# Resourcing Public Health to Meet the Needs of Rural America

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

Rural public health in the United States is a field in tension. A lack of health care access and infrastructure, a smaller population and tax base, and pervasive disparities along race and class lines complicate the work of rural public health. Rural local health departments (LHDs) are myriad in their service portfolio and activities mix because, in part, of this reality. As Beatty et al. (p. 1293) explore in this issue of *AJPH*, rural LHDs look different from their urban peers in a number of significant ways. This has changed somewhat since the Great Recession.

## THE "EITHER/OR" PINCH

Beatty et al. find that, as state and some federal sources declined as a share of LHD revenue between 2010 and 2016, rural LHDs saw relatively less local (city or county) revenue, and relatively more of their revenue share came from clinical sources. Of particular note is the reality that while urban and rural LHDs both face tremendous need to ameliorate barriers to accessing care, urban LHDs may be better positioned financially to do so while also providing population-based services. Despite rural LHDs often having "no choice but to retain direct care services because of community need and a lack of alternative support," (p. 1298) they too often lack sufficient resources to do so. There is also a natural crowding out for population-based prevention that may occur with a relatively strong focus on provision of clinical services. As more is spent on direct clinical care services, relatively less is left for public health overall, and for population-based work especially; this is the tension of choosing "either/or," but not both.[1]

## CHALLENGES WITHIN THE RURAL CONTEXT

LHDs in rural areas operate within the context of large and growing health disparities for the residents they serve, relative to LHDs in urban areas. The common refrain that rural residents are "older, poorer, and sicker," while not monolithically true, holds some merit. Rural populations are older than urban populations, on average, and have higher rates of morbidity and mortality on nearly every measure.[2,3] Rural residents also have fewer economic resources, including higher rates of poverty, unemployment, and uninsurance.[4] The overall population of rural areas has also been declining in recent decades,[4] leading to declining tax bases and increasing constraints on meeting the public health and health care needs of the rural residents who remain.

Meanwhile, access to health care in rural areas is a persistent—and growing—problem, perhaps best highlighted by the ongoing crisis of rural hospital closures.[5] Such closures occur amid workforce shortages, financial pressures serving un- and underinsured individuals, large geographic distances patients must travel for care, and limited capacity within small facilities. Even in places where rural hospitals remain open, many rural areas have seen service lines disappear (e.g., obstetrics, pharmacy, psychiatry, nursing homes), while others have always lacked specialty care.[3] While they ideally act as complements to one another, rural LHDs may be left to fill in the gaps in the absence of formal health care and clinical services.

## RURAL LOCAL HEALTH DEPARTMENTS AS SAFETY NETS

Rural LHDs are among the most varied of all health department types in terms of service mix. They are more likely to be smaller and serve wide geographic areas. Like the private sector in rural America, there is substantial difficulty attracting and retaining staff to the public sector in rural areas. History, need, and happenstance have contributed to the variety and service mix observed across rural LHDs. When the 1988 Institute of Medicine report called for a divestment in clinical services from local public health, many were able to follow this guidance. Rural LHDs, however, especially in the South, largely could not and did not, often because they act as the safety-net provider for their community. A number of clinical and inspection and regulatory services are required by state laws. To the extent that many rural LHDs discontinued certain clinical services, the services would simply not be available in their community. Even today, with ostensibly greater access to care through the Affordable Care Act (ACA), there are tremendous pressures put on LHDs to incentivize clin ical service provision to make up

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for gaps in the formal health care system. As Beatty et al. note, rural LHDs are more reliant on state and federal sources, with relatively less capacity to generate revenue through local tax base given small population sizes. When federal and state priorities shift, so does the money, and so does the service mix at LHDs. There are also a number of federal policies pressuring rural health departments in a post-ACA landscape.

Rural LHDs face a confluence of pressures from the federal level, both as a clinical provider generally and a safety-net care provider specifically. In places where clinical services are otherwise unavailable or inaccessible for the general population through the health care sector, rural LHDs play a critical role in meeting the needs of the rural residents they serve. This might include providing primary care, screenings, treatment, vaccinations and other preventive care, and maternal and child health services. Too often, access to these basic services is otherwise sparse in many rural areas. While federal investment in rural health care, largely through Medicare reimbursement, has helped to support safety-net providers in rural areas, including rural health clinics, critical access hospitals, and federally qualified health centers (FQHCs), more than half a million rural residents live in a county with no such facility.[6] Those residents without even basic access to health care are disproportionately located in the southeastern United States,[6] where many states have thus far chosen not to expand Medicaid, further creating barriers to accessing care for too many rural residents. Such pressures mean that LHDs find themselves needing to provide clinical care, often without sufficient resources to also address broader public health concerns.

## A CHANGING LANDSCAPE IN THE TIME OF COVID-19

At the time of writing, in the midst of the COVID-19 pandemic, the future of rural public health and public health more broadly is uncertain. Unprecedented strain on the public health and health care systems may well motivate a reimagining of support for rural public health, support that might actually create other avenues enabling access to care. This could free rural health departments to focus more on population-based services, in line with Institute of Medicine guidance. It seems more plausible, though, that rural LHDs will likely always be involved in some type of clinical care provision, given history, funding, and need. As such, rural public health should be recognized as the critical safety net provider it is, alongside FQHCs and critical access hospitals. More than that, LHDs are the only entity with the responsibility and authority for the protection and improvement of population health for their entire jurisdiction. Their catchment area is the community. As such, rural public health should also be recognized for leadership at the community level in policy and practice and adequately resourced to achieve their major roles—safety-net clinical care provision, inspection, regulation, and population-based prevention. AJPH

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### CONFLICTS OF INTEREST
The authors declare that they have no conflicts of interest.

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