quality and quantity of health care available to Americans differs from city to city, county to county, and state to state. Some of those geographic divisions have excellent resources for health care, and some do not. What is disturbing though about the state of health care in the United States is the overall amount of money spent on health care; the number of dollars spent on health care in the United States is greater than any other country, but the quality of health care is far less; in fact, it is 37th best of all the industrialized nations in the world (World Health Organization 2000).

Although the social problems both in the US and abroad greatly abound and cannot be causally pinned on inequality, health care issues clearly have more potential consequences than any other inequality; therefore they need to address these issues with some urgency. Some of the reasons for inequalities are addressed by LeGrand (1986). They include:

> Absence of medical facilities in poorer areas; the poor having worse access to such facilities as do exist, owing to their possessing fewer cars and telephones: manual workers, unlike the salaried middle class, losing money when they take time off to go to the doctor; failures of communication between essentially middle-class medical staff and working class patients. (P. 120)

At the level of the individual, good health or at least stabilized health problems are necessary to maintain an existing social status (if it is satisfactory) or to step out of an oppressive social status to a situation in which they are able to contribute in some positive way to society, therefore some of these issues must be addressed. Good personal health is at the hub of an individual's ability to succeed and act as a productive, contributing member of their society.

The importance of health care continues though, for the economic impact of health care is also great for the larger society. As previously established, a physically-healthy society yields a more productive society. The immediate economic costs of preventative medicine and even medicine for early intervention of disease on government-funded health care programs may seem startling to budget writers in legislatures at the state and federal level. However, the benefit of investing in a system of health care that will manage illnesses well rather than ignore the health care needs of certain areas of society until the members thereof are so disabled that they must be cared for still, at the state level, will be worthwhile. Dr. Uton Muchtar Rafei from the World Health Organization (2000) for South-East Asia said:

> Choosing the right interventions and providing incentives to the providers is one way to improve the performance of the health system. WHO calls for a new "universalism"- which means providing the simplest and most basic quality care for all, including the poor…The main challenge for the governments in these countries [South-East Asia] is to find ways to raise general revenue for health care, …Overall, it is the responsibility of governments to set the regulations and ensure compliance and exercise health intelligence to ensure equity in provision of health care. (P. 1)

Rafei is speaking about poverty stricken nations; and while this may seem irrelevant to the case of disparities among the various populations in the US, it is actually

important to note the actions being taken by countries who are like-wise trying to escape disparities, even if they are not in the same economic strata as the US. Rafei's comments are a call to realize that as governments, political leaders, members of societies, and as autonomous beings, our society will fare better when systems are put in place to provide quality health care.

Research Objective

This study is exploratory in nature because of what will prove to be such unique outcomes. The purpose of this project then is to explore potential reasons for homogeneity of health outcomes in rural counties in Alabama in spite of factors that would predict a wider array of outcomes. This exploratory goal will be attained by first conducting a literature review on the typical relationships between demographic information and health outcomes. Second, a thorough examination of the health outcomes in the rural counties to be discussed in Chapter III will be made. Finally, results will be reported on the findings of health predictors and outcomes of the counties.

The research goal is clearly in line with what Suchman (1963) identifies as mutual goals of sociologists and public health researchers: to describe and explain incidence and prevalence rates for whole populations. He continues by saying that sociology and public health "share a common concern with *populations* of individuals, a theoretical orientation toward abstract *generalizations*, and a methodological approach that emphasizes *quantitative*, statistical methods" (p. 28). Furthermore, Suchman iterates that sociology and public health are fields that both are mostly interested with the behavior of groups rather than individuals.

Rural Health Care Structures

Research shows that physicians have the tendency to locate their practices in urban and suburban centers and that rural populations are often neglected by health care providers (Cockerham 2003). Perhaps this is because of the sparseness of rural populations, populations which are unable to pay or lack insurance, lack of access from rural communities to professional, cultural, educational and other resources for physicians' families, or other reasons. The possibilities and probabilities of why physicians choose not to locate their practices in rural communities are endless, but the fact is that most new physicians are not moving to the underserved areas.

Cockerham (2003) also indicated that the physician shortage in rural areas is compensated for by foreign physicians who agree to serve in designated physician-shortage areas as a way to pay for their education. Often, this presents a problematic factor compounding the potential causes for disparities: rural areas typically have poorer educational systems than urban and suburban areas, and an uneducated populous may have difficulty relating to or communicating with one who does not share a common first language, especially if they are ill (Stoever 2000).

Lack of access by rural populations to medical care, coupled with the greater tendencies that rural populations have to "self-destruct" are likely causes of inequalities in the quality of health that is evident there. "Rural residents are more likely than people in urban areas to engage in behavior that can harm their health because their level of self efficacy is often low" (Flora, Flora and Fey 2004:100). A great example of this phenomenon is cited further in the Flora, Flora and Fey text: "Smoking has obvious implications for health, as does obesity, which is higher in rural areas than in urban

areas" (p. 100). These preexisting conditions in rural communities are ones that only make the need for adequate health care and a stronger social system, eliminating inequality, more prominent.

Strickland (1996) purports that health status is shaped by residence, region, race and socio-economic status. The purpose of his study is to examine those factors to determine the potential barriers to health care for minorities, which are the ability to pay, perception of need, service availability, accessibility of services and the perception of racism. The variable, perception of racism is very important in Strickland's study. Specifically the study says that blacks in the South are one and one-half times less likely to be insured than are whites from the South. The uninsured, then are some of the most vulnerable, and in fact, they are situated right in the midst of the deep south where the current study is being conducted. A logical conclusion then would be that in counties with higher rates of African Americans, health outcomes would be worse than counties with lower rates.

Data from the Office of Rural Health Policy (1997) suggested that twenty million Americans live in areas with a shortage of primary care physicians. Where there is no doctor there can be no treatment, hence the health quality of residents will be poorer, or the residents will have to put forth more effort to receive treatment. In a classic study by Stanley Lieberson (1958), it was noted that physicians tend to return to their ethnic communities to practice medicine. This could be a problem with the inequality of physicians in non-metropolitan areas (Rushing and Wade 1973; Rushing 1975). These areas have a greater percentage of minorities, and minorities are consistently a small percentage of medical school classes. To some extent the problem is being addressed by

rural physician placement programs which first identify the need based on a standard of an ideal ratio of physician to residents. This is the number of physicians per 10,000 residents that should be present to ensure proper access to health care. When this ratio is not met, government subsidized programs are drawn upon to counteract the deprivations (Blumenthal, Mort, and Edwards 1995).

Health Professional Shortage Areas (HPSA) are identified by the Bureau of Primary Health Care of the US Department of Health and Human Services based on three measures. These include the rationale of an area for the delivery of primary health care services; populations with less than one physician per 3,500 people, or greater than one per 3,500 but less than one per 3,000 with unusually high needs for primary care providers or insufficient capacity of existing primary care providers; and primary medical care professionals in contiguous areas which are overly utilized, excessively distant or inaccessible to the population of the identified area (HPSA 2006). Certainly this designation program was devised to help bring attention to the needs of areas experiencing health care disparities.

Earlier the differences in communication styles between foreign doctors and citizens were addressed. That issue exists as well for African-American patients and doctors and Euro-American or While patients and doctors. Some other cultural issues potentially impacting health care inequalities include the divide between African-American and Euro-American cultures. Although both races speak the same language, the dialect is sometimes different. Not only is the dialect of language different, but communication barriers abound in other ways as well. One study found that white physicians tend to dominate conversations with black patients, nearly consuming

seventy-three percent of the time. In visits with white patients, the physicians only talked forty three percent of the time. This communication boundary, a phenomenon rooted in cultural differences, has an adverse effect on the quality of health care patients receive (Johnson, Powe, and Cooper 2004). While the current study is not solely centered on race issues, this nuance is important because of the concentration of minorities in rural or non-metropolitan communities, as well as the high percentage of physicians which are white.

Another study (Laviest and Amani 2002) noted the quality of interpersonal care related to race and gender. His finding was that African-American patients rate their visits lower than whites when with a white physician, but if they are being treated by a fellow minority, they rate their care as much more participatory. Additionally, among the groups who reported having choice in their physician and seeing a physician of the same racial/ethnic background, a greater level of satisfaction was also reported. The results of the data analysis indicated that all respondents reported greater satisfaction when they were being treated by physicians of the same ethnic group. This was true not only among African-Americans, but also across several racial mixes. The reasons for this are unknown, but the authors' speculation was that patients are more comfortable if the physician was of the same race. It could be that patients feel that their physician will operate with a greater sense of urgency and attentiveness than someone not from their own ethnic background. Another suggestion was that race concordance could be a manifestation of large-scale racism. Rather than indicating an increased comfort level with the physician of the same race, it shows a defined discomfort with the physician not of the same background. The final explanation was that patients perceive the nonverbal

cues or verbal tone “handed down” from a white physician to a minority. These studies indicate that physicians find minority patients to be less intelligent and more risky in their behavior than that of patients of their own race. It is as if the physician feels that the patient is causing his or her own illness, so the physician will extend no sympathy to the patient (Laviest and Amani 2002). Again, while not specifically related to barriers in non-metropolitan counties, the composition of rural populations and physicians cause these findings to be of noticeable value.

More confounding impacts are seen when observing links to disease. Residential locale produces certain cultures and fosters values among the individuals living there. This culture of race and location could include violent behavior, illegal drug activity and unhealthy eating behaviors; further, accessibility not only to health care, but to recreational facilities and to healthy foods is limited in some poor neighborhoods. These factors all confound to prevent individuals from having a healthy lifestyle. Haas et. al. (2004) found that the racial or ethnic composition of counties could impact access to health care for the residents, finding that 4.3 percent of blacks found it difficult to obtain any type of health care when they lived in a county with 40 percent or more blacks. He also noted that nearly 19 percent of blacks who lived in a county with a low prevalence of blacks encountered difficulty obtaining health care.

Not only are the effects of segregation obvious at the neighborhood and community level, they are also evident at the county level as well. Williams and Collins (2001) found similar results, that “Segregation can also lead to racial differences in the purchasing power of a given level of income for a broad range of services, including those that are necessary to good health” (p. 410).

Williams and Collins (2001) also found that with the narrowing of the black-white gap in economic status, the health gap narrowed. One could make the mistake of concluding that health status, then, is directly related to the income levels of populations. But further findings indicate that income is related very closely with education. This could indeed be the major element. Educated members of a community could work their way out of the depravity, or they could remain in the community and work diligently for change.

Williams and Rucker (2000) indicate that closure of health care facilities in low-income areas is occurring at rapid rates. They also advocate for a fight against that trend. The other fight worth enduring for minorities and poverty-stricken individuals is the movement from fee-for-service policies to a managed care system. Because minorities do not have access to insurance at the rates afforded whites, this is a barrier to health care for the minority population.

Further, while the fee-for-service system raises issues for patients, research also indicates that the alternative, managed care policies, could negatively impact minority physicians. Williams and Rucker (2000) said

> A 1994 survey of black physicians at a national conference found that 92 percent believed that managed care plans terminated the contracts of black doctors more often than those of white doctors. In fact, 88 percent had been refused in a contract by a managed care organization and 71 percent had lost patients to a MCO with which they were not affiliated. At the same time, 71 percent had at least one managed care contract and 75 percent indicated that their practice had grown or remained stable in the previous year. (P. 32)

This is simply an indication of perception, not actual occurrences; but if the perception is realized and black physicians are being wrongly displaced, this certainly is a potential

barrier for rural populations. Earlier data show that physicians are likely to locate among those patients of their same ethnic background. Displacing physicians is not helpful to the patients they serve, nor is it helpful to the physician. This should be addressed in order to prevent further such problems from arising.

Alternative Sources of Care

What do patients do when they are unable to afford to schedule an appointment because of costs? Cockerham (2003) indicated that underprivileged individuals with minimal social ties, low funding and no other source of medical care resort to the emergency room as a means for care when they become ill. This is the natural default for those who do not have accessible primary health care because of minimal administrative barriers at the "gates" of the emergency room and the fact that most communities have a hospital within driving distance. While Afilalo et al (2004) conducted their research of non-urgent emergency department usage primarily in Quebec, their studies did stretch into the US a bit. One of the findings was that American non-urgent patients had a higher propensity to be unemployed, below the poverty line, and to be of an ethnic minority background. Furthermore, in these populations, Medicaid, as a main source of health care, was a reliable predictor of this phenomenon. This study also cited another similar exploration indicating, the non-urgent group as consisting of younger women who lived predominantly in rural areas; these patients predominately visited public hospitals, and they primarily had Medicaid insurance. The chief complaints were of skin and subcutaneous disease. To contrast that though, Pollock (cited in Afilalo et al 2004) said that just having an insurance policy is no guarantee that people who need services will

get them. They also indicated that it is critical to steer away from immediately associating access barriers with lack of health insurance.

Another study conducted by the Ambulatory Care Statistics Branch of the National Center for Health Statistics (Burt 2004) calls the individuals whom Emergency Departments have to treat as a result of Primary Health Care Access Barriers "safety-net populations." The safety-net's themselves are emergency departments, public hospital systems, community health centers, rural health centers, and other clinics run by local health systems. Although, as indicated in the paragraph just prior, some do not believe that insurance should immediately be equated with access, Burt says that those who rely on the safety-nets are the uninsured persons; low income, under-insured; Medicaid beneficiaries; SCHIP (State Children's Health Insurance Plan) beneficiaries; and persons with special health care needs. These populations put a great burden on the safety-net hospitals because the hospitals are forced to provide large amounts of uncompensated care. Other technical factors of Medicaid reimbursements confound the problem, but the primary issue is the impact of health care disparities on rural residents. The problem with misuse of emergency rooms potentially is that it could impact the quality of services that the hospital would be able to provide. Eventually this could lead the hospital and emergency department to close. The study went on to identify the southern region as the most highly burdened safety-net region with a probability of .61. The Northeast was the next with .25 probability; the West has a .24 probability, and the Midwest has .16 probability. This has significant implications for this study as the counties examined are in the heart of the south—the region with the highest probability for Emergency departments with high safety-nets stemming from the most barriers to health care.

