Leveraging Interest to Decrease Rural Health Disparities in the United States

See also Erwin, p. 1533.

The work of Case and Deaton[1] highlighting "despair deaths" has brought significant attention to the challenges rural residents face, and J. D. Vance's recent memoir *Hillbilly Elegy*[2] has provided a story to complement the data. Although both shine a welcome light on rural health issues and challenges, it is perhaps the election of 2016 that most amplified these issues, leading many to ask, "What is happening in rural America?"

We need to be cautious to not overinterpret trends on the basis of any one study, memoir, or even election outcome—ultimately, rural America remains quite diverse, and there are innumerous assets in our rural communities. Not everyone in a rural community is a drug addict, one man's experience cannot be generalized to an entire region, and a national election driven by a desire for change does not necessarily reflect the values and priorities of an entire segment of the population. Nevertheless, there is palpable frustration in much of rural America driven by individuals feeling neglected and left behind. In communities that are struggling economically, with low educational attainment and rising health inequities—where they feel ignored by one party and taken for granted by the other—is it really surprising that a message of change was appealing?

RURAL INEQUITIES

Although the attention the election brought to rural inequities is welcome, as rural health researchers, we are disappointed that it has taken so long to arrive. Health disparities among rural residents were well documented by the Centers for Disease Control and Prevention in their *Health, United States, 2001: With Urban and Rural Health Chartbook* (bit.ly/2uqwCtV). With support from the Health Resources and Services Administration Federal Office of Rural Health Policy, the nonpartisan and objective research organization NORC at the University of Chicago Walsh Center for Rural Health Analysis developed *The 2014 Update of the Rural–Urban Chartbook*.[3] This chartbook further documents these health disparities and demonstrates many of the trends that we see related to rising mortality rates attributable to suicide and unintentional injury, which includes opioid overdose. We also learned through our work that rural populations are diverse and that rural disparities differ across rural regions.[4] Work conducted by colleagues at the South Carolina Rural Health Research Center provided an even more detailed look at rural disparities, showing an interplay between geography and race/ethnicity in which rural minority populations fare worse than do rural Whites.[5] As far back as 2008, we documented rising rates of opioid and heroin use in the Appalachian Region.[6]

Why did it take us so long to get here? We would argue that public health as a field and many funders of public health programs and initiatives have been slow to direct resources to rural communities. We believe much of the reason behind limited public health investments in rural communities is a rational desire to maximize program impact (i.e., focus on larger population centers) combined with rural small numbers challenges that make it difficult to both efficiently direct resources on the front end and demonstrate outcomes on the back end. Although the rationale may be understandable, the end result is that rural populations who feel neglected and left behind are in fact being neglected and left behind by the very institutions that concern themselves with decreasing health disparities and improving health equity. Ultimately, we have reinforced the feelings of neglect that exist in many of our rural communities by our own inaction.

OPPORTUNITY FOR PUBLIC HEALTH

The question before us then is "How do we use this moment in time to decrease health disparities, improve health equity, and advance public health?" We would argue that public health as a field has a tremendous opportunity before it. If we demonstrate empathy by directing resources to address rural population needs; if we provide resources for rural communities to generate locally driven solutions by using their many assets; if we strengthen rural communities by providing tools, resources, and technical assistance to accelerate change; and if we invest in our rural communities, then we are likely to demonstrate how public health can improve health in rural

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communities and eliminate geographic health inequities.

The basic capacities to use this investment are already in place. Although often not as strong or secure, rural public health infrastructure and capacities exist in many of our rural communities across the nation. Many of our public health workers serve in rural local and state health departments around the country, and they can be our envoys to help address the needs of rural populations, putting a positive face on our field and growing support for the work that we do. (Indeed, 59% of local health departments in the United States are classified as rural.[7])

Empowering our rural public health workforce to better conduct the work of public health and to more effectively communicate the benefits they bring to their communities will help engage rural residents, which will in turn create demand for public health among rural policymakers. All of us who work in public health, regardless of our population focus or the disparities and inequities that our programs seek to address, stand to benefit from broader support for our field, which includes rural residents, institutions, partners, and policymakers. The bottom line is this: what's good for rural residents is good for us all. AJPH

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Deaths of Despair: Why? What to Do?

See also Erwin, p. 1533.

This issue of *AJPH* includes a further analysis by Stein et al. (p. 1541) of a phenomenon first identified by Case and Deaton in a *Proceedings of the National Academy of Science* publication. Case and Deaton documented a rise in the mortality and morbidity of middle-aged White non-Hispanic men in the United States after 1998, but not in Hispanics or African Americans. This phenomenon was not the case in other Organization for Economic Cooperation and Development (OECD) countries where the mortality and morbidity rates for this group continued to decline annually.

WHAT WE KNOW

Case and Deaton found that the increase in mortality was largely related to suicide, accidental poisonings (including opioids), and chronic liver disease or cirrhosis, and was associated with a substantial increase in psychological distress among this population group. Moreover, this increase in cause-specific mortality drove the all-cause mortality for middle-aged White non-Hispanic men up, a previously unnoted finding, and this increase in mortality was more prevalent in those with a high-school-or-less education. All-cause mortality for Black non-Hispanics and Hispanics continued to improve in the same population, creating a diminishing divergence in mortality among those three groups. This increase in mortality has been described as "deaths of despair."[1] Subsequent analyses by these same authors have shown that this trend is continuing.[2]

The article by Stein et al. further defines the population experiencing this increase in mortality between 1999–2001 and 2013–2015. The authors examined the nature of place (urban, suburban, small or medium metro, and rural), as well as race/ethnicity, age, and cause of death. This stratification produced 48 subpopulations for analysis. In 39 of the 48 subpopulations, mortality rates improved. In the nine in which improvement did not occur, the rates were highest in non-Hispanic Whites, largely in rural or small or metro counties, and were the result of suicide, accidental poisonings (including opioids), and liver disease.

Although Blacks continue to have higher mortality rates, the difference in the Black versus White rates has been steadily decreasing. Rates for Hispanics also show a decreasing difference in mortality between Whites and Hispanics. In all cases, the risk of death increased 40% to 50% in rural as opposed to suburban counties. Whites aged 45 to 55 years in rural counties were the most likely to die prematurely. Surprisingly, in addition to other causes of death in this population, they also showed an increase in death from chronic diseases, such as cancer and heart disease, which was not the case in older populations aged 55 to 65 years in the same setting. However, in all cases in which there was an increase in mortality, it was primarily related to suicide, accidental poisonings, and liver disease.

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