Commentary

Racism and Health in Rural America

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Abstract: This commentary responds to the recent article by Dr. James et al. on racial and ethnic health disparities in rural America, published in the November 16 issue of *Morbidity and Mortality Weekly Report*. We applaud Dr. James and colleagues for their important contribution uncovering intra-rural racial and ethnic disparities and build on their paper by discussing potential mechanisms, including structural racism. We also discuss several pragmatic steps that can be taken in research, policy, and practice to address racial and ethnic disparities in rural communities and to work toward health equity for all rural residents.

Key words: Rural, disparities, race, ethnicity, racism.

The word "rural" often evokes scenes of pastoral landscapes and agrarian occupations or of small towns where everyone knows everyone else. In this traditional imagery, rural residents are frequently assumed to be—and are portrayed as—White. More recently, rural life has been described, in the media and in research, as a struggle, with public health crises such as the opioid epidemic and rising mortality rates, which have had a disproportionate impact on White rural residents.[1,2] While these images and issues are based in real life stories of some rural residents, in the way of sweeping generalizations, they do not reflect the reality of *all* rural residents.

Far from being homogeneous in the racial and ethnic profiles of their residents, rural areas in the U.S. are increasingly diverse both racially and ethnically. In fact, more than 20% of all rural residents (more than 10 million people) are people of color* and American Indians. While people of color have lived in rural communities for centuries, substantial growth in their numbers has occurred over the past several decades, with no sign of those trends slowing.[3,4] Still, there has been a notable lack of research on intra-rural differences in health by race and ethnicity. As such, findings reported by James et al. in the *Morbidity and Mortality Weekly Report (MMWR) Rural Health Series* make an important contribution to that space and move the conversation on rural health forward in urgent and important ways.[5]

Putting Findings from MMWR Paper in Context

As Dr. James and her coauthors show, people of color and American Indians in rural communities generally suffer worse health than White people in those communities. Specifically, using data from the 2012-2015 Behavioral Risk Factor Surveillance Survey (BRFSS), they found

*Rural populations are defined as populations living outside of metropolitan areas. The term "people of color" is a socio-political construct used to refer to individuals not of European ancestry, including individuals of African, Latino/Hispanic, Asian, or Pacific Islander descent.

that rural residents from racial and ethnic minority populations were more likely than their non-Hispanic White counterparts to have poor/fair self-rated health, to be obese, to go without physician care because of financial concerns, and to have no usual health care provider.[5] These findings reflect wider-ranging racial and ethnic disparities in health and access to care,[6–8] but this was the most comprehensive study to date documenting such disparities specifically occurring among residents of rural, non-core counties, that is, non-metropolitan counties with no town of 10,000 residents or more.[9]

However, people of color and American Indians in rural areas are not unilaterally worse off than White people. There are certain areas where racial and ethnic minority populations exhibit greater resilience to particular health behaviors. For example, Dr. James and colleagues find the highest rates of binge drinking in rural areas among rural White adults,[5] and recent mortality data indicate that the rising tide of the opioid epidemic has led to an increase in overdose deaths that disproportionately affect rural White men.[10] Additionally, rurality appears to be protective against the risk of suicide for African Americans, in contrast with other races/ethnicities, while suicide rates in general are higher among rural residents than among their non-rural counterparts.[11] (For African Americans, suicide rates are highest in urban communities.[11]) When examining racial disparities in a rural context it is important to recognize the specific kinds of resilience that rural communities may confer, especially when there is a cultural, historical, or spiritual significance to place in a rural context, as is the case with predominantly African American communities in the Black Belt of the Southeastern U.S. or tribal communities living on reservation lands.

Above and beyond health outcomes, the paper also demonstrates significant differences and disparities in socio-demographic characteristics within rural communities by race and ethnicity. These differences generally render people of color and American Indians more

vulnerable than White rural residents. For example, Dr. James and colleagues report that fewer than 10% of people of color and American Indians in rural communities have a college degree, compared with 16% of non-Hispanic Whites. Additionally, more than half of rural people of color and American Indians have an annual income below $25,000, compared with fewer than one-third of non-Hispanic White people in rural communities.[5] In light of research showing a strong connection between socioeconomic factors and health,[12] future work must build upon the James et al. findings to examine how much these social factors act as determinants or mediators of health outcomes and health disparities in rural communities. For example, would adjusting for them erase any of the differences the authors found in health? If so, effective health interventions may include addressing economic disparities.