Defining the Problem

Americans tend, in moments of ethnocentrism, to think of this country as superior to others, but this is not always the case. The World Health Organization (2000) gives credence to this misconception. The World Health Organization outlined three goals for a good health care system which include:

> (1) Good health: making the health status of the entire population as good as possible across the whole life cycle, (2) Responsiveness: responding to people's expectations of respectful treatment and client orientation by health care providers, and (3) Fairness in financing: ensuring financial protection for everyone, with costs distributed according to one's pay. (P. 1)

These are the criteria by which health care systems are ranked in WHO studies, and the American system did not fare well. The outcome of a study of the 191 member countries of the World Health Organization indicated that the United States has the costliest health care system in the world, but only the 37th best in health care quality (2000).

This finding indicates the US health care system is operating inefficiently. Although health care spending is greater for a larger number of individuals per capita in America than anywhere else in the world (World Health Organization 2000), the quality of the health care provided to the people in the United States appears to be of lesser concern. Because the US lags greatly behind other nations in the provision of services but spends so much more, accessibility and quality deficiencies for certain individuals and perhaps even entire populations in the country must abound. Ayres (World Health Organization 2000) reported that the United States is "the only country in the [industrialized] world, except for South Africa, that does not provide health care for all of

its citizens" (p. 5). This assessment is at least one directive for researchers to begin to try to understand the disparities that exist. Simply acknowledging disparities reported in global studies by organizations like the WHO is insufficient. The fact that some individuals or whole groups of individuals are not receiving proper health care should be alarming. Because the spending exceeds all other nations, and the quality lags so far behind that of other nations, problems exist within the system. Therefore, it is imperative that the citizens seek to reform the system. In order to understand the needs for reform, it is critical that researchers zoom even further and examine microcosms of the population. The health care issues within various regions, states and communities of the American nation must be examined and compared.

It has already been established that problems exist in the system, somewhere. But the difficulty of following up on such a study as the World Health Organizations' in 2000 is that precise areas of disparities are not discussed. Rather, that is left vague. The larger indicators have been discussed and layed out, but the rest is left to be determined.

This social inequality of health care distribution is a difficult and complex topic as it relates to other social concerns. So, the importance of health care for societies can easily become convoluted in discussions about other social ills, but ignoring the topic will have grave consequences for societies.

Cockerham (2003) says that:

> The problem of equity with respect to health services is and remains a serious problem in American society. In a free market system lacking national health insurance, those persons who are economically disadvantaged are also medically disadvantaged when it comes to obtaining quality services. (P. 295)

One sector of society where the economically disadvantaged are concentrated is rural non-metropolitan areas. It is in these types of societies that consistently display high levels of disparities in health care. Rural communities will be examined later to see how deep the problems in the American health care structure are and to try to ascertain the root causes of such problems.

To examine these counties' health care quality differences, a framework of capital—economic, social, and human—will be used.

II. LITERATURE REVIEW

Social issues surrounding barriers to primary health care are immense. In this context the term “barriers” indicates or implies that inequalities exist. These inequalities are inclusive of the larger issues that must be examined.

With knowledge comes responsibility, and with the knowledge of the inequalities, efforts must be made to solve or alleviate the problems that are present. Inequality issues can be recognized by examining race/ethnicity, political structures, economic issues and still other factors that will arise as the study continues.

The conflict theory perspective of society would indicate that the inequalities that exist will lead to conflict and ultimately to change (Turner cited in Cockerham 2003). Furthermore, Turner believes that the values of advanced democracies promote equality but that the economic system of capitalism produces considerable inequality. He further explains that conflict emerges as a result of states of government trying to resolve the conflict and bring equality to the society which is laden with an inherently unequal economic system. This economic system has as its driving force capital, and too frequently, the focus fails to be equally centered on all types of capital: human, social, economic, and cultural. It stays focused on economic capital to the expense of other forms.

Inequality and Capital

General issues of social inequality have been debated for centuries by philosophers, sociologists, historians, economists, and probably academics from any other discipline or by lay-folks from no discipline at all. A great deal of inequality exists both within society and among societies; and based on the literature about the topic, there must be as many explanations for the inequality as there are forms of inequality itself. Many factors contribute to inequality, and these may include the economic structure, such as socialism, capitalism, et cetera, on which a nation is built. Other historical events like wars and civil unrest can lead to inequality. Events of nature like famines, floods, tornadoes, or hurricanes can even lead to inequality as well. Furthermore, majority religious groups can oppress religious groups that are in the minority calling on "god" or a higher power as the reason for doing so. Additionally, a nation's laws and social structure can lend themselves to the promotion of inequality in a system. Because so many factors can impact the level of equality, or lack thereof, in a social structure, it becomes difficult to pinpoint a single cause of the examples of personal or structural inequalities that can be observed.

Within the field of sociology, multiple schools of thought regarding the origin of inequality exist. Sociologists have offered explanations for the inequality historically in terms of two perspectives: Functionalist or Conflict. These two broad ideas about the inequality in society are only a large framework for explanation, but neither are they the end of the discussion nor are they the conclusion of the problem. The concepts of stratification and inequality once offered in those terms have to be altered as society itself has shifted. One such shift is the move towards a knowledge-based society. Nico Stehr

(1999) indicated that there are significant reasons for the emergence of knowledge as a stratifying—or inequality-causing— element. One such principle is "the relative decline in the immediate and unmediated importance of the economy for individuals and households" (p. 57). Additionally, Stehr says that "knowledge should be seen as a resource insulating and protecting individuals and households from the immediate impact of the vagaries of the market and coercion" (p. 59). He continues on to make the point that "In knowledge societies, inequality becomes much less obvious, concrete and visible social phenomenon than in industrial society" (p. 59). This is a crucial point that must be understood as sociologists strive to adapt their methods and theories to understand inequality in current times. The approaches to understanding and explaining inequality must change as society changes, and theorists and researchers must be flexible to embrace those changes.

This battle to understand what the causes of inequality are is becoming more refined through the use of a term that Marx initially made popular by promoting the idea of conflict between the bourgeoisie and the proletariat, the two classes of society, as he viewed things. That term, capital, traditionally referred to the economic matters that were involved in oppression of the proletariat by the bourgeoisie. This is one of the changes or alterations in the explanations of inequality that should at least be understood. Complete embrace of the concept is not necessary as members of different schools of thought have different opinions on the usefulness of the term. However, the idea of capital has taken on new perspectives in the twentieth century that really are worthy of consideration. One of those new perspectives is that of, social capital, and according to some academicians, it helps further the explanation of inequality. The ultimate goal of these explanations, of

course, is to offer solutions to the problem of poverty in the world and, in this case, to provide a lens through which to view the phenomena in West Alabama of inequality in the health care structures and outcomes.

Forms of Capital

Social Capital is just one of the forms of capital which are viewed as an "alteration" of the original form of capital which was solely economic in nature. While social capital will be the primary lens through which we will view the health care disparities in West Alabama, we should first briefly examine the other forms of capital that have been presented to gain some context for what alternatives forms of economic capital are. Alejandro Portes (1998) emphasized the difference in the types of capital with an analogy of economic capital being a substantive thing that is found in people's bank accounts. Further, he distinguished between human capital and social capital, saying that human capital is in the psychy of individuals, and that social capital is in the context of people's relationships. He believed and taught that to have social capital, individuals must relate to others for the actual source of his or her advantage.

The concept of cultural capital, human capital, political capital, and social capital all are very similar in their function in society regarding equality issues, but each has slightly different roles. The distinctions between each of them are critical to a proper understanding of what their usefulness is in academic research.

Cultural Capital

Cultural capital is also known as legacy; it largely has to do with the socialization of an individual. Flora, Flora and Fey (2004) say that parents "pass on an understanding of society and their role in it, speech, dress, and ways of being…that in turn affect the

choices their children make" (p. 25). Bourdieu said that cultural capital can be thought of as congealed and convertible social energy. Cultural capital determines how we see the world, what we take for granted, the things we value, and the things we perceive as possible to change; it is transmitted through families and other kinship ties as well as communities and other formal and informal educational systems. The problem is that these community systems can also contribute to inequality; understanding the relationship to inequality is crucial to combating the differences, hence the reason for studying it. Bourdieu (1986) said that Cultural Capital exists in three forms.

> The *embodied* state, i.e. , in the form of long-lasting dispositions of the mind and body; in the *objectified* state, in the form of cultural goods (pictures, books, dictionaries, instruments, machines, etc.), which are the trace or realization of theories or critiques of these theories, problematics, etc.; and in the *institutionalized* state, a form of objectification which must be set apart because, as will be seen in the case of educational qualifications, it confers entirely original properties on the cultural capital which it is presumed to guarantee. (P. 253)

This concept is not a simple one. In an attempt to understand the idea, a significant comprehension of the process of socialization should be had to be able to adequately grasp the way in which cultural capital is communicated.

Human Capital

Human capital is another term that has its roots in the idea of economy. Gary Becker (1993) expounded upon this idea. He says that "…economists regard expenditures on education, training, medical care, and so on as investments in human capital." Becker continues to explain that "They are called "human capital" because people cannot be separated from their knowledge, skills, health, or values in the way they can be separated form their financial and physical assets" (p. 1).

Flora, Flora and Fey (2004) say that human capital is inclusive of the "attributes of individuals that contribute to their ability to earn a living, strengthen community, and otherwise contribute to community organizations, to their families, and to self-improvement" (p. 80). This is a broad concept, including interpersonal skills, values and leadership capacity. In earlier historical times, this concept was related to the ability of individuals to complete physical work, perhaps on a farm or in a factory. The value of human capital in this regard was particularly valuable in rural communities. In modern times, however, this element of human capital has not been well rewarded. Certainly though, the concept of human capital refers to the benefits that come from a strong health care structure. Without the health quality that is a product of the health care structure, no one is able to make significant contributions to society—clearly an issue related to human capital.

Political Capital

Capital of the political nature consists of organization, connections, voice, and power. "Political capital is the ability of a group to influence the distribution of resources within a social unit, including helping set the agenda of what resources are available." (Flora, Flora and Fey 2004:108). In sum, political capital reflects the power a community holds. Understanding political capital is crucial because it not only reveals who runs things in communities, but it also helps to explain how groups which are excluded are not considered in the decision making process.

Political capital is the one type of capital that is able to be converted into social capital, cultural capital or economic capital. As stated above, political capital is very closely related to power. Each time a member of a community who holds political capital

converts that to social, cultural or economic capital, he is utilizing that power. Ultimately, political capital will be necessary to bring change to the people who experience poverty. It will be a necessary product, as well, to bring changes to communities with great disparities like Dallas County and Sumter County.

Social Capital

As the theme of capital continues into the focus of this chapter and narrows for the purpose of this research, it is critical to glean the fact that social capital is a concept that emphasizes the factors and processes in a society that lead to inequality. Social capital requires community; it requires sharing and relationships (Nayaran 1999). Where social capital is higher, generally equality tends to be higher. Thus, it is important to understand what this emergent idea of non-monetary *capital* is.

Bourdieu (1986) succinctly defined social capital as "the aggregate of the actual or potential resources which are linked to possession of durable network of more or less institutionalized relationships of mutual acquaintance members with the backing of the collectively-owned capital" (p. 248-249). As stated above, social capital requires relationships and networks. The phrase, "It's not what you know; it's who you know." has been popular and is a great summation of the concept of social capital. While Bourdieu initiated this approach, it has been altered a bit. One such alteration is Nayaran's (1999) definition of social capital for the purpose of the World Bank is the norms and networks that enable people to act collectively. As should be evidenced in the results and discussion of this research, these networks are crucial to receiving quality health care.

Clearly, the forms of capital are all useful and meaningful; in fact, each of them function in society to accomplish or prevent its members from obtaining a needed product, service, or relationship. However, social capital is what will be examined most closely in the rest of this analysis for the purpose of examining health quality outcomes.

History of Social Capital

Social Capital originated from a researcher in the field of education. Lyda Judson Hanifan was an educator in the rural areas of West Virginia, and in an effort to emphasize the importance of relationships, she coined the term "social capital." In introductory remarks about the idea, she (1920) said:

> We not only refer to real estate or to personal property or to cash, but rather to that in life which tends to make those tangible substances count for most in the daily lives of people: namely good will, fellowship, sympathy, and social intercourse among the individuals and families who make up a social unit, -the rural community, whose logical center is in most cases the school. In community building, as in business organization, there must be an accumulation of capital before the constructive work can be done….The community as a whole will benefit by the cooperation of all its parts, while the individual will find in his associations the advantages of the help, the sympathy, and the fellowship of his neighbors. First, then, there must be an accumulation of community social capital. Such accumulation may be effected by means of public entertainments, picnics, and a variety of other community gatherings. When the people of a given community have become acquainted with one another and have formed a habit of coming together occasionally for entertainment, social intercourse, and personal enjoyment, then by skillful leadership this social capital may easily be directed towards the general improvement of the community well-being. (P. 78)

While Hanifan's new concept did not immediately begin to permeate researchers' literature, it slowly gained momentum beginning almost 40 years later with Jacobs (1961). As could be expected with such a delay in the embrace of these ideas, it was in a slightly different context than in the initial introduction of the concept. Hanifan (1920)

introduced the concept in relation to a rural area, but Jacobs (1961) spoke of social capital more in reference to city development: “These networks are a city's irreplaceable social capital. Whenever the capital is lost, from whatever cause, the income from it disappears, never to return until and unless new capital is slowly and chancily accumulated” (p. 138).

The idea was mentioned again by Hannerz (1969) regarding urban neighborhoods and the poverty found therein. Subsequently, “social capital” was re-introduced by perhaps one of the most famous Social Capital Theorists Pierre Bourdieu (1984), who began to discuss this idea that would offer contemporary theorists and researchers a completely new paradigm for thinking about inequality and disparities that plague both industrialized and developing nations. His initial introduction to the idea of a definition for social capital was only the beginning of a series of commentary that is mentioned in nearly all work on the topic:

> Take social capital, for example: one can give an intuitive idea of it by saying that it is what ordinary language calls 'connections'. ... by constructing the concept, one acquires the means of analyzing the logic whereby this particular kind of capital is accumulated, transmitted and reproduced, ... the means of grasping the function of institutions such as clubs or, quite simply, the family, the main site of the accumulation and transmission of that kind of capital, and so on. ... So it was necessary to construct the object that I call social capital ... to see that high-society socializing is, for certain people, whose power and authority are based on social capital, their principal occupation. (P. 114)

With the emergence of Loury (1977), ideas about the application of social capital began to broaden.

> The merit notion that, in a free society, each individual will rise to the level justified by his or her competence conflicts with the observation that no one travels that road entirely alone. The social context within which individual maturation occurs strongly conditions what otherwise equally competent individuals can achieve. This implies that equality of opportunity... is an ideal that cannot be achieved. (P. 176)

According to Coleman (1994), the Social Capital to which Loury is referring is "useful for the cognitive or social development of a child or young person." He points out that they are resources that are different "for different persons and can constitute an important advantage for children and adolescents in the development of their human capital" (p. 300).

