Health Equity in Midsize Rural Communities: Challenges and Opportunities in a Changing Rural America

See also the *AJPH* Rural Health section, pp. 1274–1343.

Increasing premature mortality in the rural United States has brought new attention to rural health disparities. However, public health research on rural–urban disparities often overlooks the demographic, cultural, and economic heterogeneity of rural America.[1] Addressing health inequities between urban and rural areas, as well as within rural areas, requires an approach that considers the heterogeneity of communities across the rural–urban continuum as well as the growing sociodemographic diversity within rural settings.

Although discussions of rural areas often conjure images of open space and towns of a few thousand people, most rural residents (59%) live in "micropolitan" communities: nonmetropolitan areas with from 10 000 to 50 000 people. In the past two decades, micropolitan areas (which are distinguished from smaller, "noncore" areas) have experienced economic adversity and demographic changes that present unique challenges and opportunities for public health. We discuss recent changes in the economic conditions and demographic composition of micropolitan communities, evidence about health in micropolitan communities, and obstacles and opportunities for intervention to promote public health and health equity in micropolitan communities. We draw on our work in Iowa to illustrate potential strategies for using community strengths to implement evidenced-based public health interventions in micropolitan settings.

CHANGING ECONOMIES AND POPULATIONS

Shifts in the US economy over the past several decades, including deindustrialization, consolidation of agriculture, and widening income inequality, have corresponded to shifting economic conditions in micropolitan communities.[2] Micropolitan areas nationwide experienced slow recovery from the Great Recession (2007–2009) and faced elevated poverty and unemployment rates longer than did urban areas or noncore areas. Some micropolitan areas have also experienced faster increases in income inequality.[2]

Changes in micropolitan economies have coincided with changing micropolitan demographics. Micropolitan areas experience out-migration because of urbanization, whereby younger, more educated residents depart to pursue opportunities in urban areas. At the same time, other population groups relocate from urban to micropolitan areas to seek employment and more affordable costs of living.[3] As a result, micropolitan communities are experiencing faster rates of growth in Black, Asian, Latinx, and immigrant populations than are noncore areas. Between 1990 and 2010, the proportion of micropolitan residents who were Latinx doubled nationwide.[3]

CHANGING HEALTH

Understanding recent changes in the economics and demographics of micropolitan communities can inform our understanding of recent trends in micropolitan health. The limited research that disaggregates micropolitan from noncore areas tends to find that micropolitan areas have a slight health advantage over noncore areas with regard to risk factors for poor health, such as obesity, smoking, and physical inactivity. However, some evidence suggests that this micropolitan health advantage may be eroding. Researchers who examined trends in potentially excess deaths in metropolitan, micropolitan, and noncore areas from 2010 to 2017 found that micropolitan areas experienced the highest annual percentage increase in excess deaths because of heart disease or chronic lower respiratory disease than did any other rural–urban category.[4]

Declines in health in micropolitan areas have not been experienced equally across all segments of the population. For example, a study of trends in midlife mortality found that adults in micropolitan and noncore areas had large increases in midlife mortality rates between 1999 and 2016. However, this pattern was largely driven by non-Hispanic White groups; trends in micropolitan midlife mortality rates varied widely

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across racial/ethnic groups, with micropolitan American Indian/Alaska Natives experiencing a much greater increase in midlife mortality than micropolitan Whites, and micropolitan Black adults experiencing a reduction in midlife mortality.[5]

Understanding patterns in health among racial/ethnic subgroups in rural settings will require careful research grounded in the growing literature on structural, historical, and policy influences on racial/ethnic health inequities, including interpersonal and systemic racism. Future research should examine the health implications of racialization processes in micropolitan settings, as well as the specific structural forces shaping rural life for communities of color. Future work should also consider other dimensions of diversity in rural communities, such as gender, sexual orientation, disability, nativity, and other health equity priority areas.

PROMOTING HEALTH AND HEALTH EQUITY

Just as micropolitan communities are unique economically and demographically, they are unique contexts for public health intervention. Local health departments (LHDs) in micropolitan areas have greater institutional resources than do noncore health departments, which may result in a greater capacity to address complex public health challenges. For example, micropolitan LHDs are 3.4 times more likely to hold public health accreditation board accreditation than are noncore LHDs. In Iowa, where our team's work is focused, a recent survey of LHDs found that micropolitan LHDs were generally more likely than were noncore LHDs to use evidence-based practices for chronic disease prevention and were more likely to have a public health administrator with bachelor's- or higher-level training in health sciences.[6]

However, micropolitan LHDs perform a wider range of services than do noncore LHDs. Most micropolitan LHDs perform key public health activities that are typical of LHDs in noncore areas (but often performed by health care or social services agencies in urban areas): immunizations, communicable disease services, maternal and child health services, and family planning. However, at the same time, micropolitan LHDs also perform services typical of urban LHDs, such as regulation and inspection of restaurants, schools, and daycares. Micropolitan LHDs perform these activities with less funding per capita than their noncore counterparts have (https://bit.ly/36YUB4q).

The high demands on micropolitan LHDs can pose a barrier to implementing multisectoral approaches, such as those recommended by Public Health 3.0, which encourages public health agencies to move beyond addressing proximate determinants of health (e.g., health care, health behaviors) to address social determinants, such as economic development, transportation, and housing. Although micropolitan LHDs may have a limited capacity to lead complex multisectoral strategies, micropolitan areas benefit from a concentration of institutional resources that could be used for multisectoral collaborations. In Iowa, where our work is focused, we found that the majority of micropolitan communities have a local YMCA, and many communities have community action agencies, community colleges, or local foundations that could participate in multisectoral public health efforts.

It is essential that the needs and perspectives of minoritized or marginalized populations be represented in multisectoral partnerships. In micropolitan communities where residents of color have recently arrived, advocacy groups may not be as formalized as they are in larger cities. Alternate representatives, such as faith leaders, informal community leaders, or businesses, may need to be identified as partners. With support and coordination, micropolitan communities may be well placed to build multisectoral partnerships to promote health and health equity.

Community-engaged research approaches can be a strategy to ensure that local knowledge is used to tailor multisectoral interventions in the demographic, cultural, and economic heterogeneity of rural America. An example of using a participatory approach to adapt a public health intervention to a micropolitan setting is Active Ottumwa: a lay health advisor intervention to promote physical activity in a micropolitan Iowa community.[7] Diverse actors, including the park system, school district, and churches, collaborated to present free physical activity opportunities led by local residents.

Careful attention to the diversity of rural contexts across the rural–urban continuum and the diversity of communities within rural settings is essential for effective intervention to promote health and health equity. It is essential to develop health equity strategies that are tailored to the unique needs and strengths of micropolitan communities. AJPH

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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