Rural residents face distinct health challenges due to economic conditions, cultural/behavioral factors, and health provider shortages. This comprehensive text about the issues of rural public health is the only book to focus on rural health from the perspectives of public health and prevention. Providing a cohesive synthesis of current research and practice, the book covers specific diseases and disorders faced by rural populations, service delivery challenges, disadvantages wrought by a shortfall of rural practitioners, and promising community health approaches and preventive measures.

The unique health systems and policies that have evolved in rural communities are addressed, as well as the unique ethical landscape of rural public health practice. Chapters cover a variety of specific health issues as well as environmental/occupational health, minority health, migrant farmworker health, and elderly health in rural areas. The text also discusses such health promotion strategies as integrated care and faith-based initiatives. Nearly all chapters offer best-practice recommendations and evidence-based prevention programs. This book is a cohesive, centralized resource for researchers, public health practitioners, health organizations, and graduate education programs focusing on the public health of rural populations.

Key Features:
- The only text to address rural health from the perspectives of public health and prevention
- Includes best-practice recommendations and evidence-based prevention programs
- Presents a cohesive, expansive synthesis of current research and practice
- Addresses specific diseases and disorders of rural populations, service delivery problems, and practitioner shortfalls
- Discusses promising community health approaches and preventative measures
Rural Public Health
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Rural Public Health
Best Practices and Preventive Models

Jacob C. Warren, PhD
K. Bryant Smalley, PhD, PsyD
Editors

© Springer Publishing Company, LLC.
To my parents, Mark and Rita.

—Jacob

To my parents, Terry and Becky.

—Bryant
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Preface

When we look at the unique health needs that residents of rural areas face, an unfortunate theme begins to emerge: Many people feel that, given the proportion of Americans living in rural areas is the smallest it has ever been, the health problems faced in rural areas must be similarly waning.

Unfortunately, this couldn’t be further from the truth.

Despite decades of documentation of the unique public health needs of rural areas, rural groups continue to face challenges in everything from initial access to care to severity of chronic disease sequelae, due to a unique combination of economic, cultural, access to care, and sociodemographic influences. The interrelationship of these factors is complex and difficult to address, and, unfortunately, relatively little attention is paid to rural populations at the highest levels of public health research.

When considering health promotion and intervention, rural residents are much less likely to have access to even basic primary care, are more isolated from hospitals and trauma centers, are more likely to be uninsured, have worse health outcomes in many of the most common chronic conditions (including heart disease and diabetes), and are more likely to live in an area without a robust public health infrastructure. Many rural residents must travel more than 30 minutes to access health care services, and living in a setting where public transportation is not available and poverty is at its peak, travel to prevention and self-management resources can be even more burdensome.

At the same time that rural populations face unique barriers to health, however, they also have unique opportunities and strengths for addressing health needs. For instance, the self-reliance and dependence upon local community, often cited as a barrier to health promotion, can be viewed instead as a strength. Capitalizing on that norm to empower community health workers offers opportunities for intervention that may not exist in the same way in more urban areas. Similarly, the strong presence of groups such as churches can also play an important role in promoting rural health.

In approaching this book, our intent was to create an organized, succinct reference discussing both the current challenges and future directions
of rural public health. It is intended for public health practitioners, researchers, students, and other professionals who work in rural settings or who are interested in learning more about the unique aspects of public health in rural areas. While we wish there were even more literature and evidence-based practices to present, the fact remains that this is still an emerging field due to the paucity of population-level rural health work currently funded and conducted. The book first presents some of the best-established challenges in rural public health, including medical care barriers, workforce issues, and ethics, followed by some of the specific rural-focused solutions that have been developed through faith-based initiatives and integrated care efforts. The book then discusses both the scope and state of prevention for specific health issues in rural settings, including mental health, substance abuse, heart disease, obesity, diabetes, HIV, environmental health, minority health, migrant farmworker health, and elderly health. The text then concludes with a summary of the future directions in rural public health to serve as a road map for moving forward.

We hope the book serves as a means both to document the challenges we face in rural health, as well as to present the current best practices and emerging models for moving the field forward. Rural areas continue to need innovative and cutting-edge programs to address their health needs, and we hope this book can help continue the drive forward for the health of tens of millions of rural Americans.

