Part One

Rural Communities in Context
Chapter 1

Understanding Rural America
A Public Health Perspective

Richard A. Crosby  Baretta R. Casey
Monica L. Wendel  Laurel A. Mills
Robin C. Vanderpool

Learning Objectives

- Understand the unique aspects of rural America and the key contextual influences on rural public health.
- Identify key determinants of rural health disparities in the United States.
- List and explain eight major influences on rural health disparities.
- Compare and contrast rural health disparities to those experienced in urban and suburban areas of the United States.

Covering about two-thirds of the land in the United States, rural America is extremely diverse. The diversity found there exists as a function of rich cultural traditions handed down from generation to generation as well as from adaptations to the environment and the livelihood it supports. Thus, it is indeed important to know that term rural America is far too vague to have any practical value in this book. Instead, rural America should be thought of as a tapestry of rural cultures—shaped by geography and tradition—that spans from the rural poverty of the Mississippi Delta to the rural isolation of states like Montana and Wyoming. Rural life, and the associated challenges to public health, is therefore difficult to describe in a single chapter. Recognizing this,
we urge you to remain mindful about this tapestry as you read this chapter, which by necessity will need to broadly describe rural America and its public health issues. Please also bear in mind that rural is not just a place. Instead, the term represents a culture of rural people who typically have tight-knit communities, strong ties to the land they live on, and a long history of shared life experiences. Despite the poverty that often characterizes rural areas, the isolation of rural places, and the growing digital divide that places rural Americans at a disadvantage in many ways, rural people may commonly perceive their lives to be of very high quality mainly because of their strong sense of community, extended families (most of whom may never leave the community), and an aesthetic beauty offered by life largely unspoiled from the trappings of urban settings.

People in rural areas of the United States do have a great deal in common: a strong sense of independence, pride in their community, and self-reliance. Although these qualities can be valuable assets to public health programs, they can also be obstacles that prove difficult to overcome. As an example of using rural assets to advance a public health agenda, consider the case of southeastern Kentucky, where a cervical cancer program known as Faith Moves Mountains (FMM) has been used to successfully promote and increase Pap testing among medically underserved women living in a high-incidence area for cervical cancer (see Chapter Nineteen) (Schoenberg et al., 2009). The program works through key community stakeholders—women who are well connected throughout the community. These women conduct educational sessions in churches and subsequently navigate women into screening for cervical cancer. In this rural culture (as is common in rural America), churches are a focal point of communities, serving as a mechanism for the creation and maintenance of social capital. Social capital can be thought of as sense of cooperation, reciprocity, and trust among community members (Putnam, 2000). As such, social capital is widely recognized as one the principle factors in any organized effort to promote public health (Kreuter & Lezin, in press). The FMM program tapped into this local source of social capital, thereby using the asset of the rural tight-knit community as a method of diffusing innovations (e.g., Pap testing) in public health. The FMM investigators are now extending their successful faith-based approach to improve eating and exercise behaviors of community residents as well as to achieve reductions in tobacco use. At its heart, FMM is about using rural social capital to catalyze the adoption of health-protective behaviors among people otherwise at-risk of morbidity and early mortality.

Rural “assets” can also be a barrier to public health efforts. For example, in many of the tight-knit rural communities across the United States, a sense of independence can be taken to the level of actively avoiding assistance from people who are not part of the community. In these modern times, this pioneer
mentality can be quite limiting in terms of public health. In the absence of outside assistance, residents may create alternative beliefs and practices regarding health and healing. A rural community that is resistant to outside influences thus becomes figuratively isolated from the diffusion of public health innovations such as improved dietary practices, screenings for the early detection of cancer, cholesterol-lowering drugs, occupational safety measures, the use of contraceptives, cervical cancer vaccines, the use of infant car seats, and improved dental hygiene practices.