It is also worth noting the fact that the James et al. paper finds sizable differences in the geographic distribution of racial and ethnic groups. For example, far from being equally distributed across the country, non-Hispanic Black adults are much more likely to reside in the South (94%; including the South Atlantic, East South Central, and West South Central census regions) than any other racial or ethnic group in the study, including non-Hispanic Whites. More than one-third (37%) of all rural non-Hispanic White adults live in the Midwest and nearly 40% of American Indian/Alaskan Native adults live in the West.[5] Geographic distribution matters because, as the authors note, different locales expose individuals to different state and regional historical, policy, environmental, and social contexts.

Within Rural Communities are Diverse Populations

People of color and American Indians in rural communities include both recent immigrants and people with deep historical roots in rural communities, including Indigenous people and descendants of former slaves. Both of those populations have faced centuries of systemic

oppression that may manifest itself in poor health outcomes today.[13] Thus, the dynamics that relate to health for rural people of color and American Indians include both 1) challenges faced by rural people generally, where residents are lower-income, older, and sicker and have poorer access to health care systems and services;[14,15] and 2) exacerbation of these challenges based on immigrant status and structural racism.[16,17] The second set of dynamics are particularly reticent to change and may drive some of the outcomes uncovered in the work of Dr. James and her colleagues as well as other researchers in rural health and health equity.

The historical and structural contexts of race in the United States render people of color in general, and Black and American Indian people in particular, vulnerable to poor health owing to challenges in accessing care, lower quality of care, and worse outcomes of care.[18,19] Indigenous communities have suffered loss of land, livelihood, and health, suffering poor health outcomes for centuries.[20] With origins in slavery and genocide, health decrements for Black and Native people in rural communities are longstanding. Immigrants to rural areas face challenges, too, including language, cultural differences, and barriers to accessing health care.[21] Immigrants are also disproportionately represented in physically demanding work in rural areas, including in agriculture.[22] Addressing challenges faced by rural residents, and especially by those who are immigrants or those who suffer longstanding structural inequities, is a crucial component of research, policy, and clinical strategies aimed to improve rural health.

Improving Health for Rural People of Color and American Indians

Dr. James and colleagues highlight the rapidly changing demographics of immigration in rural America[3] and make recommendations that address improving care for this population through, for example, meaningful implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards.[23] In this discussion, Dr. James and colleagues make useful and practical

suggestions for how to leverage existing tools to work toward health equity in rural communities.[5] However, in noting that these tools can be used by "rural communities to] identify disparities and develop effective initiatives to eliminate them,"[5[p. 1]] they are putting the onus on the community. Certainly, interventions should be community-driven, but state and federal policymakers have a responsibility to support these efforts. Rural communities are already disadvantaged in terms of socioeconomic status and infrastructure and there is evidence that rural communities with higher proportions of racial and ethnic minority groups face even steeper challenges.[24] More attention should be paid to how existing tools and resources are used and to whether they serve to widen disparities between communities that have the capacity and resources to devise and implement solutions, compared with those that do not.

Historical populations, such as African Americans living in the Black Belt[25] and Native communities on tribal lands,[26] are not as prominently discussed in the article; certainly the health challenges that span generations are particularly entrenched and resistant to change. Importantly, however, these merit sustained attention. Explicit and implicit narratives concerning race and racism are omnipresent today, in heated debates about Black Lives Matter, police brutality, and the role of protests in today's society.[27] Usually lost in these debates, though, is the rural context, where deeply-entrenched systems of oppression may be difficult to overcome, especially if widespread imagery of rural life does not include images of people from racial and ethnic minority populations.

Addressing the Historical Context of Racism in Rural Communities

In order to achieve health equity, it is crucial to prioritize efforts to recognize and dismantle the pernicious effects of racism on health in rural communities. To do so, it is important for researchers, policymakers, and clinicians involved in rural health care to do three things.

First, recognize how racism has shaped the history of rural communities. For example, it is important to understand the establishment of living arrangements and conditions for people of different races, and how race may have influenced the allocation of resources and opportunities differentially.[28] Was the local hospital segregated by race at any time? For how long and to what extent does the residue of such a history affect health care delivery at the hospital today? Were discriminatory housing policies in place that separated neighborhoods by race? And, importantly, how does this historical context shape access to resources and opportunities today?