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The idea of protecting the health of rural populations, or rural public health if you will, is not new. In fact, all societies have roots in rural lifestyles if you go back far enough, so you could almost argue that the bases of all public health lie in rural living. In reality, however, most public health principles and practices are developed, applied, and evaluated in urban settings. It is easy to see how this “urban-centric” approach to public health would have developed: Given that most of public health has its foundation in infectious disease epidemiology and control, it is not surprising that urban models were at the forefront of development. After all, urban areas are the places where risk of contagion is the highest.

As the field of public health grew beyond infectious disease concerns to encompass areas such as maternal and child health, chronic diseases, and mental health, the shift from an urban focus to a more inclusive view of all geographic diversities did not follow, however. Despite its influence in all of our lives from the food we eat to our frequent source of recreational activities, rural areas are remarkably understudied—particularly given the fact that approximately one in five Americans lives in a rural area and 75% of the nation’s counties are rural. Although surprisingly limited, the literature does agree, however, that rural areas have unique health considerations that ultimately result in persistent health disparities in outcomes ranging from diabetes to suicide. These disparities occur both when comparing rural groups to urban groups, and when comparing rural subgroups to each other. For example, in many measures of health, rural African Americans and Latinos have even more disparate health outcomes than their Caucasian
rural counterparts (see Chapter 9 for an example of this effect in cardiovascular disease). Rural areas have unique health problems, resource shortages, demographic characteristics, cultural behaviors, and economic concerns that combine to impact the health of their residents.

Two of the most pressing challenges faced by rural residents are poverty and access to basic health services. Rural residents are more likely to live below the federal poverty line, with minority rural residents particularly impacted (African Americans, for instance, have poverty rates that are more than double that seen in nonminority rural residents). Rural residents also go longer periods of time without health insurance and are much more likely to live in a health professional shortage area; in fact, 63% of all Health Resources and Services Administration (HRSA)-designated primary care health professional shortage areas are in rural/frontier areas, and it would take more than 4,000 new rural-practicing primary care providers to address this need.

Unfortunately, despite the recognition of the breadth of challenges faced in rural public health, there has been remarkably little progress in eliminating rural health disparities. Much research and action make the assumption that theories, practices, and programs developed in urban settings will be, for the most part, translatable into rural settings. As we will discuss throughout this book, this simply is not the case, although this notion has largely stifled rural-focused research for the better part of at least 50 years.

DEFINING RURALITY

Many researchers agree that one major complication in examining rural health outcomes is the lack of a consistent, objective measure of rurality. When one thinks of rural living, one often calls to mind images of vast, sweeping landscapes, fresh air, and sunshine. Much less frequently called to mind are the unique social, cultural, behavioral, economic, and environmental features that combine to create one of the most challenging settings for establishing and maintaining good health.

The scientific study of these features is significantly impeded by the lack of a clear, consistent definition of what truly constitutes rurality. Definitions vary dramatically across agencies and research groups, and include everything from simple population numbers to complex algorithms that simultaneously examine multiple variables. Even within these types of designations there are variations in the levels of definition—some agencies opt for a rural/urban dichotomy, whereas others rate rurality on a 6-point scale (varying by both population size and proximity to more urbanized areas).

The three leading federal agencies involved in setting rural definitions are (a) the Office of Management and Budget (OMB); (b) the Census Bureau; and (c) the U.S. Department of Agriculture’s (USDA) Economic Research Service. Interestingly, the definitions put forth by these agencies do not actually strive to define rurality; they instead typically define urban/metropolitan, with “rural” being functionally defined as any nonmetropolitan area.
CHAPTER 1. WHAT IS RURAL?

The OMB definition focuses on defining counties, and functionally defines rural ("nonmetro") counties as those in which there is neither a city nor urbanized area with 50,000 or more inhabitants. This is useful as a clear-cut, mostly objective definition that can be easily applied (thus its widespread use); however, it focuses only upon population size, ignoring the many other factors of rurality that can influence health outcomes. It also does not take into account the wide variation that can occur within a single county, particularly counties with large geographical areas.