A Few Basic Principles

In addition to understanding the concept of rural assets, we urge you to keep the following principle in mind: geography is critical—it shapes culture and practices of people. In many ways, geography determines something that scholars have termed context (Phillips & McLeroy, 2004). Context includes infrastructures such as roads and bridges, social structures such as community leadership and key opinion leaders, physical topography such as mountains and deserts, and community structures such as common values and history. Rural health disparities are often an outgrowth of contextual issues. For example, consider a typical rural Appalachian community set in steep mountains that are far too covered in timber and rocks to build roads on. Consequently, the roads are all built in between the mountains; these narrow valleys are called hollers. Hollers are the same places that rainwater runoff filters into creeks. People build their homes (or place their mobile homes) in the hollers because the cost of doing so is far less expensive than building on mountain sides. Building in the hollers also prevents the concern of not being able to get off the mountain at times of inclement weather from late autumn to early spring. A holler may house several extended families in thirty or more dwellings. In the spring, hollers are prone to flooding and the low-lying homes can be damaged or even swept away. In the winter, driving out of the hollers into the steep mountains may be impossible because of snow and ice. This same geography does not support farming, so people are forced to travel to towns or cities for gainful employment or work literally within the mountains as coal miners. As you can imagine, the geography described in this brief example has a profound influence on the context of rural life in Appalachia.

It is also important to understand that rural cultures' interactions with race and ethnicity have a profound influence on public health. This is known as composition (Phillips & McLeroy, 2004). In essence, the disadvantages that US minority members so often experience are compounded by the disadvantages created by the lack of employment and educational opportunities in rural areas as well as historical policies such as
as slavery and the creation of Indian reservations. Indeed, minorities in the rural parts of the United States have been referred to as a forgotten population (Probst et al., 2004).

Finally, as you read this chapter (and this entire book), please understand that health care and public health are two very different concepts. Public health is about prevention and its focus is always on entire populations. An all-too-frequently-held belief is that health care is the key to improving the health of the public. In actuality, this idea is arguably false. Ample evidence suggests that the key to improving public health lies in reversing the actual causes of death such as tobacco use, overeating, sedentary living, alcohol use, and other behaviors that lead to morbidity and early mortality (Farley & Cohen, 2005; Mokdad et al., 2004). Thus, we will use the phrase rural public health to represent the combined efforts to prevent the actual causes of disease and death (behaviors and environmentally driven causes) as well as issues pertaining to a lack of health care. The combination of prevention approaches and health care improvements are the very reasons we decided to create this textbook. Indeed, this is the first book to take this combined approach to rural public health. Unfortunately, despite a great deal of published papers on public health very little attention has been devoted to rural public health. As suggested by Phillips and Mc Leroy (2004) rural public health focuses on reducing population morbidity and mortality through multilevel, tailored, prevention efforts (primary, secondary, and tertiary) accounting for the unique context and composition of rural communities. Rural public health also takes an ecological perspective, meaning that the prevention approach works within the context of families, communities, culture, societal norms, and public policy.

An Overview

Galambos argued that rural health disparities have been a “neglected frontier.” This reality is indeed unfortunate given that significant numbers of people live in rural areas (Galambos, 2005). Depending on how rural is defined, the total rural population accounts for between 10 and 28 percent of the entire US population (Hart, Larson, & Lishner, 2005); however, the land mass occupied by rural residents is approximately twice that occupied by urban residents.