In 1986, Useem and Karabel contributed to the evolution of the idea of social capital, and in 1990, as mentioned above, Coleman offered significant insights into the concept with his commentary which comprised the *Coleman Report* (1966). Perhaps the most common definition cited in works utilizing the concept of Social Capital was offered by Bourdieu in 1992. The definition was very simple and succinct. He said that

> Social capital is the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition. (P. 119)

Additionally in 1992, Burt offered insight and expanded the idea of social capital to include ideas regarding the impact of social capital on whom you reach and on how you reach them. He said:

> There are two routes into the social capital question. The first describes a network as your access to people with specific resources, which creates a correlation between theirs and yours. ... A second line of work describes social structure as capital in its own right. The first line describes the network as a conduit; the second line describes how networks are themselves a form of social capital. ... Both lines of work are essential to a general definition of social capital. (P.11)

From this point forward, the research using social capital as a theoretical center has expanded at a phenomenal rate. Significant contributions were made in each consecutive year beginning with the aforementioned research in 1992. In 1997, the

research escalated very rapidly and included at least five major contributions to the concept. In 1998, eight expanded versions of the definition of Social Capital were offered, and in 1999, Nan Lin offered the following comments on the progression of the topic of social capital:

> These debates and clarifications lead to the suggestion that social capital, as a concept, is rooted in social networks and social relations, and must be measured relative to its root. Therefore, social capital can be defined as resources embedded in a social structure which are accessed and/or mobilized in purposive actions. By this definition, the notion of social capital contains three ingredients: resources embedded in a social structure; accessibility to such social resources by individuals; and use or mobilization of such social resources by individuals in purposive actions. Thus conceived, social capital contains three elements intersecting structure and action: the structural (embeddedness), opportunity (accessibility) and action-oriented (use) aspects. (P. 35)

Lin offered these elements as microcosms of the larger concept itself. They certainly are helpful but are only representative of varying ideas presented by a great deal of authors on deviations that should be made when discussing social capital as a theoretical framework for one's research.

The trajectory of social capital has been presented from the time it was first mentioned in 1940 until the end of the twentieth century. From the year 2000 forward, the idea has been adopted largely by the World Bank and by other international development organizations as a means for analyzing poverty from a national level all the way to local levels; ultimately, the goal of utilization of the theory is to help build communities into healthy, sustainable areas that can prosper in their own right. This is certainly the goal in this study as well: to offer suggestions for Sumter and Dallas Counties to be built into healthy, sustainable areas which can prosper.

Various Perspectives on Social Capital

Much evidence exists that indicates "Social Capital" can have both positive and negative influences on society. Research shows clearly that where social capital abounds, communities are likely to experience lower crime rates, have better health, higher educational achievement, and better economic growth. However, evidence also exists indicating that groups with high levels of social capital have the resources then to oppress other groups and keep them from rising out of their circumstances to a lifestyle in which the oppressed would be able to obtain higher levels of social capital (Flora, Flora and Fey 2004).

Certainly the strength or lack thereof, in this network of relationships that is defined as "Social Capital" is what impacts equality levels: "Those communities endowed with a diverse stock of social networks and civic associations are in a stronger position to confront poverty and vulnerability, resolve disputes, and take advantages of new opportunities" (Narayan 2000: 226). These networks really do seem to be crucial for poverty issues, rather it is real or perceived. Wilson (1987) indicated that one of the defining features of poverty is the absence of social networks and institutions necessary to secure good jobs and decent housing . Lin (2001) says that social capital refers to the resources embedded in social relations. Lin's use of the word "embedded" is not often emphasized, but it is perhaps one of the most crucial portions of that statement. For anything that is embedded, there is a greater level of difficulty obtaining a full understanding of the issue itself. The idea of being *embedded* connotes something that is not obvious and visible; it is hidden deep in the society and is a part of the structure to the extent that it may not be extractable for analysis. This is where the difficulty emerges.

Social Capital in Research

The concept of social capital has garnered many different perspectives and opinions regarding the effectiveness and value of its use as a theoretical base for research. One particular work, *Social Capital: A Multifaceted Perspective* (2000), outlines many of these ideas. This book was actually written with an audience of economists in mind because it was within the discipline of economics that the term was founded. The book presents many definitions and variations on the usefulness of the term, "social capital" in academic and development literature. Many researchers have pointed out that the term is a metaphor, and that should be the central focus of any discussion that uses social capital as a guiding force in research. The variation of articles in the book does present an accurate depiction of the differing uses of the term social capital. This term social capital requires a very firm explanation of how the researcher/ writer intends for the idea to be utilized in their literature. Other concepts in sociology and various academic disciplines carry with them a denotation that needs no explanation.

With the emergence of social capital as a concept which is being used more and more frequently in cross-disciplinary literature, however, it must have some validity. The most attractive fact about the concept is that it is multifaceted. That this concept is centered on relationships between people, organizations, and institutes is very important and helpful.

Social Capital in Health Literature

How is this idea of capital specifically relevant to the study of health care outcome disparities? Becker (1993) says:

> In a rich country such as the United States, health is not often thought of as being an important component of human capital, but in poorer countries, illness and impoverishment limit the contributions of large parts of the population as members of the workforce, as community members, as contributing family members, and as citizens. Communicable diseases associated with poverty may also spread to those who are not poor, reducing the effectiveness of human capital. (P.40)

Ability to access health care is largely related to one's ability to navigate the social system—either the government system, private system or some combination of both. While it may not be evident at first glance, social capital defined as the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition (Bourdieu 1986)—is absolutely crucial to accessibility to health care.

Michael Harrington (1984) writes that the problems of poverty and misery in the United States now are the result of the economic and social transformations that have occurred in the larger social system that constitutes the society. To understand the problems of inequality and misery, Harrington proposed that the entire social system must be examined as well. Social capital gives us such a framework and is helpful, particularly, here for examining the inequalities evident in the health care outcomes in West Alabama.

Additionally, Social capital, as previously indicated is largely related to socioeconomic status. Suchman (1963), in a classic work on sociology and public health, said:

> One of the demographic variables receiving the greatest attention and which has proved to be as essential to an understanding of health as to social process is socioeconomic status. It should come as no surprise to the sociologist that large differences in the incidence of disease are to be found among different socioeconomic groups… socioeconomic status

> could e expected to influence the entire disease process from exposure to disease-causing agents to ability to resist. (P. 50)

Regarding the tendency of individuals to help-seeking behavior, McKinlay (1980) introduced the importance of social networks. He said that anchorage, size, range, strength of ties, density, content, dispersion, frequency, directedness, and reachability. These all fit into a model he designed to explain the typical sequence of stages in help-seeking behavior. According to McKinlay,

> *Size* is the number of people with whom an individual maintains meaningful social contact, including any dormant relationships that are or can be activated when particular needs arise.
>
> *Strength of ties* is a combination of the amount of time, the emotional intensity, the intimacy (mutual confiding), and the reciprocal services which characterize the tie.
>
> *Density* is the extent to which the individuals in a network know and have contact with one another independently of a focal individual.
>
> *Content* is the inferable meanings which persons in a network attribute to their relationships with others.
>
> *Dispersion* is the ease with which individuals can make contact with, or activate contacts with, others in the network.
>
> *Frequency* is the amount of contact between individuals comprising a social network.
>
> *Directedness* is the extent to which contact between individuals associated through the network is unidirectional or reciprocal.
>
> *Reachability* is the extent to which an individual can use relationships with others to contact other people who are important to him or alternatively, the extent to which people who are important to him can contact him through those relationships. (P. 78)

Each of these terms are related to the concept of social capital. Ultimately, the ability to obtain health care is the factor that determines health outcomes when disease has begun to plague a patient's body.

The idea of social capital will be the guiding concept from here as the inequality in health care is presented. It will be a framework through which the problems can be assessed, understood and explained.

III. METHODOLOGY

In this chapter, the methods used for collecting the data will be examined. First, the reasoning for selecting the chosen counties will be presented. Second, an overview of what the disparities in the counties are will be examined. Following that discussion, general comments on the value of and reasons for qualitative research will be offered. Fourth, the instrument used will be explained, and the value of the pilot tests will be examined. Finally, a discussion on the way in which access to the subjects interviewed was obtained will ensue.

Selection of Counties

A review of the literature on health disparities was conducted at the outset of the study to provide a framework for thinking about health care issues. Subsequent to conducting the literature review, a thorough examination of various health care predictors like hospital bed count per county, ratio of physicians in each county, nursing home beds, and other general demographic information such as minority rate, which in Dallas County is 66.7% and in Sumter County is 75.2% (Center for Demographic Research 2006), was studied as well as the health outcomes in the same counties of the Black Belt Region of Alabama was performed in a comparative manner. The data used in this comparison was obtained from the Alabama Center for Demographic Research in their Health Data Sheet (2006), Population Data Sheet (2005), and Education Data Sheet (2005). Upon examining the information, it became apparent that Dallas and Sumter counties deviated

from the typical model for predictor-outcome relationships, and that "normal" indicators were not applicable. In this regard, then, quantitative analysis was used; otherwise, a purely qualitative approach to determining the reasons for such outcomes was utilized in the study. The unit of analysis for the study is the county, and as already indicated, the counties were selected based on the unique nature of their health outcomes, not at random.

The results outlying the typical model for predictor-outcome relationships of health quality predictors and health outcomes necessitated an exploratory study of the two counties, hence the use of a qualitative methodology. Such details including health predictors and outcomes will be included in following chapters that exposit the findings of each county.

Because of the qualitative and exploratory nature of this study, succinct conclusions will not be made; rather, observations will be stated, and directions for future research will be provided. It is important to note at the outset that because this phenomenon is specifically observed in this population, the findings will not be generalizable beyond the counties studied.

The primary research question addressed by this study is: **how can a county with such limited resources (Sumter) have health outcomes better than in some cases, and just as good as in others in comparison to another county with a nearly full-service hospital, a family-medicine residency program, and a county in which a far greater percentage of its citizens reside in the city where the health care is offered (Dallas)?**

This study should offer significant insights to this question of public health since a sociological approach has a "'natural' contribution to make to the study of problems in the field of public health" (Suchman 1963:30). This study is designed to explore a phenomenon that runs counter to the data and research presented by long-standing organizations like the World Health Organization.

Qualitative Methodology

To understand what is going on in the counties, it is critical to go there, to feel the social climate of the counties, to understand the people, and to gain some insight into the social and political contexts (Stake 2005). "Issues are complex, situated, problematic relationships." (Stake 2005: 445). The issues cannot be understood until researchers immerse themselves in the communities where the relationships exist. That is what the researcher tried to do for just a few short days; to go there and to gain some brief insight into the complexity of the relationships by talking to various members of communities in each county. Clampet-Lundquist (2003) said that

> Listening to people's experiences, and including the full rich texture of their stories in the data analysis allows one to describe, explain, and theorize based on a multi-layered detailed picture. (P. 125)

The counties were each examined independently, as cases of their own. The goal is not to understand the specific nuances of Dallas and the details of Sumter Counties as much as it is to understand why Sumter County has higher health quality than that of Dallas County. There is an objective much greater than that of each case itself. Stake (2005) says that the instrumental case study is used to provide insight into an issue or to

redraw a generalization. Specifically,

> The case is of secondary interest, it plays a supportive role, and it facilitates our understanding of something else. The case still is looked at in depth, its contexts scrutinized and its ordinary activities detailed, but all because this helps us pursue the external interest. (P. 444)

Dallas and Sumter Counties had to be examined to find out about the inherent difference between the two, but to become bogged down in details about each county, again, is not the goal of the study. The interest lies mainly in the unique nature of the new paradigm to which Grix (2001) spoke:

> The key development in the new paradigm can be summed up in the following… A move to more qualitative research methods (interviews and small scale targeted surveys) to get at actors perceptions of their relations with others. (P. 203)

This is exactly what is done. A qualitative approach is taken to understand the key development in the new paradigm—the paradigm in which Sumter County had better health outcomes than Dallas County.

Establishing Groups and Determining Appropriate Representatives

Major categories into which individuals in Dallas and Sumter Counties could be situated to ensure confidentiality were constructed in the initial phase of designing the methodology. Stake (2005) said: "For qualitative fieldwork, we draw a purposive sample, building in variety and acknowledging opportunities for intensive study" (p. 451). With his insight in mind, efforts to obtain an effective representation of the whole population were made. Several groups were considered, but the following were decided upon:

1) Health Care Administrators
2) Health Care Practitioners

3) Political Leaders

4) Community Leaders

5) Religious Leaders.

Each of these groups holds some level of influence over the health care structure itself, so that is why they are grouped as such. Stake (2005) addressed the need to include such a diverse type of population in such a study:

> Case research seeks the nature of the case, particularly its activity and functioning; its historical background; its physical setting; other contexts, such as economic, political, legal and aesthetic; other cases through which this case is recognized; and those informants through whom the case can be known. (P. 454)

Although consideration was given to constructing a group for health care consumers that was not done because by default everyone interviewed in the study is a consumer of health care. Access was gained to these individuals through random phone calls, leads from contacts through Auburn University Cooperative Extension Service, and by reference of various community members once the researcher was already positioned in the county. None of the participants were compensated for their time or comments. Once in the counties, it became impossible to gain access to Health Care Administrators; therefore that group was no longer considered for participation. Additional interviews were made with members of other groups to ensure enough responses since the Health Care Administration group was eliminated. Observation of Table 4 will gives insight into the make-up of the participants.

Table 1. Interview Participants

Group	Dallas	Sumter
Community Leader	2	1
Political Leader	1	1
Religious Leader	1	2
Health Care Practitioner	1	2

Qualitatitive Questions

Questions centered on health care access issues, perceptions about the value and importance of health care, satisfaction with the health care services available, and ability to travel to health care providers outside of their county. A guideline to follow during the interviews was constructed addressing all of the issues above, and though with most subjects, all of the questions were answered, some interviews were not completed because of unplanned calls, meetings, or other distractions out of the control of the participant or researcher.