The Census Bureau’s definition, on the other hand, identifies urban areas (not counties) as those in which there are 50,000 or more people, and urban clusters as those with at least 2,500 people. Anything that is neither an urban area nor an urban cluster is considered nonurban, applied in practice as rural. However, because the Census Bureau’s definition is based largely upon assemblages of census tracts/blocks, the definition is difficult to apply and can lead to seeming “islands” of urbanicity or rurality within the opposite geographic designation.

The USDA has five different ways of classifying rural areas, many of which measure rurality on a continuum, taking into account the diversity that exists within rural settings. Some of these definitions (such as the Frontier and Remote Area codes) even provide suboptions within the definition. The two most commonly used USDA classifications include the Rural-Urban Continuum Codes (RUCCs) and the Rural-Urban Community Areas (RUCAs). The Rural-Urban Continuum Codes classify counties according to a 9-point continuum based upon population size, degree of urbanization, and proximity to metropolitan areas. These codes are defined in Table 1.1.

Table 1.1 Rural-Urban Continuum Codes, With Number of Associated Counties*

<table>
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<tr>
<th>Metro Counties</th>
<th>Nonmetro Counties (considered “rural”)</th>
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<tr>
<td>1  413 Counties in metro areas of 1 million population or more</td>
<td>4  218 Urban population of 20,000 or more, adjacent to a metro area</td>
</tr>
<tr>
<td>2  325 Counties in metro areas of 250,000 to 1 million population</td>
<td>5  105 Urban population of 20,000 or more, not adjacent to a metro area</td>
</tr>
<tr>
<td>3  351 Counties in metro areas of fewer than 250,000 population</td>
<td>6  609 Urban population of 2,500 to 19,999, adjacent to a metro area</td>
</tr>
<tr>
<td>4  218 Urban population of 20,000 or more, adjacent to a metro area</td>
<td>7  450 Urban population of 2,500 to 19,999, not adjacent to a metro area</td>
</tr>
<tr>
<td>5  105 Urban population of 20,000 or more, not adjacent to a metro area</td>
<td>8  235 Completely rural or less than 2,500 urban population, adjacent to a metro area</td>
</tr>
<tr>
<td>6  609 Urban population of 2,500 to 19,999, adjacent to a metro area</td>
<td>9  435 Completely rural or less than 2,500 urban population, not adjacent to a metro area</td>
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</table>

The USDA RUCA codes classify census tracts based upon population density, level of urbanization, and the degree to which residents of the area commute to more urbanized areas. The 10-point scale is further subdivided, ultimately resulting in a 33-category classification system. These codes are important from a policy perspective because they are used in combination with the county-level census definition to define eligibility for rural-specific funding administered by HRSA, but are very complex and difficult to both apply and interpret differences found among RUCA areas.

In addition to their individual strengths and weaknesses, attempting to compare across different definitions is very difficult, significantly impeding the ability of researchers and policy makers to compare across individual studies. Just comparing the OMB and census dichotomous definitions highlights this complexity—when comparing the classification of counties by the two definitions, nearly 20% are classified as rural by one definition, but not the other. Because these definitions are often used to determine eligibility for certain types of funding, these differences in opinion can directly affect millions of rural residents. When considering the multiplicative effect that comes with the plethora of other definitions of rurality, it is easy to see how something that at first may seem simple is in fact quite complex. A comprehensive examination of the strengths and weaknesses of the OMB, Census Bureau, and USDA classifications can be found in a 2005 article published by Hart, Larson, and Lishner in the *American Journal of Public Health*.

While many of the USDA definitions in particular further subdivide rurality based upon quantitative information, there is also a well-recognized qualitative separation often used when describing rural areas: rural versus frontier. Frontier communities represent the extreme of rurality, with definitions ranging from population densities less than or equal to 6 people per square mile to complex scoring methods that take into account travel time to market centers and medical care. Large portions of the western United States and nearly all of Alaska are considered frontier because of their extreme remoteness (many areas of Alaska, for instance, are only accessible via plane or helicopter). Many of the disparities discussed throughout this book are even more pronounced in frontier areas because of their extreme geographic isolation; however, frontier areas are even more understudied than rural areas and the literature is severely limited.