This book is dedicated to the illumination of public health issues and challenges for this often-neglected population of Americans. In this chapter, you will learn about eight key factors that profoundly influence disparities in rural public health. We will then provide you with key principles that can be applied to improving rural public health. Throughout the chapter, we will provide you with case studies, vignettes, visual displays, and photographs designed to help you learn the concepts easily. Chapter One is an overview and many of the concepts you learn in this chapter will be discussed in
subsequent chapters to aid the learning process. Chapter Two is then quite specific as it describes various systems of measuring **rurality** (what constitutes being rural) in the United States. Chapter Three then provides a succinct history of rural public health and further elaborates on a few of the concepts introduced in Chapter One. Chapter Four expands on the concept of overlapping disparities by describing the problems and issues faced by rural minorities. With these four chapters firmly behind you, the book then introduces the concept of rural public health systems, including health policy and efforts directed toward population-level change. After an introduction to rural public health systems (Chapter Five) you will learn about these concepts by reading chapters focused on specific rural states: Colorado (Chapter Six), Kentucky (Chapter Seven), Alabama (Chapter Eight), and Iowa (Chapter Nine). You will then be ready to learn about three key skills in conducting activities toward improving rural public health: (1) assessment (Chapter Ten), (2) coalition building in rural areas (Chapter Eleven), and (3) capacity building in rural areas (Chapters Twelve). The book will finally take you through a series of applied chapters (Chapters Thirteen through Twenty), each devoted to specific health issues such as adolescent health, food disparities, oral health, physical activity, farm injuries, mental health, cancer prevention and control, and tobacco prevention.

**Eight Key Factors**

Understanding rural public health requires that you first understand some key factors that influence this broad construct. In essence, any given rural community can be said to possess certain characteristics that affect its ability to promote and maintain health. A spidergram is a simple way of providing a snapshot of all factors of such a complex idea at one time. Each factor in a spidergram is represented as a “leg” of a spider, with incremental measures along its axis. In this instance, factors associated with a rural community’s ability to improve and maintain public health is the purpose of the spidergram:

- Geography
- Occupation
- Infrastructure
- Demographics
- Digital divide
- Access to care
- Social capital
- Political voice
The factor being assessed of any community can be “measured” along each spider leg and then plotted. After all of the legs are plotted the connected dots form a polygon. In turn, the area of the resulting polygon represents the degree of the community’s ability to promote and maintain the health of its residents. Thus, a small polygon represents poorer ability and larger polygons reflect more advanced capability. Clearly, a critical goal then is to increase the size of the polygon for a rural community. Figure 1.1 provides an example of a spidergram that plots the areas of three hypothetical rural communities.

As shown in Figure 1.1, each of these three rural communities requires a substantial degree of intervention given the very small size of their polygons. Figure 1.1 also illustrates potential priorities for intervention by graphically showing which legs (factors) of the spidergram are the shortest, thus implying greater potential for expansion. It is indeed quite fair to say that no two rural communities are likely to have the same shape polygon. Thus, the size and the shape of the polygon are important features. As is true for any spider, the movement of each leg affects the other legs and thus it is important to grasp that each leg is somewhat related to the others. To help you better understand the spidergram shown in Figure 1.1 we will systematically describe each of the eight legs.

Geography
As described earlier in this chapter, features of the land provide a variety of environmental and natural resources affecting the ways communities and their residents sustain themselves. For example, fertile farmland, minerals, oil, natural gas, and bodies of water all enable communities to incorporate farming, mining, drilling, fishing, and tourism, respectively, into their local economies. These economies also influence the rate of development and population growth. The most obvious characteristic of rural communities is the relationship between the population and its geography—a primary determinant of population density. However, in addition to population density, geography contributes to several other factors influencing rural public health.

Rurality and geographic isolation have been identified as contributing to poorer access to care (see Chapter Three), lower rates of preventive screening, decreased treatment for chronic diseases and mental health problems, and higher rates of morbidity from acute and chronic conditions (Eberhardt & Pamuk, 2004; IOM, 2005). Natural boundaries such as mountains, deserts, and rivers, as well as historic human-created boundaries such as railroad tracks, bridges, interstates, and dams, serve to connect and divide communities, thereby creating geographic isolation. In turn, this geographic isolation also presents challenges in developing and sustaining services because there is inherently less demand and fewer resources.
Figure 1.1. Spidergram Examples: Owlsley County, Kentucky; Leon County, Texas; Issaquena County, Mississippi
Occupation

The wealth of natural resources that so often characterize rural America also creates important occupations for rural residents. Unfortunately, these same revenue-generating jobs are often extremely hazardous. For example, Ricketts (2000) indicates that mortality and morbidity due to agriculture, mining, forestry, and fishing dominate the rural landscape. Public health efforts are needed to improve on-the-job safety in rural communities; in Chapter Seventeen, you specifically will learn about efforts to prevent tractor rollovers among farmers.

