Toward Optimal and Equitable Rural Health

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

When this *AJPH* special section on rural health is published, the United States as a nation, the individual states, local communities, and US citizens will still be addressing and be affected by the COVID-19 (coronavirus disease 2019) pandemic, which will have resulted in more than two million cases of COVID-19—the disease caused by SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2)—and more than 115 000 deaths in the United States. The pandemic has made obvious the importance and value of a competent, adequately resourced public health system and competent, adequately resourced hospital care, particularly critical care. The pandemic has also exposed the weaknesses and fragmented nature of the public health system and infrastructure in the United States and the medical care delivery system and infrastructure, which should, but do not, function as virtually one unified health system.

WHAT THE PANDEMIC HAS WROUGHT

The pandemic has resulted in rapid adoption of and transition to digital approaches to public health (contact interviewing and contact tracing) and to the provision of clinical care using telehealth platforms and modalities. Reimbursement mechanisms, long proposed but not acted on, were quickly brought online to enable payment for telemedicine. That quick transformation and capacity building has not, however, made up for the threat to the economic viability of the large and small US health systems. The stay-at-home orders and recommendations and the complete lockdown of significant parts of the economy (including self-imposed and guidance-based limits to "elective" medical services) have had a detrimental economic impact on ambulatory care practices, specialty and diagnostic care, oral health care, and hospital-based care, and, arguably, detrimental health effects on individuals and communities. In addition, health departments' diversion of staff attention to COVID-19 has contributed to delays and short staffing of other public health activities.

WHY THE FOCUS ON COVID-19?

So, why spend two paragraphs on the COVID-19 global pandemic rather than start with rural health in a rural health editorial for a special *AJPH* section on rural health? There are three reasons: COVID-19 changes everything, the weaknesses exposed because of COVID-19 have long been known to persons studying rural health in the United States, and the solution set to address rural health challenges in the United States will be informed by the experience of responding to the COVID-19 pandemic.

One recent report[1] on rural health is representative of the attention to rural health in just the past 12 months. It is important to note that approximately 20% of persons living in the United States reside in rural areas. That is approximately 60 million persons—which is approximately as many people as in the population of a few individual countries, notably Italy, Tanzania, and South Africa. The 60 million persons in the rural United States are, of course, distributed across 3000 counties in 50 states and tribal lands. The 60 million are heterogeneous and diverse, and within the heterogeneity, there is even more heterogeneity (including race/ethnicity) by region, state, and county. In addition, compared with persons living in the nonrural United States, those in the rural United States, in general, are older and have lower household income, lower overall educational attainment, a higher burden of chronic disease risk factors and chronic disease, and less access to medical care because of a lack of availability, long distances to care, and inadequate health insurance status.

The disproportionality of individual health factors in the rural United States suggests we need uniquely rural-focused solutions. Interestingly, though, these same types of factors have contributed to the disproportionality of COVID-19 among "essential workers" and to the disproportionality of severe and fatal COVID-19 among the elderly and those with underlying medical conditions in all of the United States.

The deficiencies in public health and clinical care (primary care and hospital care, in particular) infrastructure and systems existed in the rural United States before SARS-CoV-2; however, COVID-19 clusters and hot spots have made visible to many the weaknesses in rural public health and the limitations of sparse clinical care capacity to optimally conduct testing and contact tracing, on the one hand, and to deliver quality medical care to all (including adequate intensive care unit bed and staff capacity and availability of ventilators), on the other.

Solutions have been deliberated, proposed, and, to some extent, initiated on the rural

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health front. However, in this time of COVID-19, as we look forward to what the US health and health care ecosystem should look like and how it operates in a continued COVID-19 or post–COVID-19 world, there is an opportunity, a window, if you will, to engage in the reckoning to redesign and adequately support and sustain (with appropriate levels of funding and decision-making authority) a new health and health care system that optimally serves persons living in the rural United States.

The deliberation and redesign should include capacity for appropriate convening, governance, assessment, planning, and evaluation at the local, state, regional, tribal, and federal levels. In a digital health world, appropriate technology and trained staff for public health surveillance, disease control, telemedicine, and telehealth must be considered and prioritized. The workforce must be composed of new multidisciplinary, diverse, cross-sectoral teams that deploy approaches to address health issues with population-based, nonclinical strategies that pay attention to socioeconomic, environmental, and behavioral factors that promote health, achieve health equity, and prevent disease. The teams must also provide quality clinical care, which includes assessing social issues, counseling for healthy lives, delivering vaccinations and other preventive services, and diagnosing and managing diseases.

TRANSFORMING HEALTH THROUGH PREVENTION

This special section of *AJPH* will add to the collective knowledge and understanding of rural health in the United States and will propose a set of comprehensive solutions. In addition to the special section public health practitioners, preventive medicine physicians, social services professionals, other practitioners, and researchers must be at the tables in the "never again" meetings organized to transform the health and health care systems in the rural United States in addition to the United States in general. Preventive medicine brings the perspective of population health—broadly or narrowly defined and addressed by government agencies, health plans, and health systems—and the understanding of structures, tools, processes, policies, resources, and governance needed to achieve optimal and equitable health for all. AJPH

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CONFLICTS OF INTEREST

The author has no conflicts of interest to disclose.

REFERENCES

1. Harrington RA, Califf RM, Balamurugan A, et al. Call to action: rural health: a presidential advisory from the American Heart Association and American Stroke Association. *Circulation*. 2020;141(10):e615–e644.