When selecting a particular definition for a study, outreach initiative, or policy decision, it is recommended to select the definition that is most consistent with the intent of the project; for instance, if a project is focusing on decreasing travel distance to a source of care, utilizing a definition of rurality that takes into account provider shortages or actual distance to care could be most beneficial.

**SO WHAT IS RURAL?**

Overall, the lack of consistency in definition of and within rural areas often leads to conflicting study findings, which partially help to explain why some rural-focused studies seemingly contradict the findings of preceding (or subsequent)
studies. Regardless of the definition used, however, rural areas are largely accepted to be those in which population density is lower than a “typical” setting and one in which access to basic services (including health care) is often impeded by sometimes great distances. Beyond these quantifiable characteristics, however, rural areas have a unique cultural background and heritage that can impact health behaviors and outcomes in strong and surprising ways. When thinking of rural residents as a cultural group, it is helpful to consider the fact that there are actually more rural residents than any racial, ethnic, or sexual orientation minority group, representing a large group of individuals being strongly influenced by a culture unto itself that is often not recognized as such.

For rural residents, this culture is shaped by many key factors that include population density and geography, agricultural heritage, economic conditions, religion, behavioral norms, health care stigma, and distance to care. These factors combine to impact not only their potential need for health care, but also the ways in which residents will seek out care (or avoid it). Taking these cultural factors into consideration in the planning, execution, and even evaluation of rural health programs can help ensure public health efforts adequately and appropriately reach rural groups.

**Remoteness and Isolation**

The most intuitive concepts of rurality stem from ideas of “open land” that are typically associated with rural living—farmlands, fields, prairies, and mountain valleys. As discussed above, many definitions of rurality are in fact based upon similar notions of population size or density; as such, the underlying implication is a dispersed population separated from other residents (sometimes by miles) and other population centers (sometimes by dozens, if not hundreds, of miles).

In addition to the separation this creates from other community members, geographic isolation also contributes to the potentially life-threatening distance to medical and mental health care that is available. A common feature of many rural areas is distance from medical care providers and emergency care, likely fostering notions of having to be self-reliant for health issues. Also, because of the increased travel distance associated with seeking health care in rural areas, rural residents likely perceive receiving treatment as even more of an inconvenience and burden to friends and families. For health care providers, this can lead to a perception of noncompliance that is dictated less by choice than by circumstance; exploring the root of failure to complete regimens or inability to attend skill-building workshops may help address core barriers that would otherwise be missed. Because of the increased difficulty in receiving services, it is even more critical for rural health providers and public health programming to be convenient and adaptable, but it is also important to emphasize to rural clients the importance of continuing a program to help ensure they remain motivated throughout the difficult process of commuting to and from the care or program that is frequently many miles away.
This geographic separation from other individuals and from care providers has a distinct influence upon the culture of rural areas. Rural residents are often portrayed as independent and self-sufficient—characteristics that stem from necessity when geographically isolated from other groups of people and from service providers. These norms of self-reliance can directly impact an individual’s willingness to seek care. For mental health in particular, resistance to therapeutic techniques and to revealing to friends and families the presence of an illness will be amplified in rural settings.

**Agriculture**

Associated with notions of “wide-open spaces” is the frequent agricultural nature of rural areas. Farming has long been seen as a rural pursuit. In fact, one of the earliest discussions of rurality argued that all of the cultural and economic conditions present in rural areas stem from their direct tie to agriculture. Early sociological reviews on the measurement of rurality proposed that a crude measure of rurality could be constructed using the percentage of residents whose employment is agriculturally based. While not all rural areas are agricultural, there is an undeniable influence of farm living on many rural residents. As with geographic isolation, farm living fosters a sense of independence, strong work ethic, and personal responsibility that will likely spill over into general personality characteristics. It may also influence the view rural residents have on the role of children in supporting a household, as farm families typically rely on children within the family to help operate the farm.

**Poverty**

As mentioned, rural areas have long been recognized as having high rates of poverty and unemployment that directly impact the health of their populations. Because rural economies often center on agriculture, a highly volatile market, economic uncertainty is almost a staple in rural communities. Poverty is also strongly associated with a lack of health insurance, further making affordable health care harder to reach for rural residents. As such, individuals from rural backgrounds may be unable or unwilling to spend limited income on treatment.