Outside of working with natural resources, other job opportunities in rural communities are found in manufacturing, health care, and service sectors. However, large manufacturers may not choose to build in rural communities because of limited access to interstate transportation routes or major railways. Small rural hospitals are not only a source of local employment, but also an economic and social mainstay. In the 1980s when rural hospitals were closing at a rapid pace, many rural communities were significantly affected. In order to stay competitive, rural hospitals must provide inpatient, outpatient, home health, skilled nursing, and long-term-care services. Unfortunately,
service-related jobs often pay only minimum wage and come without benefits such as health insurance and paid sick leave. All four employment areas are sensitive to the national economic environment, particularly recessions, which often lead to less demand for consumer products, less health care use, layoffs, and closures. Furthermore, imagine how an independent, small farmer might be affected by skyrocketing gasoline prices when crop subsidies are flat or decreasing or how a rural hospital can compete with an urban hospital, which can offer a higher salary and benefit package.

**Infrastructure**

*Infrastructure* is best defined as the degree to which various structures (physical, political, social, legal, etc.) and systems (governmental and nongovernmental) within a given community have been developed. A vignette is useful as a starting point here. In a rural county in east Texas, there was an effort to expand local mental health services through the use of telehealth technology. Very simply, the community planned to use a secure network connection, high-definition cameras, and large monitors to provide mental health services over long distances. Although the health care providers and the community were fully ready to implement the services, it took two years to establish a secure connection due to the community’s difficulties with physical infrastructure. Getting a simple connection for telehealth was less of an issue but getting the necessary bandwidth for the encryption needed for security was challenging simply because these services were not available in that rural area.

Building infrastructure obviously requires financial and personnel resources that are often limited in rural communities. In addition, federal and state resources are often distributed based on population, which further disadvantages rural communities and perpetuates the lack of needed infrastructure.

**Demographics**

In addition to geography, occupation, and infrastructure, public health practitioners must take note of the demographic characteristics of their rural communities. Due to the out-migration (leaving rural counties to move to urban areas) of younger individuals, rural communities are typically made up of older populations that in turn have higher rates of chronic conditions; this places a heavy strain on local public health resources (IOM, 2005).

As discussed previously, many rural communities have large concentrations of minority populations creating a synergistic effect of “race and place,” leading to pronounced health disparities (Probst et al., 2004). One of the most stunning examples of rural health disparities was provided by Murray and colleagues who dissected the US population into “eight Americas” based on socioeconomic factors such as race, income, and place of residence (by county).
These different Americas have distinctly diverse mortality rates, highlighting huge disparities among different subpopulations such as southern, low-income blacks, low-income whites in Appalachia and the Mississippi Valley, western Native Americans, and northland low-income rural whites (Murray et al., 2006). Similarly, in 2007 the New York Times published a feature story on the increased infant mortality rates in Mississippi, which reached 17 deaths per thousand live births compared to 6.6 deaths for white women in 2005 (Eckholm, 2007). And in southern Arizona, the Pima Indians are recognized for having some of the highest rates of diabetes in the world; 50 percent of adult Pima Indians have diabetes and 95 percent of those with diabetes are overweight (NIDDK, 2002).

Additionally, poverty rates in rural areas are higher compared to urban areas (Blumenthal & Kagen, 2002; IOM, 2005). More than one in four non-metropolitan Hispanics, African Americans, and Native Americans live in poverty. In 2002, nonmetropolitan poverty rates for non-Hispanic African Americans and Native Americans were 33 percent and 35 percent, respectively, which was more than three times the rate for non-Hispanic whites (11 percent). The rate for Hispanics (27 percent) was more than twice as high (ERS, 2004).

