A Public Health Lens on Rural Health

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

The call for articles for this *AJPH* special section on rural health began with these words: "Rural health in America is at a crossroads." When that call was issued in late 2019, we had no idea how our world would change, and the impact of COVID-19 on the rural United States has caused a seismic shift, buckling that crossroad. COVID-19 aside, the crossroads still exist: predominately a declining and aging population, with a steadily eroding health infrastructure and shrinking economic base. For many, the road out is the only viable path. What vision of rural public health in the 21st century evokes the possibility of a reinvented and reinvigorated rural landscape?

CELEBRATE THE GOOD AND IDENTIFY DISPARITIES

Meit and Knudson (p. 1281) begin the special section by noting that the prevailing narrative about rural America is a dystopic one, often driven by the very attempts to identify opportunities to improve rural health by focusing on inequities. Their work instead sheds light on the good in rural America: pride of place, resilience, social cohesion, cross-sector engagement, and innovation. Ever present in assembling this special section was their appeal to create a better balance in the narrative about the rural United States while still providing new perspectives on rural disparities.

Probst et al. (p. 1325) focus on rural–urban mortality gaps in their examination of mortality differentials across geography, race, and ethnicity for 2013 through 2017. The rural Black population experienced the highest mortality from cardiovascular disease, cancer, and stroke, whereas rural American Indians/Alaska Natives experienced the highest unintentional injury mortality. The authors surmise that failing to consider race and ethnicity while investigating overall rural–urban health disparities risks leaving minority health disparities unaddressed.

Jensen et al. (p. 1328) provide additional perspectives on rural–urban disparities, focusing on depopulation and increasing diversity. Population loss attributable to youth out-migration leaves an older rural population, which will ultimately overwhelm the remaining, aging health workforce and infrastructure. They also call for future research on the impacts of climate change on rural population health and aging.

RURAL GOVERNMENTAL PUBLIC HEALTH

Beatty et al. (p. 1293) examine changes in local health department (LHD) funding sources between 2010 and 2016, finding that urban LHDs relied more on local funding, whereas rural LHDs depended more on state and federal funding. Rural LHDs generated more revenue from Medicare and Medicaid and tended to provide more clinical services. The authors call for greater consideration of community needs in response to the push for LHDs to divest from clinical services in favor of population health programs.

Leider et al. (p. 1283) go even further in their article on the expansion of rural–urban mortality disparities over the past 40 years, describing the national message regarding what LHDs "should do" as creating a "counterproductive stigma" associated with LHDs providing clinical services. Like Beatty et al., Leider et al. call for a consideration of individual community needs for determining services provided by LHDs. Both make the case that improving the rural governmental public health enterprise will improve rural health.

CHANGES IN HEALTH CARE SERVICES

Kozhimannil et al. (p. 1315) discuss whether US rural hospitals provide labor and delivery care. Their findings that fewer than half of all rural hospitals provide obstetric services are especially disturbing given the increasing number of hospital closures: since 2010, some 90 rural hospitals have closed and hundreds more are at risk for closure.[1] State-level perinatal quality collaboratives[2] and the Rural MOMS Act[3]—which provides funding to establish rural obstetric networks for improving outcomes in perinatal and maternal morbidity—are among the authors' potential solutions for rural obstetric care.

Telemedicine broadly offers the possibility of expanded access to care for rural populations, and telemental health services, as described by Patel et al. (p. 1308), have the potential to decrease the significant rural–urban gap in providing mental health services. Between 2010 and 2017, telemental health use increased by 425% among rural Medicare beneficiaries diagnosed with schizophrenia or bipolar disorder, although the overall rural–urban difference in specialty care's use of telemedicine did not change. Services could be expanded, the authors suggest, if Medicare allowed rural patients to receive telemedicine visits in their home.

Palma et al. (p. 1304) describe the University of Iowa's Mobile

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Clinics as both a source of care for underserved populations—rural residents as well as immigrant and refugee populations in urban settings—and a service learning opportunity for health professions students. For almost 20 years, students have provided free health screenings, education, and basic services, grounded in core values of health equity, service, diversity, community, and integrity. Team-based care through a health equity lens affords them opportunities to address social determinants of health while gaining "exposure to lessons of cultural humility in the heartland" (p. 1305).

OPIOIDS AND RURAL HEALTH

DuPre et al. (p. 1332) describe an outbreak of hepatitis A in Kentucky associated with opioid use disorder. Their analysis revealed that despite disability, poverty, and low education, counties with more married adults, residential stability, and lower income inequality had lower hepatitis A rates. The authors suggest that considering such risk and protective factors can inform expanded recommendations for hepatitis A immunization programs, especially for communities hit hardest by the opioid epidemic.

Liu et al. (p. 1318) describe an opioid buyback program at a rural Veterans Administration hospital in 2017 to 2018. Of particular value in this study, when information tracked by pharmacists on the return of unused opioids was provided to the prescribing physicians, such feedback resulted in a subsequent 27% decrease in opioid prescribing without an increase in refills.

These articles provide new insights into, and possible means of addressing, the rural opioid epidemic.

COOPERATIVE EXTENSION AS A FORCE

Cooperative extension has been part of the rural landscape for more than 100 years and is known primarily for its work with farmers; however, as Buys and Rennekamp (p. 1300) describe, cooperative extension has the potential to be a significant force for improving rural health. With offices in nearly every county in the United States, cooperative extension can use its strengths in health and nutrition education, experience in building collaborations, community development and sustainable systems change, and expertise in recruiting and training a strong volunteer base to partner with rural governmental public health to improve rural health.

There are whole journals dedicated to rural health. What does this *AJPH* special section contribute to that corpus? This collection of articles examines rural health issues through a public health lens. The COVID-19 global pandemic has exposed the constraints and limitations of our nation's public health infrastructure and heightened awareness of the importance of, and need for, prevention, protection, equity, and system change. The need is great in the rural United States. Our hope is that these articles, and invited editorials by Wykoff, Sanchez, and Dearinger, will bring fresh perspectives to the issues of rural public health and inspire readers to probe new avenues for improving rural health. Such inspiration can create new options at the crossroads. AJPH

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CONFLICTS OF INTEREST
The authors have no conflicts of interest to declare.

REFERENCES

1. Frakt AB. The rural hospital problem. *JAMA*. 2019;321(23):2271–2272.

2. Henderson ZT, Ernst K, Simpson KR, et al. The National Network of State Perinatal Quality Collaboratives: a growing movement to improve maternal and infant health. *J Womens Health (Larchmt)*. 2018;27(3):221–226.

3. Congress.gov. 116th Congress. S.2373: Rural Maternal and Obstetric Modernization of Services Act or the Rural MOMS Act. Available at: https://www.congress.gov/bill/116th-congress/senate-bill/2373. Accessed June 6, 2020.