The impact of poverty on both physical and mental health status has been well recognized, and poverty has long been one of the largest focuses of social justice movements seeking equality in health for all. While publicly supported services are sometimes available (but still limited in rural areas), individuals living in poverty have been shown to have a mistrust of public services and a general fear regarding the stigma associated with having to seek public assistance.

**Religion**

Religion plays an extremely prominent role in rural areas, particularly in the rural South. Rural residents are more likely to regularly attend Church, and
many aspects of religious beliefs can impact an individual’s approach to and perception of health. Some beliefs can foster a sense of hope for the outcome of treatment, but others may foster a sense of fatalism (that an outcome is “in God’s hands”). When considering mental health, rural religious individuals are more likely to believe that the Church can answer life’s problems and that psychological problems should be handled within the family or the Church. In addition, nearly three fourths of all Americans use their faith as a way to cope with stressful life experiences.

Increasingly, Churches and other religious organizations are being seen as a unique partner and access point for reaching rural populations. Many faith-based and faith-placed initiatives have been developed within rural settings, ranging from basic health screenings to establishing faith-based community health workers. The literature surrounding faith-based public health initiatives is still growing, but it is clear that the connection between health and Churches will continue to grow and will play an important role in addressing the health needs of rural groups. For more details on faith-based initiatives in rural settings, see Chapter 5.

**Behavioral Norms**

There are many health-related behavioral norms that will also impact mental health treatment (see Chapter 7 for details). Rural residents (and rural youth, in particular) are more likely to engage in alcohol and substance use due partially to permissive cultural norms regarding such use in rural settings. Addressing these cultural norms can be very difficult, but should be considered if working with rural clients with substance abuse concerns. Similar health risk-taking behaviors such as smoking and sedentary lifestyle are also more prevalent in rural settings, and may make it even more difficult when working with clients wanting to address these issues.

Prevention and intervention programs for rural groups must take into account these prevailing norms, and find unique ways to address them. For instance, a physical activity program that recommends going to the local high school track may be completely inappropriate for a county with either no track, or potentially even no high school. Taking a critical eye to established programs, or, even more effectively, creating rural-specific programs, will be important to not only shift these norms, but to ensure that programs are adequately addressing barriers to changing those norms.

**Stigma**

Particularly within the area of mental health, there is generally a negative perception toward those receiving services in rural areas. This stigma has a direct impact on rural residents’ likelihood to not only seek care in the first place, but also the likelihood of their continuing care for the recommended course of treatment. Unfortunately, it also impacts rural clients’ willingness to share their mental health struggles with others. If social support is needed...
as a part of the treatment planning process, clients may not be as open to
discussing their needs with friends and family members. Practitioners and
public health workers focused on psychological outcomes must consider the
impact of the culture of mental health stigma in rural regions and be pre-
pared to pursue unique ways of counteracting its effects.

Beyond mental health, the stigma surrounding certain physical health
conditions can also impact willingness to both disclose presence of a condi-
tion and to receive appropriate care for it—HIV, for instance, is a generally
stigmatized health condition for which the stigma is only amplified in rural
settings.

CONCLUSION

Although difficult to define, there is no doubt that rurality plays an important
role in the health of millions of Americans. From access to care to receptivity
of services, living within a rural area is associated with a variety of disparities
discussed in more detail throughout this book. By recognizing the socioeco-
nomic and cultural factors unique to rural areas as not only contributing to
health disparities (e.g., higher smoking rates) but also as providing avenues
for addressing them (e.g., faith-based initiatives), rural public health practi-
tioners can begin to make long-needed progress in protecting the health of
one fifth of the U.S. population.

By recognizing the importance of rurality in resources, norms, personal
decision making, worldview, and interaction patterns with other people, the
helping professions can begin to culturally tailor their messages, approaches,
and interventions in a way that will provide maximum impact for rural popula-
tions. Public health training programs should incorporate basic knowledge of
rural culture into their curriculum—not only within rural-focused programs,
but, more importantly, outside of such programs where rural competency
might not otherwise be acquired.

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