Finally, education is interrelated with an individual’s health status and is directly related to future job opportunities. Whereas upwards of 80 percent of all rural Americans complete high school, far less (16 percent) receive a college education compared to their urban counterparts (27 percent) (IOM, 2005).

**Digital Divide**

The term *digital divide* refers to a growing disparity between rural and nonrural Americans—one that involves access to and use of the Internet. Broadband access is an important issue in rural America. Evidence suggests that a significantly smaller number of rural homes have broadband access compared to suburban or urban homes. The term *access* is critical here because it is certainly not the case that simply having access always translates into an affirmative decision for people to adopt broadband (or other high speed Internet) technology. Some evidence suggests that adoption of this technology is a function of two key demographic factors: age and socioeconomic status, with younger age and higher socioeconomic status being predictive of broadband adoption. Thus, because rural Americans have a higher mean age than nonrural Americans and because collectively they have a lower socioeconomic status, it is quite likely that adoption once access is available is also slower among rural Americans. We will briefly discuss the issues affected by access and adoption.

*Broadband access is an important issue in rural America.*
Access to broadband technology is an unfortunate function of economics. Simply stated, the physical construction required to bring this technology to rural homes is often deemed (by the companies providing service) too expensive given the low population density. Stated differently, the potential number of customers (best case scenario) is not large enough to justify the initial outlay of money to provide the service. This may be an intractable problem. Unfortunately, this specific economic problem translates into much larger problems when thinking about the consequences of this digital divide. For example, one likely and long-lasting consequence is that rural children and adolescents will lack the same daily opportunities afforded to their nonrural counterparts relative to the vast number of websites that offer ways to advance educational opportunities. To the extent that commerce has become intimately linked with the Internet, rural Americans may also lack some of the employment opportunities afforded their nonrural counterparts. This same dynamic may also apply to purchasing given the ever-expanding number of companies that offer price reductions for products and services purchased online.

With regards to broadband adoption, rural Americans can behave quite differently from their nonrural counterparts. For example, the concept of paying yet another “utility bill” may be quite unacceptable for rural folks living in poverty. The access issue previously described did not include the notion of costs—the two constructs are indeed quite distinct. Thus, even when a company does invest in a broadband infrastructure for a rural area, it is not fair to assume that this service will be provided at a price equivalent to the same service offered in suburban and urban areas (in fact, a logical assumption is that price would be much higher to compensate the company for the greater cost of building the needed infrastructure). Adoption of broadband access in rural areas may also be affected by cultural norms suggesting that communication with “outside cultures” is not necessary or even desirable.

**Access to Care**

Considering all the factors discussed up until this point, it is not difficult to conclude that rural residents also face access to health care problems. Access to care can have multiple meanings. For example, distance and lack of transportation serve as barriers to care. Patients may have to travel hours and many miles to receive health care, especially in frontier communities. Additionally, public transportation is not readily available in rural communities and patients without their own form of transportation must rely on family members, friends, or social service agencies to take them to their appointments. See Figure 1.2 for a map showing areas with high proportions of carless households in the United States.

Compounding distance and transportation barriers, there may be a limited number of health care providers available in rural communities. Almost 80
percent of nonmetro US counties are in a whole or partial primary care health professional shortage area (HPSA), 60 percent are in dental care HPSAs, and 87 percent are in mental health care HPSAs (RUPRI, 2006). The majority of health care in rural communities is provided by local health departments, small private practices, rural health clinics, and federally qualified community health centers (FQHCs). Even though there are over two thousand rural-based hospitals, 70 percent of them have one hundred beds or less and must triage complicated or severe cases to larger facilities (IOM, 2005). In addition to health care provider shortages, approximately one in five rural residents are without health insurance and uninsured rates are over 30 percent in more isolated rural communities (Bolin & Gamm, 2003; Probst et al., 2004; Schur & Franco, 1999). Related, a higher proportion of rural individuals are enrolled in Medicaid and Medicare compared to their urban counterparts (IOM, 2005).