The purpose of the study was to try to understand the inter-workings of the county to get a sense for why the outcomes are as they are. Stake (2005) said that

> Case researchers greatly rely on subjective data, such as the testimony of participants and the judgments of witnesses. Many critical observations and interview data are subjective. Most case study is the empirical study of human activity. The major questions are not questions of opinion or feeling, but of the sensory experience. And the answers come back, of course, with description and interpretation, opinion and feeling, all mixed together. When the researchers are not there to experience the activity for themselves, they have to ask those who do experience it. (P. 454)

This sense of emotion and passion was certainly noticeable. It is very common to be excited about things when they are either positively or negatively

in your favor. That was the case in the interviews: those who never had a problem with the health care system were overly zealous about the positive nature of health care in their counties. Conversely, those who had bad experiences were seemingly angry about what they perceived as a lack of concern for the needs of the people in the community.

On average, the questions were very open-ended, designed to ascertain a general sense of the health care structure. The goal was to get the participants to speak about how they really perceived the state of health care in their county. The following list of questions was used for all participants except for questions 3 and 8 for health care practitioners. Specifically, question three was eliminated, and question eight was included for that group.

1. What do you think that the general strengths of the health care structure and delivery abilities are here in your county?

2. What do you believe are the major weaknesses and areas that need improvement in the county's health care structure are?

3. Do you regularly use the physicians or nurse practitioners available here? Do you have a problem getting an appointment if you need to see a HC provider? How often do you visit a doctor or nurse practitioner?

4. Do you or do you know people who obtain regular treatment outside of the county? Do you or do you know people who travel outside of the county for care? About how many people do you know who do travel for care?

5. What would lead you to seek care from an advanced medical center/ hospital outside of the county? Are you going to rely on the local physicians to direct you to go elsewhere?

6. Have you ever heard of patients being transferred from the local hospital because of need for advanced treatment?

7. Do you know people who have a problem getting to a physician if they need treatment? How well accessible is public transportation? Have you ever used it; do you know people who have; about how many?

8. (For Health Care Practitioner Only) What happens when you can't assist a patient further in their state of health? Can you give me an example of what would lead you to send the patient elsewhere for more health care?

9. Do you remember the last time you heard about preventative health programs offered here? Have you ever participated in such a program?

10. Have you ever taken loans to pay for health care? Do you know about people who have taken out loans to pay for health care? About how many such people do you know? Do you/ Do these people you know still owe money for the loans they obtained for their medical services?

11. How do you understand health care in terms of social responsibility from your personal perspective, from a government/political perspective, from a faith perspective?

12. Do you, in your role as a (HA, HP, CL, PL, RL), see Health care as a major issue in the US, AL, Black Belt, the county? How would you rank its importance (1-10; bad-good)? How bad to you think the current HC situation is (1-10; bad-good)?

13. Given 5 issues: Economic Development/Jobs, Health care, Education, Infrastructure, Crime/Law Enforcement (or National Security), how do you feel they rank in terms of importance? How do you believe most decision makers (of those in positions affecting this region) rank those issues?

Pilot Tests

One of the most helpful aspects of the research process was the pilot tests conducted on each group. Nearly two weeks before the study commenced with the documented research in the counties selected for the study, contact was made in the Auburn, Alabama, community with a representative of each of the groups to be interviewed in the field and established a time to meet and work through the questionnaire. Each of them were treated as if they were a participant in the study, and at

the conclusion of the conversation, feedback was solicited on the nature of the questions for their respective group. As a result of the feedback some slight changes needed to be made, but overall, the questionnaire was found to be adequate. The most insightful thing about the pilot tests was the ability to better judge the length of time needed for the sessions. Nearly as helpful was becoming more acquainted with follow-up questions that should be asked. Additionally, and perhaps most importantly, the pilot process increased comfortability of the researcher with the instrument itself. With the researcher being comfortable, that encouraged an environment with the participants that would allow them to feel comfortable as well. If the researcher exhibited angst in the interview, the participants would too. In fact, the researcher did note having exhibited some discomfort or nervousness in the initial pilot interviews, but by the time interviews began in Sumter County that sense of angst or uncertainty was gone. Stake (2005) commented that "The case researcher digs into meanings, working to relate them to contexts and experience. In each instance, the work is reflective" (p. 450). The ability to be reflective is a learned behavior, and it can only be learned by doing the interviews. Reflectivity is not well-attainable when the researcher is uncomfortable. So not only is pilot testing important to ensure validity in one's study, it is important to help refine the interviewing skills—particularly those of reflective listening—of the researcher.

Conducting the Interviews

Semi-structured interviews were conducted with individuals who fit into the categories listed above: health care practitioners, community leaders, political leaders, and religious leaders. Interviews were conducted in July and August 2006; they were confidential in nature and were not recorded. For the purpose of this exploratory study, it

was crucial to ensure the most open environment possible, and as Rubin and Rubin (2005) say that "Some interviewees become shy or hesitant when they know they are being recorded" (p. 110). Adams (2005) in his research on school desegregation in the Black Belt found that "The use of a tape recorder in interviews stifled conversation to the point of silence and sometimes created an uncomfortable disposition in respondents" (p. 31). Additionally, recorders often will fail or will stifle the interviewee (Lincoln and Guba 1985). Therefore, they recommend not using them "except for unusual reasons" (p. 241). However, in future studies, recording interviews maybe helpful if additional or expanded research is undertaken in this area. Rubin and Rubin (2005) also said that some interviewees "appreciate being recorded because recording ensures that you will get their message out accurately" (p. 241). While conducting the interviews with a recorder can mitigate the chances of mistakes and inaccuracies, since the data was not being coded, recording was not be necessary. The goal is to obtain attitudes and perceptions to offer insight into the current structure and to create a list of directives for future research. The goal was best achieved by using semi-structured interviews, avoiding recorded interviews and making notes during the interview, and ensuring enough time between interviews to write thorough comments about the previous interview. Interviews were conducted at places of greatest convenience for the participant; these included various places of employment, government offices, hospitals, homes and churches.

The predominant way in which the findings are reported is through the major themes and ideas stated by each respondent. Quotes may be used to emphasize the themes, but the person's name, role or position held will not be identified; the statements will only be related to or associated with the group in which the person was assigned and

their county of residence. Of course, this is necessary to ensure confidentiality of the subjects. Recorded responses will be compared and considered in the context of the county as well as in the context of the persons who offered the information. The differences in responses of individuals within and among each group are considered to determine why the residents of these counties have such similar health outcomes.

Responses will be compared against each other. Certainly the responses are important, but again, ultimately the goal is to know why Sumter County has outcomes nearly homogenous with those of Dallas County in spite of predictors that would indicate otherwise. Comparison is the way to obtain that knowledge. Stake (2005) said that "Comparison is a grand epistemological strategy, a powerful conceptual mechanism, fixing attention upon one or a few attributes. Thus, it obscures any case knowledge that fails to facilitate comparison" (p. 457). This is perhaps the most powerful tool available to answer the research question at hand. Further, he said that "A research design featuring comparison substitutes (a) *the comparison* for (b) *the case* as the focus of the study" (p. 457).

IV. RESULTS

In this chapter, results of research in Dallas and Sumter counties are presented in separate sections which are labeled by their respective county. Also in this chapter, a further description of historic problems in the Alabama Black Belt will be offered.

The need for this study is rooted in the actual and expected differences in demographic predictors (Table 2) and health system predictors (Table 3) and health outcomes (Table 4) in Dallas (Figure 1) and Sumter (Figure 2) Counties.

Table 2. Demographic Characteristics for Dallas and Sumter Counties, 2004

Variable	Dallas	Sumter	Difference
Estimated Total Population	44,715	14,078	30,637.0
Percent Black and Other Races	66.7	75.2	-8.5
Percent Persons Below Poverty	25	26.4	-1.4
Percent Unemployed	10.1	9.5	0.6
Percent High School Graduates	70.3	64.8	5.5
Percent College Graduates	13.9	12.4	1.5
Percent Under 20	30.7	30.3	0.4
Percent 65+	13.8	14.1	-0.3
Population in city of hospital (Selma; York)	19,618	2,683	
Percent county population in city of hospital	43.87	19.06	24.8

Source: Center for Demographic Research (2005)

These demographic facts are minimally insightful alone, for it is most important to view them in light of the health care qualities that characterize each county (Table 3), and the health outcomes that the counties experience as well (Table 4).

Table 3. Health Quality Predictors for Counties

Variable	Dallas	Sumter	Difference
Rate Physicians Per 10,000 Population, '05	14.5	4.2	10.3
Licensed Nursing Home Beds, '04	76.4	88.4	-12.0
Rate of Licensed Hospital Beds per 10,000, '03	47.5	23.2	24.3
Total Licensed Hospital Beds	163	66	97.0
Emergency Room (Not admitted)**	13,600	7,100	6,500.0
Emergency Room (Admitted)**	6,200	1,400	5,700.0

Source: Center for Demographic Research (2005)

Sumter County and Demographics

As I detailed in Table 1, Sumter County has a population of 14,798, more than 75% of which are minorities (Center for Demographic Research 2005). The county is positioned in West Alabama, immediately east of the Mississippi border. Minorities have comprised a majority of the population since about 1860 (Hollingsworth 1993:4). This is an important fact, especially as the history of social problems in the county is a long one. In fact, chronic problems such as little industry and few job opportunities have become so problematic that emigration seems to be the rule rather than the exception in the last half

of a century. Specifically, between 2000 and 2004, the county lost 657 people, which is 4.4% of the population (Adams 2005). Continued losses could drive down chances of obtaining additional services and economic opportunities under our current socio-structural approach that are needed to ensure a healthy, prosperous population.

Table 4. Health Outcome Characteristics for Counties, 2004

Variable	Dallas	Sumter	Difference
Life Expectancy	71.4	73.9	-2.5
Infant Mortality Rate*	10.6	9.3	1.3
Death Rate from Cancer	231.7	127.3	104.4
Death Rate from Heart Disease	372.1	374.8	-2.7
Death Rate from Chronic Lower Respiratory Disease	44.6	56.6	-12.0
Death Rate from Stroke	100.3	127.3	-27.0
Death Rate from Homicide	24.5	0	24.5
Death Rate from Suicide	13.4	0	13.4
Death Rate from Alzheimer's Disease	55.7	21.2	34.5
Death Rate from Diabetes	44.6	63.6	-19.0
Death Rate from Accidents	55.7	49.5	6.2

*All Rates are per 10,000

Source: Center for Demographic Research (2005)

The economic and social problems in Sumter County are widespread and appear to be closely related to health quality outcomes. In general, health quality is low in the county, but when compared with Dallas County, results do not seem so bad, and that is perplexing. Demographic factors related to health quality in Sumter County predict a

dire situation of health outcomes, and when compared against the same predictors of quality in Dallas County, the outcomes would be presumed to be worse. However, that is not the case, as indicated by a 2.5 year shorter life expectancy in 2005 in Dallas County than Sumter County among other things.

As I stated previously, the minority population percentage is a predictor of lower health quality outcomes at the county level as shown in a plethora of research (Williams and Rucker 2000; Williams and Jackson 2005; Williams and Collins 2001; Smith 2005; Rich 2005; Reede 2003; Probst, et al. 2004; LeGrand 1986; Kawachi, et. al. 2005; Connolly 2002). However the success of the economy, and consequently the health quality in Sumter County, maybe attributable to the long-term, stable employer which is the University of West Alabama. Other than the University, there is county government and agriculture with limited industry. A community leader in Sumter County remarked that "If you took out the University, we would have no economy, or at least the loss would be economically devastating." One of the political leaders agreed, saying that "The biggest asset to our community and county is UWA. The university provides us access to sports, cultural events, symphonies, and fine arts. They have a tremendous economic impact as the second largest employer in the county." Further exploration into the impact of stable employers in a community on the health quality of a community may be helpful.

Sumter County is disparate in a number of health quality outcomes when compared both to averages in the United States and in Alabama (Center for Demographic Research 2005). Life expectancy is the first of those: Sumter County's rate is 73.9 years, a rate 3.6 years below the national rate of 77.5 and 0.9 years below the state's rate of

74.8. Infant Mortality rates are higher in Sumter County at 9.3 deaths per 10,000 compared to 6.9 and 8.9 for the nation and state, respectively. That is a difference of 2.4 deaths per 10,000 in the nation higher and 0.4 deaths per 10,000 higher in the state. Other differences are clear in the death rates by heart disease, stroke, alzheimer's, and diabetes.

In Wilkinson's (2005) work, the impact of psychosocial problems impacting health quality is addressed. He identifies multiple issues that fit into that category, but particularly related to this study, he said that lack of social support and bad social relationships are closely related to poor health. The corollary of that could be that positive social support and good relationships would be related to positive health.

Perceived Strengths of Health Care in Sumter County

Apparently, the intense emotional investment that the health care providers make in the residents of Sumter County has a positive impact on the relationships that exists between them and their patients. This assertion is evidenced by health care providers who responded to an open-ended question about the strengths and weaknesses in the health care quality of the community by pointing out the strong bonds among their people. One of these respondents from Sumter County said: "We have a small community; a high quality of life where everyone knows everyone." This sense of community in the county among the residents and the physicians builds high levels of social capital. The same respondent continued to say that "Here, our patients get more care and a great deal of continuity." One may argue that this is simply the perspective of a health care provider, hence it is skewed, however the perspective is validated by a local political leader who said that: "I've been seeing docs here all my life. I like to go to the

doctors here because local care is more personable and because they have a feel for the community and local epidemiology since they live here amongst us." A specific example of ways that the social capital of the people is enhanced by the relationships they share with the health care providers thus increasing their health quality was given by a testimony that: "Our doctors are willing to pull in favors with the physicians at bigger hospitals where they have the equipment that we lack for patients who need procedures we cannot provide in this county." These relationships that the health care providers have with their patients are very important, and the patients are beneficiaries of relationships that their physicians have with other medical professionals outside the county.

Comfortability with Physicians

The participants were asked about their comfort with being treated by a physician in the county. Each of the participants was very happy with the primary care that the county had to offer. One of the religious leaders said that "I use Dr. ----, and I never have a problem. I go only about one time per year, and that's just to be sure everything is alright with me. I don't get sick much." The other religious leader in the survey said, "We have good MD's in the county. I use Dr. ----, and I've been satisfied… almost always, you can get an appointment same day, and there's not much of a wait. I have regularly scheduled appointments about twice per year, but if I become ill, I'll go more frequently." Similarly, a political leader responded to the discussion about health care in the community by saying that "I never have problems getting into see a doctor. The doctors keep their patient load so that it's not a problem." The community leader said

"Yes, I go to the docs here, and I don't have a problem getting an appointment. I go as needed, but I wait until the last minute to go because of costs."