Secondly, to move toward equity in health, it is important to "center at the margins." That is, become aware of the experiences or identities that are conceptualized as normal, and question that conceptualization, seeking a more inclusive view of normal if it is found to be lacking. Frequently—and highly problematically—Whiteness is the assumed baseline, and other racial and ethnic identities are seen as different, or even pathologized clinically.[29] Indeed, this is common in health services research. Dr. James and colleagues note that "the only comparisons tested were between non-Hispanic whites and other racial/ethnic groups."[5[p. 6]] Centering at the margins would put the experience of the most marginalized population at the core of the analysis, and compare other populations with the one that is suffering most.

Third, taking personal responsibility for asking the question, "How is racism operating here?" in one's own setting can illuminate actionable steps to dismantle racism in all communities, including rural settings.[30]

Building on the James et al. Article

The contribution of Dr. James and colleagues is a crucial first step in clearly laying out intra-rural health disparities by racial and ethnic identity. They propose next steps, and below we lay out several additional strategies that may be undertaken in research, policy, and clinical and public health practice.

For research, we propose several next steps for work to add more nuance and better understanding to these initial findings.

First, we suggest examining geographic differences in the disparities found in the article. For example, is being Black in the rural South associated with better or worse health than being Black in the rural Northeast or West?

Second, we recommend adjusting for socio-demographic differences to understand better how much of the health differences we see is explained by differences in income, education, and other socio-demographic characteristics. Such knowledge is important in order to determine where to target interventions.

Third, we would like to see analyses such as those conducted by Dr. James and colleagues repeated with a sample of children. Doing so would provide evidence to see whether racial and ethnic disparities in health are more or less pronounced among rural children, which will inform the course of health disparities over coming generations.

Fourth, it would be useful to conduct similar analyses in rural micropolitan counties to see whether the results hold in more populous rural settings or whether they are most pronounced in the most sparsely populated rural settings.

Fifth, and finally, we recommend examining the role of intersectionality and of other identities within groups classified as *rural*. For example, while it is useful to document racial and

ethnic disparities in rural communities, are there also disparities by sexual orientation, nativity, gender identity? How do intersections of marginalized identities influence outcomes?

For policy and programmatic interventions, we also have several suggestions.

First, as we discussed in detail above, we urgently advocate for explicitly and systematically addressing and dismantling racism in all contexts, including in rural areas.

Second, we encourage policymakers and public health practitioners and clinicians to consider workforce issues germane to these discussions. Given both the longstanding history of racial and ethnic minorities in some rural communities and the recent increases in diversity in others,[3] how do we recruit a well-trained and culturally competent or representative pool of health care providers to provide sensitive, high-quality care to *all* rural residents? Additionally, it is important to address occupational issues inherent among rural populations—for example, recent immigrants are more likely to work in physical labor in rural settings;[22] are they protected against injury? Additionally, given the aging of rural America, especially among non-Hispanic Whites,[3] we will need to rely on a diverse workforce of younger and middle-aged adults to provide long-term services and supports. How will cultural bridges in those settings be spanned? What protections and trainings will be in place for workers?

Third, we urge policymakers to think critically and proactively about the role of state and federal policies in perpetuating or alleviating rural health disparities. For example, state Medicaid policy plays an important role in access to care for economically vulnerable populations.[28] This is particularly true in rural America, where incomes are lower and reliance on Medicaid, when available, is more common.[32] In the James et al. paper, non-Hispanic Black respondents had some of the worse outcomes in the paper and were much more likely to live in Southern states where Medicaid was not expanded under the Affordable Care Act.[5] How have

changes in access to care and insurance affected health and health disparities among diverse rural residents?

Finally, we urge policymakers and the public health, clinical, and health services community to address the social determinants of health, including addressing educational quality, poverty, infrastructure, and transportation, among others. Doing so would benefit all rural residents, but might have an especially beneficial impact on the populations whose health is the most vulnerable.

There are racial and ethnic disparities in vulnerability to poor health outcomes in rural communities, and there is also a deep pool of resilience strengthening the diverse residents of rural America. We present several potential and overlapping options for research, policy, and practice to improve health equity in rural communities. Regardless of which seem most politically, economically, or socially feasible, doing nothing cannot be an option. The James et al. article illuminates shameful health disparities that build on centuries of oppression for which we are collectively responsible. In the frequent discussions about the wellbeing of rural America, we cannot allow ourselves to lose sight of such disparities and must act urgently and decisively. Ultimately, the whole of the country benefits from the vitality and productivity of rural areas, by virtue of energy and agricultural production, tourism, environmental preservation, and industry. It is in everyone's best interest to ensure that these communities are healthy, that their resources are distributed equitably, and that they are viable as homes for all people.

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