Primary care providers (e.g., physicians, nurse practitioners, physicians’ assistants) are many times the first entry into the health care system for rural
individuals. Almost 75 percent of medical visits in rural communities are to a primary care provider (Schur & Franco, 1999). Due to the lack of medical specialists in rural communities, primary care providers are required to cover a multitude of health problems: episodic care, preventive medicine, chronic disease management, pediatrics, gerontology, obstetrics and gynecology, mental health, and emergency services, to name a few (IOM, 2005). For the most part, providers practicing in rural areas do so because of their desire to live and care for rural residents; in fact, providers who were raised in rural areas are more likely to train in primary care and return to practice in rural communities (Brooks et al., 2002; Gamm, Castillo, & Pittman, 2003; Rosenblatt & Hart, 1999). However, these providers may feel professionally isolated. They have fewer of their colleagues in the community to consult with on difficult cases and are frequently on call. It is easy for these rural providers to get burned out due to longer work hours, more patient visits, cultural and professional isolation, lower net annual incomes, and a stressful role in caring for human life (Pathman et al., 2004). Further exasperating the retention of rural health care providers is the difficulty of recruiting new providers to rural America. In a position paper by the American Academy of Family Physicians (AAFP, 2009) the top five reasons new physicians give when choosing their first practice site include significant other’s wishes, medical community friendly to family physicians, recreation and culture, proximity to family and friends, and significant other’s employment. These reasons further illustrate this difficulty in recruiting providers to geographically isolated communities. Health care providers are traditionally trained in treating the symptoms and causes of disease in individuals. However, in rural America these symptoms are often indicative of a larger, systemic community circumstance. Thus, it is important that providers practicing in rural America have the necessary skills to address the depth of public health needs in the community.

Social Capital

Although definitive studies have not been conducted, it may be quite fair to speculate that rural communities have a greater degree of social capital compared to urban communities. As noted previously in this chapter, social capital is broadly conceived of as reciprocity, cooperation, and trust among community members in pursuit of a common goal (Putnam, 2000). In contrast to the negative health and sociodemographic characteristics that are often used to describe rural communities, rural residents have multiple strengths and assets that can be optimized to improve health outcomes and these assets are indeed consistent with the concept of social capital. Again, for example, rural communities are often recognized for their tight-knit, long-standing familial and
social networks resulting in shared life experiences. These networks can serve as dissemination mechanisms for health information, health innovations, and positive health behaviors. As a public health professional, you will want to identify key influential members of these networks not only to collaborate on program planning, implementation, and evaluation, but also to serve as role models for others in the network through endorsement and practice of a particular protective health behavior (e.g., cancer screening, influenza immunization, healthy diet).

Related to these strong family and social networks, rural residents typically value and are committed to their community and its members. A strong sense of community can be used to rally rural communities to promote and protect the health of their fellow residents, whether it is an environmental health issue such as mountaintop removal (a method of coal mining) or smoking prevention among school students. It is important to note that the definition of community can vary from an entire county, to a faith-based community, to the residents of an isolated village in the Great Plains. Many rural individuals want to give back to their communities, which may have supported them during difficult times such as unemployment, a cancer diagnosis, or the death of a loved one. This notion of reciprocity serves as a foundation for engaging rural communities in public health programs and interventions that in turn are more likely to be more successful and sustainable.