One of the political leaders said that "Some of the older people see docs in Meridian; they've been going over there for 40 or 50 years. No reason to change now." Although many people do utilize the services of local physicians, the proximity of other quality health care providers to the community is likely something that positively impacts the health quality of that community. Likewise, one of the religious leaders said "I know some who go to Tuscaloosa, Birmingham or Meridian if they need extensive care or if they are unsatisfied here. But most people stay here for convenience sake." However a community leader thought that there are fewer people who leave for care: "Everyone sees the General Practitioner's here. They are good at what they are good at; if they aren't, they refer on out."

The respondents all seemed to value the relationships, or social capital, with physicians in the county; but otherwise, the people in the community believe that they have some strengths beyond relationships as well. One political leader said: "In Livingston, we have a city owned/operated ambulance service; this gives us a great strength in the area of health care because ambulance services are the first in the line of defense." That same individual indicated that they have a strong health department which does an excellent job, saying that: "Poor families rely on this service; pregnant mothers rely on this service, and it is a great place for vaccinations which prevent poor health outcomes later in life." A religious leader commented that the "Facilities are excellent for a small rural area, and that Hill Hospital is excellent for treating basic needs and for helping people with substance abuse problems." A religious leader in the county

took an approach that seemed realistic, highlighting the positive aspects of the health care system and acknowledging the downfalls, saying that "we have a hospital in York that is OK, but as I understand it, is viewed as a temporary place for treatment, then for transfer. I know that it is good to have because of the ER [Emergency Room]; it is patronized largely by the poor." Clearly in these responses, there is a positive attitude among the respondents, and that was the sentiment echoed by all of the interviewees in Sumter County. The people in Sumter County seemed to be fortified with good will and strength amongst themselves—a sort of social capital. There was a sense of pride in the community and in the heritage that the county has. There is also a great commitment to fellow Sumter Countians. One of the religious leaders said with a big smile on his face: "I see Dr. -----, and (s)he is a great physician!" This level of pride and satisfaction among the people was clear, and that seemed to color nearly all of the feelings they had about their community.

Transportation

While health care may be good and available, an important part of accessibility is transportation, and that seems to be somewhat of a barrier in Sumter County. When questioned about this as a barrier to accessing health care, some of the participants, such as the religious leader who sees a number of individuals from various socioeconomic statuses said that "West Alabama Public Transportation (WAPT) provides good, reliable transportation for those who don't have a car." My initial perception based on his and other comments was positive, but reality about this issue quickly set in. Many of the individuals interviewed indicated that WAPT is the only form of transportation for some. Therefore, it is problematic for those who totally rely on WAPT when ill. One of the

political leaders said that “Yes, transportation is a major problem. We have WAPT, but it only runs on a certain schedule, so if you are ill, you may not be able to coordinate that, and if you are under-educated, you may not be able to figure it out.” A different religious leader in the same community agreed, saying that “WAPT has regularly scheduled pickups and they work on an appointment system.” Both responses bring to the surface a couple of potential problems, first, that the schedule is limited; and second, implicitly by referencing the education issue, that the system may be complicated. Another religious leader in the community who did not have great exposure to WAPT was under the impression that “I believe WAPT is good; they run quite frequently, or at least I see them around town a lot.” Still, a community leader said that “WAPT is good. It has its problems, but all complaints can’t be accepted at face value because the customer may not have done their part. The system does require an appointment/ schedule, so if the customer fails, they may be mad and take it out on the system.” While the health care professional interviewed indicated that “The top issues on the list of barriers are insurance and medications,” he did acknowledge that “transportation is a problem.” His expose' on transportation problems was that

> Older people, particularly in the black community, have to pay their kids and grandkids to take them to the doctor—in their own vehicle!!! This is wrong. Sometimes the ill persons have only a limited amount of money, so they have to decide that they are going to go to the doctor and pay for transportation rather than to pay for the meds that they really need.

That anyone would charge ill family members for transportation to a physician in their own vehicle is problematic.

Perceptions of Political and Social Value of Health Care

The various participants in Sumter County were asked about their perspective of health care's place in society and in government leaders' agendas; of course, the perspectives differed. They were also questioned about their perception of the level at which the respondents thought their quality of care is in the US, Alabama, in the Black Belt, and in Sumter County is. Some offered responses to all categories, and others only commented on one or a couple of the issues. The political leader believed that on a scale of 1-10 with 10 being the best, the health care system of the United States is about a 3-4. He also believed that Alabama was at the same level. His accounting for such a low score was based on the belief that: "We have a lot of fraud that just messes us up horribly." While he believed that the US and the State of Alabama had relatively low scores, he said that Sumter County was around 8-9. This was very surprising, so follow-up questions were asked to ascertain why he was so optimistic about the health quality there. In sum, his assessment was based on the resources they have in the county; he said: "Our resources are well utilized, our population is mostly healthy, and I think we are doing well with what we have."

One of the religious leaders said that the US is about a 5; Alabama is about a 3; and Sumter County is about a 2. He said that "America is set for self destruction; our form of government—capitalism—is 'money motivating' and it is killing us." Another religious leader said that the US could be rated at 3; Alabama, 3; and Sumter County 3. This respondent indicated hope for a successful future, but not without political will; he said: "We need the political will to do what is right. [Shouting] Taxes need to be raised—they NEED TO BE RAISED!" The community leader interviewed in Sumter

County did not want to answer the question in a straight-forward fashion, but did acknowledge some characteristics of the population in the county: "First, 50-60% of our population is on Medicaid. A lot of people have problems that go undiagnosed, and they end up in the hospital. The cost factor of that scenario should figure into research." Perhaps most importantly and credibly, because of direct interaction with patients, the health care practitioner said that the US could be rated at 7; Alabama at 4; and Sumter County at 4. The respondent referred to problems in the structure of health care as potential reasons for why the health care is not excellent; he said that "We need equal pay for equal play. We don't have that. A lot of doctors have to do a lot more work, for a lot less money. That would be one thing to entice physicians into these areas." In further statements, he said that health care quality would be better if the county had more health care providers.

To ascertain the perspective of each respondents view of the place health care should have in policy makers' priority lists a list of topics were provided, including education, economic development, health care, infrastructure and security issues (police forces, national security, etc); following the presentation of the list, participants were asked to prioritize and offer commentary on their responses. A religious leader in Sumter County said that health care should be third, with education first, economic development second, security issues fourth and infrastructure fifth. Another religious leader agreed that health care should be third and that education and economic development should be second followed by infrastructure and security issues as forth and fifth. The community leader interviewed said that he did not even believe health care should be in the top five issues. He said: "It is only an issue to those who are sick. Those who aren't in need

don't think about it. That's part of the problem with society." For the wealthy, a characterization of most of those who are in power to make decisions about health care issues, he believed that the programs available to them keep them from thinking critically about the health needs of others. He said

> There are some programs like MDVIP or VIPMD- I don't remember which- that doctors can join. This forces them to limit their practice to around 600 patients. The patients then have to pay a "membership fee" of sorts, but they go in for a complete physical each year, and they are guaranteed to see the doc if they have an illness on any given day.

This quality of access for the upper class— those typically making decisions impacting the general population— he believes, is why there has not been adequate reform to meet the needs of the most vulnerable.

A political leader, responding to the question about the priority of health care in the community, said "As a political leader, I think health care is at the top. It is in the top 3 issues, no matter how you stack it. I believe that we are responsible for the children and the elderly." He continued on to say, though that he doesn't necessarily believe that all the responsibility falls on the government: "Whose role is it? I believe it is the governments to a certain extent. Churches and non-profits will fill the void after that."

Preventative Care in Sumter County

A benefit of the health care system in Sumter County that evidences high levels of social capital was detailed by a community leader: "There is rarely a problem getting into a physicians office; the offices are busy, but thankfully, they are not over-extended." Additionally, the respondent said that "We have some decent preventative health care that is usually sponsored by our drug stores." These preventative efforts are indicative of a universal effort in the community to address health needs, not just by the physicians—

social figures expected to address such needs. The positive health outcomes in Sumter County appear to be related to the unified front of the county leadership in addressing health needs.

Each of the respondents was asked about preventative health programs in the community because excellent preventative health care could be the cause of increased quality among the people in the county. When asked about such programs, one of the leaders said: "We do preventative health in the city governments here." He said, as well, that "Other preventative health is administered usually by where you work; the Health Department does some; the Board of Education does some to try to keep their teachers healthy." He said that "We never see Extension doing anything health related." One of the religious leaders, in this regard said, "Yes, these are a major plus in our community. Several groups do things like breast and prostate screenings. I hear of things all the time, even eye care. I participate in all of the programs I can." He was well aware of the events because, he said, "The Health Department holds a big event, and they send out notices to groups and to churches to reach a broad population," and because "I see advertisements in the newspaper frequently about these kinds of programs." Another respondent, the community leader, said "Yes, I hear of preventative health programs at the drug store; they do a good job of that."

Perceived Positive Elements of the Social Structure Impacting Health Quality

The respondents in Sumter County all agreed that solid, effective basic health care and prevention is the crucial element of positive health outcomes. A political leader said "We have a working hospital in our county with several doctors affiliated. Two of those live in Livingston. We have an active recruiting strategy to get three more doctors into

our town by 2007. Even then, we realize that we will still be desperately underserved." This leader's statement indicates a passion and desire for improvement. The leader expressed pride in the level of effectiveness that the current programs offer, but also believes that improvement is necessary. This goal to keep moving forward is a sense that may be positively impacting the health outcomes for the people there. In the same county, one of the community leaders said "We have good health care for basic things, but most people go to Meridian [30-40 minutes away] or to Brian Whitfield Hospital in Demopolis [45 minutes away]. We have several good doctors in our county and some nurse practitioners." The respondent was very quick to iterate though, that "Most people go to Meridian for their treatment… it is only 30 minutes away."

Responding to the same question about positive aspects of the health care system in Sumter County, one of the health care practitioners said that the infant mortality rate had dropped significantly from 1995 to the present; he said "This has been because of education." Additionally, he said that "Cancer education efforts have been undertaken by UAB in the state; this has particularly helped reduce the amount of breast and cervical cancer cases." The practitioner, continually speaking on the theme of education, something that helps promote social capital (Flora, Flora and Fey 2004), said "We have community health advisors now; and we are seeing programs introduced to offer mammograms; help cover colposcopy; follow up on abnormal pap tests; we should see as a result a drop in breast, cervical and colorectal cancers."

An additional political leader addressing the positive aspects of the county's health said that: "A strength…is our proximity to Meridian (30 minutes), to Tuscaloosa (1 hour) with a Level 1 trauma center and to Demopolis (45 minutes). There are over 100

MD's available at Meridian and Tuscaloosa." Again, the theme of proximity to multiple centers of advanced care is addressed. One of the health care practitioners interviewed said that: "We are centered among three places with great advanced care: Meridian, Tuscaloosa, and Demopolis, so in spite of the deficiencies here in our county, health care is accessible; you just have to drive a little further than is normally considered to be convenient." Once more, the proximity to quality care centers was referenced.

Trust in Health Care Providers

There seems to be a strong reliance by residents or health care consumers on local physicians to send their patients elsewhere (Meridian, Tuscaloosa, Demopolis) if need be. Participants were asked about their confidence in physicians to send them to one of the more advanced centers if need be. One of the political leaders said:

> I go on somewhere else for specialists or surgeons since we don't have any. I get my blood sugar, blood pressure, and other routine things checked here. Doctors will send us on though if we need to go. We don't have to worry about them keeping us if we really need to go somewhere else. They'll let us know and send us on.

One of the religious leaders said "I trust Dr. --- to tell me if I need to go somewhere else; a lot of Sumter Countians go to Whitfield Hospital in Demopolis anyway. We really are in a hub of access to good health care in a number of places." Still the other religious leader interviewed said: "I've been only one time to Demopolis; I usually go to the doctor here." The community leader I interviewed said "I go, of course, if the local doctor says 'go', but if there are things out of his control like cancer, heart disease, etc, I'll go on and go without the GP's urging, and my friends and colleagues will as well. They don't all wait on their doc to tell them to go." It is very clear from the responses to this question that there are strong levels of confidence in the health care providers in Sumter County.

Other Issues

There appeared to be in the county a racially segregated health care system, so I also asked one of the health care practitioners about the apparent *de facto* racially segregated health care. He felt like it was not a hindrance to anyone, but was simply a matter of comfortability. "There is a clear racial distinction in the county, but I don't see it as a racist thing. It has to do with comfortability. I treat a very low percentage of [other race] patients. The [other race] folks are usually treated by [omitted to maintain confidentiality]." This perception may be skewed by idealism in the practitioners' perspective, but in some sense, perception is reality. The respondent's candidness about the racial segregation was insightful into the way the larger community of Sumter County is structured. Insofar as health care is concerned, previous research literature does indicate that patients have better outcomes when they are treated by physicians or health care providers of the same racial background (Williams and Jackson 2005).

Perspectives on Improvement

The respondents were all asked about their perspectives on what could be done to improve the health care system and ultimately the health quality of the residents of Sumter County. One of the religious leaders said that: "Health care is all interrelated. It is really a personal pursuit. We should all try to get our own health care, but the governments should be responsible to those who can't get their own health care without the governments need." He also believes that "We need good leadership in the communities to seek to employ and educate people. If we do that, we will see more people who can afford their own health care." Additionally, he said that "'If we had the

will, we could address all of the issues.' The problem is that people don't want to make concessions of their own agendas." A goal of his is to "build a coalition of people to help make our county a better place. Like the Indians said: 'Take care of the land, and the land will take care of you.'" He believes that "We have a generational responsibility to help the children, to help the elderly in a number of areas, but particularly in health care." This mentality is one of the counties greatest strengths the county has. There is resilience in the face of the predictors of negative outcomes, and this respondent evidences those. He observed that some of his colleagues in politics have "Depleting values. Politicians want to only appeal to us for our vote, with no commitment to help bring positive change." One of the other religious leaders was looking to the federal and state governments for the answer: he said that "The government does not need to cut funding for the poor. I feel very strongly about these issues. We have a responsibility to help those who can't help themselves and this administration is not doing that. The poor need us, and we are failing them." Still a community leader in Sumter County disagreed with this sentiment, saying "National Health care would be a disaster. We have a problem because of the entitlement mentality that prevails in society. That has driven lawsuits through the roof and thus malpractice insurance, the cost of which is passed on to patients." He believes that the problem is systemic, extending to even the pharmaceutical companies who, he said, "are another stakeholder in this problem of health care. They cost us great deals of money." So we can see that while the overarching value of the Sumter County leadership is unity in the face of problematic predictors, perfect unity does not prevail.