Rural communities are also recognized for strong faith, spirituality, and religious beliefs (each being a powerful form of social capital). Because rural individuals regularly participate in faith-based or spiritual activities, venues such as the church or powwow become potential programmatic intervention and message dissemination points. Historically, African American communities such as those found in the Mississippi Delta have significant ties to local churches, which serve as places of worship, locations for social gatherings, and political center points. Incorporating faith-based or spiritual messages (i.e., your body is a temple; do not pollute it with alcohol, tobacco, drugs) into rural-based public health programs is thus likely to increase the salience of the health protective behaviors you may attempt to promote. Additionally, by engaging these entities, programmatic activities can be held in their facilities, which brings the familiar and comfortable to the congregations.

Interestingly, rural residents also consider themselves to have a high quality of life despite the unfavorable epidemiological and demographic data that may suggest otherwise. As an example, although many rural families may not be financially wealthy, they may consider their lives rich in family, friends, community, and faith. Additionally, land is an invaluable resource to many rural communities due to its provision of food, livestock, livelihood, and history. Consider the fact that land in the Southwest has been passed on through generations of families, the mountains of Appalachia hold mineral and
timber resources vital to the local economy, and Native Americans have spiritual connection to their ancestral lands. Thus, it is important for public health professionals to identify what rural residents value in order to incorporate these assets into our outreach activities and messages.

Finally, as a public health professional, you should recognize the creativity, resourcefulness, independence, and resiliency of rural residents. Many rural communities have struggled with economic downturns, natural and human-made disasters, corporate bullying, political strife, lack of resources and infrastructure, and other challenges inherent to their geographical isolation, which has in turn made these communities stronger, inventive, and innovative. For instance, the Frontier Nursing Service, founded in 1925 by Mary Breckinridge, was created to address the high rates of maternal and infant mortality in eastern Kentucky, a region that at the time had no physicians and few roads. Through the provision of prenatal care, birthing assistance, and general family health care services by nurse midwives, Ms. Breckinridge’s innovative outreach program—much of which was delivered via horseback—contributed to significant declines in maternal and infant mortality in area. Today, some eighty-five years later, the Frontier Nursing Service operates five rural health clinics, a critical access hospital, a home health service, and a world-renowned midwifery and family nursing training program (http://www.frontiernursing.org/).

The idea of heightened social capital in rural communities has empirical support. For example, in a study testing the theory that social capital is related to health status, Folland (2007) found the relationship between the two variables to be robust for multiple variations in analysis and that rural or urban status reduced the effect of social capital on the prevalence rates of some diseases. A study examining differences in social capital between rural and urban families found that rural residents are more likely to receive social and material support from their relatives (kin) residing in close proximity than their urban counterparts (Hofferth & Iceland, 1998). Although the study primarily focused on economic exchanges, the authors concluded that persistent rural-urban differences in social capital remained and may be linked to cultural norms and the presence or absence of mediating structures to facilitate social engagement.

Focusing on broader economic issues, Israel and colleagues (2001) attributed rural-urban variations in social capital largely to structural attributes of community social capital, including “socioeconomic capacity, isolation, instability, and inequality” (p. 46). They hold that highly skilled jobs cluster in urban areas and foster a cycle in which rural communities persistently lag behind urban communities in economic capacity, leading to communities where the overall education, skill, and income levels remain lower, and expectations, opportunities, and achievement spiral downward (Israel, Beaulieu, &
Hartless, 2001). This perpetuates poverty and poor social capital in the communities where there is no intervention to interrupt the cycle. Thus, for a variety of reasons, social capital varies between rural and urban populations (Wendel, 2009).

**Political Voice**

An important principle of public health is that people can empower themselves to improve the influences that directly affect their health and well-being. Again, a brief vignette may be very useful here. In the State of Texas, incorporated cities have an extraterritorial jurisdiction (ETJ) that extends beyond their city limits proportional to the size of the population. Smaller cities under five thousand residents have half a mile of extra jurisdiction; cities over one hundred thousand have up to five extra miles. The ETJ can reach into contiguous counties but not into another city’s ETJ. This is one example of how rural communities lack political voice. In an area of Texas where one larger city’s ETJ reached into a neighboring rural county, the city purchased land in that county within their ETJ with the intention of building a landfill. They presented this information to the county commissioners’ court after the fact to let them know that it would be happening; although they were outraged, the rural county could not halt the process.