Health Care Resources and Technology

Of the two health care practitioners questioned, one gave extensive insight into the technology and resources available in the county. However, the other respondents had limited contributions to make on the issue. The health care practitioners concurred that "We have no CT scan machine. We lack technology, and that is a big setback. To counter that, we are looking into trying to use some information technology for telemedicine." This lack of technology could be costing the people of the county health quality. He said that "If we have a CT Scan machine and a good X-Ray machine, we could shoot those to a world class doc somewhere else, and get almost immediate feedback. We need to upgrade our physical plant though." He said that in Sumter County, "Most diseases are chronic; we have four times the normal risk for stroke. We have high levels of obesity; under education; no health insurance; and no drug programs." Regarding unique methods to deal with this, the respondent said "We try to make patients understand the disease process and have them participate in their health care." That requires a personal interaction with the patients, so the numbers of patients they see has to remain low; the health care practitioner said, then that they only see about 25-30 patients per day in their clinic. Again, the limited number of patients allows for personal interaction between the practitioner and the patient which appears to make a great deal of difference in health outcomes.

All of the clinics in Sumter County are privately owned; "We don't have any after hours clinics or doc-in-a box style." said one of the political leaders. The same respondent said that could be a negative thing, and that to expand health coverage, the

city of Livingston is working with the University of West Alabama to have longer hours and to provide care for the community.

Each of the respondents made some comment about the problem of insurance in accessing health care. Religious leadership said "We have a lot of people without insurance in Sumter county; and that is a real problem. Even without insurance, there are some safety nets for people for medical care, but dental care and vision care can be a larger problem for those people without insurance." A community leader agreed with the spirit of that statement, saying that "We have a lot of residents who don't have insurance.—I would say that's our biggest weakness, the population without health insurance." He did not believe that was all of the problem, though. He said that "In Sumter county we just lack sufficient amount of health care." Clearly in the responses of the non-health practitioner respondents, the comments have been centered on systemic issues. The health care practitioner said about specific problems, that "We have no specialists in Sumter County. All of our docs are family or internal medicine focused. It is a problem if people can't get elsewhere for care."

The health care practitioner also spoke about the specifics of the practice with which he is affiliated:

> We offer a sliding fee scale based on individual and family income. It is well known in the community that you can come to my office and be seen. We are a safety net of sorts to ensure that people are not forsaken. If people need medicine, there are staff who help them around needmeds.com. There are a number of prescription assistance programs.

He acknowledged that some have to travel elsewhere for care though:

> Here, you have to get treatment out of the county. A lot of people don't have the money they need to be seen by specialists. I try to maintain a good relationship with specialists in Meridian, Tuscaloosa and Demopolis.

> This helps me to be able to help patients. The specialists will work with the patients to allow a pay off of their debt. DCH in Tuscaloosa allows co-signing, so I do that for some patients to signify my confidence that they'll pay off their debt.

This is a way in which the patients have social capital—a relationship with their physician that gives them relationships with other people that they need for survival.

Of the two religious leaders interviewed about the hospital and its reliability, one responded, "Hill Hospital has a rehabilitation program. They don't treat serious issues, but only small problems. If people have big things they know to go to Meridian or Tuscaloosa. I'd go to Hill for basic care like dehydration, stitches, concussion, etc, but NOT for serious matters." One of the political leaders said "Hill Hospital is only an acute care center. They do no surgery, no babies, no ICU. About all they treat is dehydration, setting broken bones, concussions, pneumonia, flu. They do no major illness work." Another religious leader said that "No one stays at Hill Hospital for serious issues, they are transferred." The health care practitioner, when asked specifically about the hospital, said: "We have 350-400 patients in the ER/ month. We only admit 10-20 percent. The others are either released or transferred. We don't offer specialty care here."

Clearly in Sumter County, problems loom, but the leadership seem to be united around helping the most people possible with the limited resources available. The unity that they have, is indicative of high levels of social capital, and that seems to be having a substantial impact on the health needs of the people there.

Dallas County and Demographics

Dallas County has a population of about 44,000, more than 64% of which are minorities (Center for Demographic Research 2005). The County is positioned in Central Alabama, in the heart of the Black Belt. In Dallas County, racial tensions have historically been high, and inequality there has been a problem for nearly all of its documented history. Specifically, health quality is low, and as noted, the health outcomes are lower than in Sumter County in spite of demographic indicators that would predict otherwise (Table 1).

Perceived Strengths of Health Care in Dallas County

On average, the respondents felt as though the health care structure in Dallas County was strong and without any substantial problems. In an introductory conversation with the political leader, the response was given: "We have an excellent group of physicians. We even have a UAB residency program." Similarly, a religious leader said: "We have lots of doctors in our county." Furthermore, a community leader said that "We have good preventative health care programs in our county; wellness programs are done well by Vaughn Regional Medical Center." Finally, the health care practitioner said that "We have a good number of primary care providers, strong access to new technology, residency program since 1976, community college with good nursing program, and good nursing homes." These responses, though not entirely indicative of the sentiment of the community, are the general perception of leadership figures in the county. Failure to acknowledge weaknesses could perpetuate the system in its current state.

Perceived Weaknesses of Health Care in Dallas County

While generally, the respondents were in denial about the poor outcomes of their health care system, as noted previously, some would acknowledge problems. The most notable respondent to recognize the need for changes was the health care provider who said that "Though we have a large number of specialist, we have a small number of physicians overall." Additionally, the same respondent said

> Also, we lack a lot of other things, I'll list some of those for you: Infrastructure and Transportation. We have high levels of poverty, low education levels, infiltration of managed care, patient population that is highly litigious, and this frames a lot of what physicians do or don't do: medical malpractice. We have a lot of doctor shopping that leads to a lack of continuity of care. Higher commitments to patients in rural areas; we live in more of an urban environment.

Furthermore, the political leader remarked that: "There are a large number of people burdening our medical system, not just here, but everywhere. It seems that most people don't have private insurance." The religious leader offered some personal anecdotes such as the following: "I had a parishioner call me one night a few years ago because she was ill. I took her into the ER about 8 p.m. It was 4 a.m. before they saw her. That's the kind of experiences I hear about VRMC." He also discussed the digression from multiple hospitals to one hospital: "We had VRMC and Baptist Hospital, but they shut Baptist down 4 or 5 years ago. Baptist was serving people. I don't know why they shut them down." Then he reverted back to recalling interactions with the health care system: "I'll tell you another story. I had a Minister friend who had a wife got sick. He took her to the ER, and they didn't tend to her. Because of the inattention shown her, she expired before anyone could care for her."

Other problems were acknowledged by the community leader who said:

> Workman's Compensation is a real problem. I had an injury on the job, and I had to drive to Prattville (50+miles) to get a doctor who was in my network. There was good care there, but I should not have had to drive that long. My injury was last October, and I still have problems (in August). They are ongoing, and largely because I cannot get the care I need from my Workman's Comp insurance provider. Another story: I had to go to the ER to take my child. The ER had blood in the waiting room. There were ants running around. It was disgusting and unsanitary. When I was there with my child, I was waiting behind an unaccompanied older gentleman who was trembling and could barely speak. The Registrar threw a wrist band at him and instructed him to "put it on", offering no assistance. That night, all of us had to wait, and wait, and wait.

The stories relayed by both the community leader and the religious leader indicate that clearly there are problems with the health care system and the way that patients are treated. This treatment of patients is a personal issue of respective providers, which is similar to but different from the larger systemic issues in the county.

Regarding the hospital itself, the health care practitioner acknowledged problems. "As far as the hospital goes, we have mostly an indigent population in our county, but the affluent people will drive back 50 miles to Montgomery, so we have to gear most of our care to the poorer people." This was an acknowledgement that the outcomes may be problem.

Researcher's Observed Problems with the Social Structure in Dallas County

In Dallas County, the political leader denied the existence of systemic health care problems by saying that "Use of the word "disparity" implies negative outcomes in the county, so I believe that this question is loaded, and I disagree with the proposition that we have great disparities in our county." He continued on to say that "Probably only 10% of the population in need of medical care goes without what they need." In a very defensive tone, he said that "Our hospital does meet the needs of the people." In

response to that statement, the researchers asked the participant: “Don’t you think since you are in a position of prominence, you receive particularly exceptional care?” to which he sharply responded, “No. I don’t; when I go, I wait just like everyone else; there really is not a disparity.”

The defiant attitude of the Political Leader potentially is one of the causes of the perpetual health quality problems. Until he and other political leaders admit and acknowledge the problems that exist, he will not be able to participate in solving them.

Racial Distinctions

Having interviewed participants from both races, it became clear that there is a racial distinction. This was very evident from a religious leader who said that “I recently read that we are adding a black woman doctor to the staff; that will help reduce misunderstandings between races.” The racial and ethnic difference that was exposed was greater than just between black and white people; the same religious leader said: “We have lots of foreign doctors—they are good doctors, but I think sometimes people can’t understand them very well.” This is not indicative of racism, but it does show that there is a perception that the best care can be given by one of the same race.

The health care practitioner said that still among the black patients, there is a lack of trust for those in the health care profession because of syphilis study at Tuskegee University (Tuskegee 1996) and particularly due to the proximity of Tuskegee to the Dallas County community. The balance of physicians of the African American race does not correspond to the racial balance of the population.

Transportation

As noted when discussing the results of interviews in Sumter County, excellent health care maybe offered, but without transportation to the care, it is useless. Therefore, consideration of this important service was given. When asked about transportation, the community leader said:

> I believe that we are trapped in Dallas County. There is no transportation anywhere else. If you live in Dallas County, you pretty much have to get your care there. It is horrible though because at the hospital, and at a lot of the doctor's offices' I have been to, the staff is rude, they are demeaning, and just unkind. It is not always the doctors so much as the staff.

Additionally, the political leader said that

> Transportation is not a problem; anyone needing to get to a doctor can get there. We have West Alabama Public Transport that we help fund with the State and Federal government, and they can get anyone, anywhere they need to go. Mental Health also will ensure that patients get the transportation they need.

The response offered by this participant was characteristic of his other responses; with his commentary, there seems to be a reticence to acknowledge the problems in the community, and with that denial is a delay in the ability to fix the problem. This same sense of hesitance to acknowledge transportation problems was offered by the religious leader interviewed: "I don't think this is so much a problem. Most folks have cars these days." I followed up with a question about WAPT, to which the response was: "I don't know much about the West Alabama Public Transportation."

Perhaps the community leader's response was more telling though; it was prefaced with a sarcastic laugh followed by the statements: "WAPT is horrible. It only runs in certain areas, on certain days of the week, at certain times. I wouldn't put my enemies on one of those busses. They are all over the road, and they drive neither safely

nor with respect for their riders." Furthermore, the health care practitioner did not seem quick to judge public transportation; the first response was that: "Continuity of care seems to be a problem here in Dallas County… that's largely because of the doctor shopping." However the follow up statement was that "Yes, transportation is an issue, but we have some reliable forms of public transportation. Another thing we are doing is taking HC to the people with clinics on wheels." Clearly, it was not a pressing issue in the mind of the respondent. Transportation was only assessed in this study by the respondents' comments. There was no objective measure of the effectiveness thereof. It seems though that problems do exist with the ability of individuals to get to their health care professionals, but there is little concern with addressing those needs.

Trust in Health Care System and Providers

Confidence in those who provide care is essential, especially in places like Sumter County and Dallas County where access to other providers is a relatively short drive away. The sample in this study does not adequately represent those who are not able to drive outside the county, consequently being forced to use what is in their general vicinity. However, the feelings of those who do have access to care elsewhere reveal some insightful information. Each respondent was asked if they chose to utilize services available in the county. The political leader said "Yes, I do use the docs here. I never have a problem getting an appointment, and I don't know of other people that do. Also, I usually am in and out very quickly. The only thing is, we don't have an orthopedic doctor here right now, and that is troublesome because I need to see one regularly. I have to travel for that care." When questioned about frequency of visiting a physician, he said: "I go to a urologist (specialists) once per year, and I see my family doc twice per year for

check ups. Otherwise, I go there if I get a cold or something." Furthermore, the religious leader said unashamedly:

> Yes, I use the doctors here. My doctor has been in practice more than 20 years. I rarely have a problem, in fact, I don't think I have ever been really put off for an appointment, and I have to go to the doctor every 3 weeks. I had a tumor removed in 1990 (when I was xx [age deleted for confidentiality]), and I have to be sure everything is still alright with that. I go other places when I can't get the care I need here, but the doctors always point me in that direction. There were very few black doctors here when I came in 19xx. That was in the days of segregation, and it was a problem for people then. It isn't anymore.

The community leader, on the other hand, emphatically said,

> No, I don't. I would rather die in route to Montgomery or Birmingham than to go to the physicians here or to VRMC. My friend, however says that she goes to the family doctor here. For my friends, if they don't have an appointment scheduled in advance, they can not get into see the doctors here in a timely fashion. I go periodically for different things since I have various health problems. Really, it's the dissatisfaction with doctors treatment that sends me to get care at other places. I cannot stay here and be treated the way I have been for the longest.

The community leader continued with disgusting comments about the hospital, saying that "I wouldn't leave my loved one or friend in the hospital by themselves. If they have to stay, I will stay with them. If not, they'd leave your loved one lying in dirty linens. If I were seriously ill, I'd leave the hospital to go somewhere else. Our hospital is very poorly managed."

Willingness to Transfer and Leave the County for Care

In some cases, it is important that patients who are critically ill be transferred from one hospital to another or from one physician to another to receive adequate health care. To ascertain the frequency of this occurring and the perception of the health care providers' willingness to suggest the transfer, respondents were asked about their

experience with such events. One health care practitioner said "It is not common for us to transfer patients out of our hospital unless they are critically ill. We try to handle most things in house, but we do make transfers occasionally." The political leader acknowledged only that "A good many people go elsewhere for specialists." But he did not suggest that physicians in Dallas County suggest the transfer. The religious leader said,

> I go to Birmingham for very specialized care. In real serious cases, other folks I know go to UAB for care as well. I've heard of some who've been transported by helicopter for things like heart conditions. Of my parishioners, some go to Montgomery if they go other places, and some go to Birmingham. Most folks stay here though.

The community leader said that some people do not have the choice to stay or go, that they are forced out: "I knew of a patient whose doctor said to them: "I'll give you a referral to Oschner's, Mayo, or Tokyo. You're time is up with me—I have patients in the waiting room." With this comment, he left the patient sitting in the room with tears. This is the only time I've heard of someone being referred out." She said though that physicians do not usually refer out, Rather, they try to keep things in-house: "As I'm thinking about it, I do remember one doctor in the community will transfer people out, in fact, I remember that he's stabilized several people and transferred them out." Otherwise, her memory of physicians' interactions with patients was like the first encounter that she mentioned—a very negative thing.

When asked about patients being moved from the hospital, the political leader said "I hear of some, but it is very, very seldom. If they are it is usually a John Doe patient." The religious leader said, "Yes, I've heard of a few, like I said earlier, in the case of extreme circumstances.", and another of the community leaders said "Yes, it

happens, but not very frequently. I mean, my brother was very, very ill, and they took him to UAB. Most of the time, patients have to demand to be moved; the doctors won't be willing to do the referring." Finally, the health care practitioner said about dealing with patients who can not be treated in their clinic, that "I refer them mainly to physicians in town. I believe we have good specialty care here, so I send the patients to those clinics."

Preventative Health Programs

In all places, among all peoples, preventative health programs should be institutionalized as a way to minimize future costs of health care, and to ensure the best possible quality of life for all parties. Hence, the issues of preventative programs were addressed among respondents in both counties. In Dallas County, the political leader said

> We have great preventative programs here. A lot of them are done by Vaughn Regional Wellness Center which is not part of the hospital. It is an individual entity. They do things like blood pressure, cholesterol; they go into schools and elsewhere like that. It is helpful for catching things that otherwise may go unnoticed.

In the African-American community, there is a unique approach to preventative health care. The religious leader offered some insight into that approach by discussing what is done through the churches: "In the black community, most churches have a RN who does wellness work. This has minimized the need for government or industry intervention." This is a strong evidence of social capital that exists among certain populations.

In the county at large, and particularly in Selma, the community leader said that "Yes, I hear of them [preventative health programs] occasionally, but since the competition hospital closed, there's less and less of it." This was the first hint of a

problem, in the area, but it did not stop there. Even the health care practitioner acknowledge substantial problems in this area: "There are some things [preventative health programs] in the community, but they tend to be "fluffy". They are organized by '501c3's' who have questionable ethics." The implication was that these organizations conduct free of charge services to sell a product or greater service later on. The health care practitioner said "Our practice does very little preventative care, unfortunately. Health fairs are usually done by clinics or groups hired by clinics as marketing tools to bring people into their practice." The positive outreach done by the clinic with which the health care practitioner is affiliated is "direct patient care". The respondent said "This forces us to look at the whole patient, to see their lifestyle, to understand their circumstances and treat accordingly, including prevention."

Medical Debt

Medical debt which is debt accumulated to pay expenses related to the health care of an individual or their family, continues to be a problem. Each respondent was questioned about their knowledge of or encounters with medical debt based on a follow-up conversation with one of the earliest subjects interviewed who indicate that it was a problem in the county.

The political leader said "I know a lot of doctors don't get paid what they are supposed to, but I don't hear about loans so much." Further, the religious leader said: "I haven't heard of many problems with medical debt. A doctor in our community has a private practice and is on staff at the hospital. If he has patients needing attention, he'll be sure they have it." Also, "I know that the health department will send nurses 2-3 times per week if patients need that help to keep costs down for them; I feel like everyone

combined does a good job of making sure the elderly have the care they need." This, again, represents a strong evidence that the people there sense bonds of social capital among themselves and in the community, but it was a failure to really acknowledge the problem of medical debt. The minister was African-American, so it could be that the lack of knowledge of medical debt was related to racial distinctions: that African Americans have less access to loans to pay for needed health care.

However, in other areas, the community leaders acknowledged that it is a problem, saying that medical debt "happens all the time." One of the leaders said:

> We have poor, very poor technology here in Selma. Some people are able to go on payment plans, but not all. For the very ill, debt is inevitable. This problem projects itself into issues of referral, too. When people can't pay their bills to one doctor, that doc is not going to refer him to another doc.

This may not be the case though. This kind of unfounded statement represents a sense of distrust, as has been evidenced by this participant all throughout the interview process. Even if the statement is false, though, her sense guides her, and in some way, it is reality. This is an indicator of relatively low levels of social capital among one group of the society there in Dallas County: white, middle class residents.

Speaking first hand about payments to clinics, the Health Care Practitioner said, "Of course, this is a problem. There are groups here that help with these problems though. One of those is the Annie Graham King Foundation for Medical Debt Relief. They provide matching funds for people who can not pay all of their bills."

Social Responsibility and Health Care

Each respondent was asked to address their perspective on health care in its place in society. The political leader said that "Health care is very important, but that it is not

the role of government." Counter to that, the religious leader interviewed said "I think that health care works primarily out of the government. I believe we need more the role of government in health care today." However, he did say that "Where there are problems, I'd blame them mostly on the hospital rather than the government."

The community leader said that "Health care should be a community effort, a family effort. In some families, youth will charge their own grandparents to drive them into the doctor. This is a real problem." She continued on to say that "Our mayors, city council members, other leaders need to make this a priority; problems need to be precisely identified and addressed, but I don't believe we need socialized medicine." The health care practitioner said that

> Most people think we need a National Health Care System, and with those people I say, I agree: we need reform in every facet. We need more malpractice reform, we need tort reform, we need pharmaceutical regulations, we need to re-look at health insurance. It is a burdensome system that we have.

When asked for an open-ended assessment of the health structure in the county, the political leader said that "In Alabama and Dallas County, we need more physicians and specialists. I think we have an adequate health system and good providers, but every system can make room for improvement."

In a spirit of honesty and integrity, the religious leader responded that "I believe that I can't answer this very well, because of who I am and who I know, I get attention that some folks may just not get."

An additional question was asked of the community leader regarding rating the health systems in the state, region and county based on a 1-10 scale. She responded: "I don't know about the US; AL—8-9; BB—6-7; DC—2." Her follow remarks were that "I

believe that the single parent families are crippled by welfare systems. It needs reform; it really needs to address families in need." The health care provider was asked if the quality of health care in Dallas county were to be brought to the level of the region (7), what would it take? "To move the care in Dallas County to a 7, we need to have more consideration by the staff, doctors, nurses for patients time, for their overall care; doctors need to quit talking down to their patients or over their head." Furthermore, "The ER in our county needs to get it's stuff in order; if one goes into the ER in dire straights, they need to be treated in a timely manner; not as the doctors, etc get ready."

The health care practitioner was asked the same thing but chose to respond in a different way, saying: "In Dallas County, we have a PR problem. The system is not as bad as a lot of people think it is. One of the problems we have is that there is no network of the people who are doing good things. I believe, personally, that crime is the biggest public health problem we have in Selma."

Prioritization of Health Care

The respondents were given five major issues-- Economic Development/Jobs, Health Care, Education, Infrastructure, Crime/Law Enforcement (or National Security)-- and asked to rank them in order of importance to society. The Political Leader said "I'd rank, Education, Economic Development, Health Care, Infrastructure, Law Enforcement." He raised an important point, saying that: "I believe that education is an integral part of health care."

The religious leader ignored this portion of the interview, and the Community leader said that education should be first, followed by law enforcement, health care,

infrastructure and economic development. Otherwise, the interviews were cut short and this questioned was not answered.

Each of the respondents in Dallas County, except the Political Leader, who could perhaps most effectively address the disparities, seemed dissatisfied with the health quality and with the effectiveness of the system. This lack of confidence in the system is likely a result of the minimal levels of social capital in Dallas County.

The statistics discussed early in this chapter are indicative of undesirable disparities, but the reason for them was not so clear until these interviews revealed such high levels of dissatisfaction with the system. The lack of social capital is evident, then, in the responses of everyone from Dallas County.

V. DISCUSSION

The Alabama Black Belt has been one of the poorest regions per capita in the state of Alabama and in the nation, and because of that, it has been the focus of a great deal of research on a number of segments in a number of areas: from health care to economic development to issues of natural resources and environmental problems. As such, one of the political leaders interviewed for this study, stated that the Black Belt has been "Studied to death, and that it is time someone do something with all the studies that have been done." This need for improvement in the region was echoed by everyone interviewed in the data collection process. In both of the communities, there seems to be a great love for home and a passion for the community, but that passion comes with a sense of desperation that things are not as they should be. There is a longing for improvement and a sense of satisfaction at the same time; perhaps this is because of the security and peace found in the deeply embedded family roots and the existing social structure that is characteristic of many rural areas. And though progress has been made in the social, educational and economic development of the counties of the Alabama Black Belt in recent decades, this study indicates that there is a great deal more to be done.

Socio-Structural Issues Impacting Health Quality

The community leader said that: "We have much more problematic social structure issues [than just healthcare]. Our police force is horrible, and we have a high

crime rate. The problem is a cycle: we have bad policemen, then high crime, no police want to work then we have high crime… it just repeats itself." Clearly in the community, problems beyond basic provision of health services impact the residents' quality of health. This was also evidenced by comments made by the health care practitioner: "We have a segmented population; some people have never traveled out of the county for anything, much less health care. Others wouldn't dare be treated here. Some get to choose, and they stay here very happy with our services to them." The provider was simply noting the great difference in the accessibility of services to different groups of people, a discrete level of inequality.

Even the most pleasant of the respondents, the religious leader, made comments like: "I know that for me, I'd rather be in the hospital in Montgomery than at VRMC." This theme was echoed through out the responses of the participants in Dallas County. There seems to be an underlying distrust in the health care system in Dallas County that was not present in Sumter County. This distrust was seen across races, ages and constituency groups (with the exception of the health care provider), and I propose that the distrust is indicative of some unidentifiable problems that account for the unusual health quality outcome data.

There seem to be a number of other potential reasons for the inequality and disparities that are evident in the counties, and although some political and community leaders believe that higher levels of funding for health care programs would eliminate the disparities, the fact that expenditures for US health care are more than any other nation in the world dispel this as a sole method for alleviating the problems. As noted previously, the tendency of the US has been to spend a great deal more than other developed nations,

but health quality results do not reflect the exorbitant amount of money being spent. The results of the assessment done by the World Health Organization (2000) are very similar to the results evident in small communities as well such as in Dallas and Sumter Counties. Clearly, the phenomenon observed even in this microcosmic sample is that in spite of a better infrastructure in one county over another, the health outcomes are not significantly better.

The question, then, necessarily emerges: if funding is not the sole problem of health care, then what is? It was explicated earlier that most literature and research today indicates that with the increase in minority population, decrease in physician to patient ratio, decrease in hospital beds per members of the population, decrease in median income, as well as other variables typically referred to as health care predictors, that the health outcomes decrease (Cockerham 2003). These health quality outcomes are clearly perplexing then. However, the findings of this study should help raise the attention of a phenomenon that has not been yet documented in the Black Belt: that despite the funds being spent and the accessibility of health care in Dallas County, the outcomes are not always better than other counties—in this case, Sumter—where there are fewer resources.

This finding may cause policy makers to re-think the way the funds are allocated in the Black Belt, thus improving the health quality for all of the people in that region by tapping into the cause for the better outcomes with less resources. As indicated in the results section, the relationships, or social capital, that lie among the people in the less developed health system of Sumter County might more than make up for the lack of resources such as physicians and facilities that are missing in that county. While this study cannot be generalized to any populations other than the ones studied, it is clear that

there is a substantial impact of relationships on health quality. This should prod future research on the phenomenon observed in the current study.

Alternative Explanations for the Observed Phenomenon

While it may be desirable to believe that the main reason for the different outcomes is simply higher levels of social capital—a positive thing for Sumter County—other reasons or potential reasons should be considered. One respondent during the interviews offered such a potential explanation.

A community leader in Sumter County said that:

> The difference in numbers in Dallas and Sumter county may stem from the segment of the population who are unable to obtain any health care and are therefore never diagnosed with cancer, heart disease, etc… there are a lot of people who never visit the doctor—they can not afford it.

This was the only clear and explicit alternative reason offered to the strength of the relationships and the investment of the physicians in their Sumter County community. In fact, I asked a health care provider in Dallas County about this potential explanation. The response was that while it is a possibility, it is not a reliably alternative explanation. That same provider was baffled and unsure of why the differences may exist. Deducing ideas from some of her comments, it appeared that she felt that the lack of continuity of care in Dallas County could contribute to the disparity. That lack of continuity stems from the availability of "doc-in-the-box" clinics where patients go for basic illness to receive treatment. Each time they go, treatment maybe administered by a different physician or nurse practitioner. The provider in Dallas County seemed to be quite concerned about that tendency.

Suggestions from the Literature

Comparative analysis of these two counties to obtain insight into the phenomenon is grounded in a variation of Suchman's (1963) research on sociology and public health. He said that "Ecological comparisons between different areas showing high and low rates of disease according to the social characteristics of these areas have been used to identify possible social factors in disease" (p. 49). The research at hand is not exactly trying to show the factors in disease, rather it seeks to show the factors in reducing death by disease in the two counties, comparatively. Counter intuitively, in this case, there is evidence that the levels of death by preventable diseases are lower in Sumter County than Dallas County. He continued on in his discussion of the relationship between the two disciplines of public health and sociology to say that "While these ecological comparisons can produce worthwhile hypotheses for further etiological research, by themselves they cannot be taken as proof of a causal relationship or even an association between the factors being studied" (p. 49). So, in this study, it is important to not infer cause and effect, but to just consider the possible relationships between social capital and the difference in the rates of death by preventable diseases. Other sources (Holmes 1956; Miller and Ingham 1976; Marmot 1975; and Neser, et al 1971) speak to the results of social networks on positive health outcomes. The dates on these studies show just that the idea of social capital and relationships as support systems in preventing and overcoming disease have has been around for a great deal of time, and indeed, this study shows that the impact of relationships in health care is still vastly important, perhaps even more important than technology.

Directions for Future Research

After having been in Dallas County talking to various members of the community, the question of the value of the Residency Program from the University of Alabama at Birmingham was raised. No research documenting the value of the residency programs in rural communities was found. This would be a helpful question to address because it could be that while decision makers assume that placing extra health providers in these rural communities is beneficial, there are other social issues like continuity of care that need to be accounted for with residents who rotate in and out every three years. Certainly, this is not a conclusion, but a question that became apparent after having visited with the people in the community. One of the community leaders even indicated that after having experienced the health care system before and after the introduction of the residency program that her inclination was that while not directly related to the residency program, the overall quality of health care in the county had decreased. Though unable to draw any conclusion about this problem, the researcher did come to believe that it is something that needs to be addressed in future research.