Another vignette is also quite helpful in understanding the spidergram leg of political voice. In a specific instance, many Iowa residents had advocated against the presence of concentrated animal-feeding operations in their communities by blocking construction permits, signing petitions, holding courthouse rallies and protests, and filing nuisance lawsuits (Osterberg & Wallinga, 2004). As a community, their active belief in their own ability to correct an otherwise unhealthy and undesirable influence on the environment was indeed the key to their action, which eventually created change, thereby protecting the health and well-being of their residents.

Yet one more vignette is quite applicable to the concept of political voice. Leon County in rural east Texas is the county home to a predominately white population of close-knit people tightly tied to the community (through churches and schools) with some employment, ranching, and very few health resources. One school nurse serves five school districts. Obesity is rampant, as is substance abuse, domestic violence, elder abuse, and mental health issues (depression and anxiety). The county has a high degree of income inequality. Education levels are relatively low, with 13.9 years of school being the mean. As is common in rural areas, out-migration has created an older-than-average population in this county; 27 percent are sixty-five or older, 28 percent retired, and the median income is $50,000. Strikingly, 24 percent of people surveyed said no one in the household earned money (CCHD, 2010). The primary challenges
to public health in this county once involved a lack of government support for basic services to its residents. However, this began to change in 2005 when a county health resource commission was formed. This commission slowly helped people develop and use their political voice and brought people to hold health care providers accountable and have a better sense of being health care consumers.

Conclusion

Rural communities often have a strong community identity and a great deal of local pride. Although this can sometimes impede progress in health promotion, strategically employed, these characteristics can also be an asset. For example, rural communities are more likely to have a greater proportion of older adult residents. Although this can create a greater demand for specialty care and human services, it can also provide a strong pool of volunteers for community-based initiatives. Another example relates to a sense of independence that many rural communities uphold—valuing the ability to “pull yourself up by your bootstraps” and not needing (or wanting) help from outsiders. Admittedly, this can inhibit some efforts to assist local communities. However, framed the right way, this mentality can also facilitate capacity building. In essence, rural health promotion efforts should capitalize on this type of independence by framing change as a challenge that only “locals can handle.” Framing interventions so that a rural community can build their capacity to conduct them on their own and so that they will not need help excessive from the government or outsiders may create an environment that invites technical assistance in planning and development.

Summary

- Rural America is extremely diverse; it is far from being homogenous.
- Rural health disparities are vastly unexplored and improved efforts to rectify these problems are greatly needed.
- At least eight dimensions can be used to describe rural health disparities in any given area or community (represented by a spidergram).
- Rural social capital is one example of a rural asset that can be used to improve intervention capacities.
- Rural public health is affected by a host of contextual factors ranging from individual beliefs to culture and geography.
For Practice and Discussion

1. In this chapter you have learned about various rural assets. The rural assets that we have described are certainly not inclusive of all the strengths of rural communities. We challenge you to consider additional characteristics of rural areas that can be capitalized on to reduce rural health disparities. Working with colleagues from your class, please identify three additional rural assets and compose a brief justification for each that provides the logic you used to arrive at your choice.

2. One leg of the spidergram is the digital divide. Carefully read this chapter again and (while doing so) ask yourself the question, “Is access to broadband Internet a desirable priority for rural America?” Consider the following points as you reflect on this issue. First, is it possible that many rural Americans are better off being unexposed to the multiple influences of the Internet? Second, are various rural cultures always compatible with the mainstream (corporate) culture that pervades the Internet? Third, to what degree will the future demand high-speed (at home) Internet to compete in an increasingly demanding domestic and global economy? Finally, to what degree is rural Internet access a necessity to rural public health (now and in the future)?

Key Terms

- infrastructure
- political voice
- rurality
- social capital

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