Furthermore, while physicians can be combating this problem of health disparities on the front lines of medicine daily, other measures must be taken to ensure that this problem is minimized to the greatest extent possible. One such effort may involve a reworking of the bureaucracy that controls the system. Laws, regulations and policies in place are not "poor-friendly." Efforts to reduce the number of barriers to health care should be made, while offering training in patient relations to the individuals who process files and medical records would be another way to prevent discrimination. It was documented that patients rarely felt intimidated by physicians; rather the people working

in their office, processing the records and bills were usually perceived as offensive such. This finding was validated at least twice by participants in this study, an example of which was cited by the community leader in Dallas County who recalled being in the Emergency Room at the local hospital and seeing a receptionist throw an arm band at a very ill patient.

Policy makers' predicament of meeting the health care needs of their constituents becomes increasingly difficult as health care quality outcomes remain stagnate while the costs for health care services increases. The data in this study coupled data that indicate an increase in the uninsured and underinsured is troubling. The total number of individuals without insurance or without adequate insurance is 61 million which is 35% of the population (Schoen et. al. 2005). Because only 65 of every 100 people in this nation have access to the health care, action must be taken to reverse such problems. While funding for health care must increase to meet the demands of development and research in the profession and to provide basic care for all individuals, avenues other than the financial misgivings must be examined as possibilities for the disparities.

Policy makers should be engaged in efforts to combat those problems of health care disparities as well. The discussion at hand emphasizes the multiple social factors involved, and while all of those should indeed be considered a factor in the health and well-being of a population, there are specific areas emphasized by The Alliance for Health Reform (2003) that should perhaps take priority. These include such measures as

> Basing decisions on resource allocation on published clinical guidelines; removing barriers to care by taking steps such as providing translators where needed; insuring that financial incentives do not overly burden or restrict minority patients' access to care; supporting the use of community health workers and multidisciplinary treatment and preventative care

> terms; and finally, collecting and monitoring data on patients' access and utilization of health care services by race, ethnicity and primary language. (P. 4)

One of the health care providers participating in the study in Sumter County expressed great concern about the lack of equipment their hospital had. In fact though, that is not causing the people in the county to experience poorer health outcomes than Dallas County. As discussed in Chapter 1, Mechanic (2005) indicated that technology can lead to greater inequality. It could be that the lack of technology forces the physicians to engage their patients in more traditional forms of healing. Also, it may be that when physicians have access to technology, they view that as the only form of treatment. Furthermore, it appears that in counties with more advanced technology, there is a great distinction between those who have access to care and those who do not. In Sumter County, all residents saw physicians with basically the same training and the same resources. This idea that technology may lead to greater inequality is something that should be further examined in future research studies. Findings from such research could impact budgetary allocations for the health care system.

These research outcomes indicate that the relationships that individuals have within their community impact the quality of health care that they receive. In fact, a quantitative study with a large sample could fit a model assessing the moderating factor of patient-physician relationships on health quality outcomes in communities with different levels of accessibility to health technologies and expanded health care specialists.

Also, throughout the course of this study, it became clear that there is a need for further research on the impact of patient load of physicians, racial congruence of patients

and their health care practitioners, and the power of social capital on the health quality outcomes. These things could be explored via a number of approaches, including qualitative and/or quantitative analyses as mentioned above.

In the time between now and when further analysis is conducted on these issues, general education and awareness should be raised about the impact of poor health on the community. As was discussed in Chapter 1, health quality is very much interrelated to other social institutions such as the economy, the religious institution, among other things. In Chapter 4, it was noted by a community leader in Sumter County that he perceived health care not to be one of the top five issues that should be addressed because it is only an issue important to those who are ill. That attitude could preclude individuals, groups and governments from making an investment into the health care system of a community because of lack of exposure to the impact of health issues on society at large. Further, as was discussed, the political leader interviewed in Dallas County was continuously emphatic that the health care system in his community was beyond adequate. He was clearly not aware of the disparities, and until he becomes educated on such problems and on their importance, he will not be able to affect change in the society.

Also, preventative services should be promoted. This work indicates that there is a much greater awareness in Sumter County about preventative health care than in Dallas County. No causal link can be shown, but it is important to emphasize that in the community where preventative care is well known and used, there are better health outcomes.

Limitations of the Research

As was discussed in the Chapter III, one group of individuals was sought for interviews that were not accessible: health care administrators. They seemed to be so busy and constrained with their work that they were unable to contribute to the study. That proved to be the case during the pilot testing phase as well as during the interview processes in Dallas and Sumter Counties. Had their constituency been represented, information about the typical type of patient seen (ie: Medicaid, Self-Pay, Insured, Un-insured, etc) would have been more easily addressed. Without their knowledge and expertise, that information was not easily available because the only other group who would have known, the health care practitioners, were more concerned with different factors impacting health quality.

Additionally, the lack of "typical health care consumers" contributing to the responses limits the effectiveness of these findings. This study really is aimed at addressing the needs and outcomes of two indigent populations, and without a first-hand responses from that population, it is difficult to speak to their true experiences with the health care system.

Also, the questionnaire that was developed did not directly address issues related to social capital. Though the pilot testing phase was helpful, in retrospect, there are still limitations to this study because of the questions were not open-ended enough. The responses, in some cases, were limited to yes/ no.

Finally, the data on which the assumption about the health care difference is based is from one year alone. It would be helpful for validating the study to look at these

differences over the course of a decade or more to determine if there are still the health quality differences in spite of predictors which would indicate different outcomes.

Final Direction

In general this study proves to be quite insightful into a phenomenon that has not been seen before. It is counter-intuitive, and the health quality outcomes in Dallas County versus Sumter County, in light of the health quality predictors go against a plethora of research. The findings in this study need to be further explored and researched to reach reliable and valid conclusions before making legislative or policy decisions based on them.

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APPENDIX

FIGURE 1: MAP OF DALLAS COUNTY

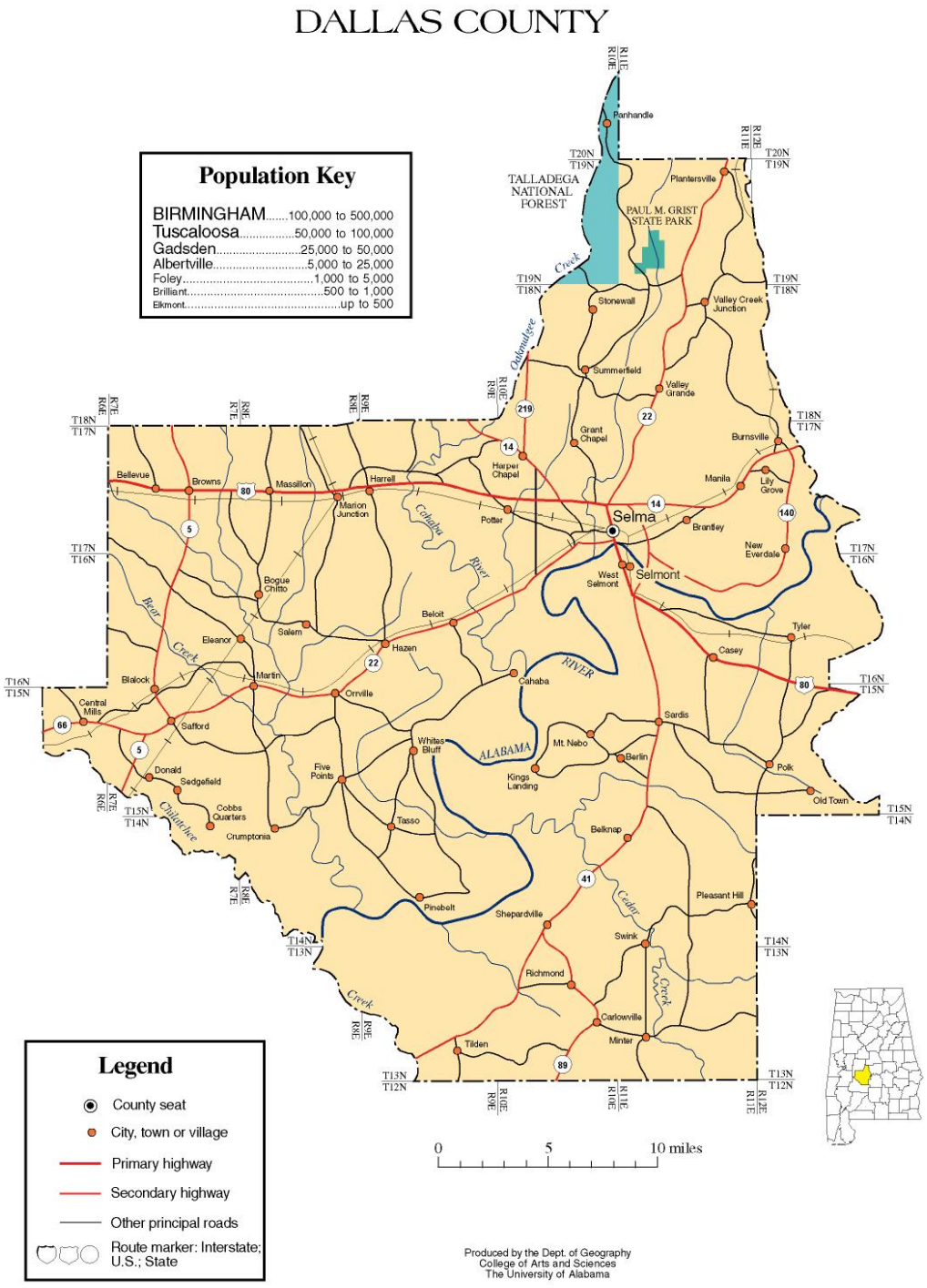
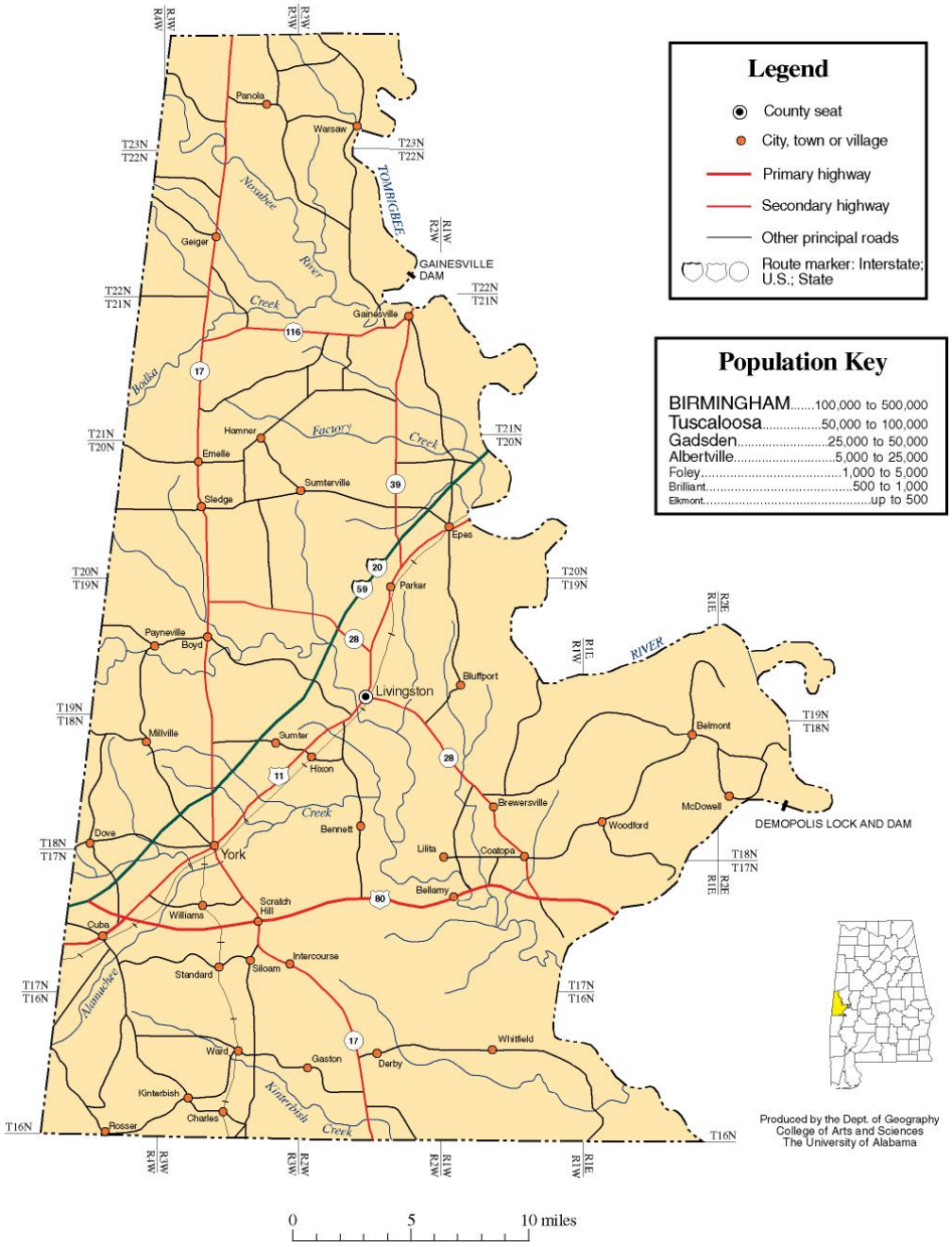


FIGURE 2: MAP OF SUMTER COUNTY



PERSONAL THOUGHTS ON THE RESEARCH EXPERIENCE

I greatly enjoyed conducting the research in a qualitative fashion because I believe that I was truly able to understand the feelings of the people in the communities. They relayed personal experiences that cannot be accounted for with quantitative research. The emotion and passion captured in personal conversations is so critical to understanding the outcomes of any statistical analysis in a community, particularly the health outcomes. When my major professor and I first looked at the outcomes in Dallas and Sumter Counties, I was perplexed. No mathematical analysis or quantitative study could have explained the outcomes, it was necessary to go there, to bode with the people, and to learn their ways. I do not believe that I was able to learn all of the ways and to obtain a full sense of the emotion and passion of the people, but I certainly did get some powerful insight into it. Using qualitative methods is not easy, but it is rewarding and insightful.