REPORT 7 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-25)
Addressing the Health Issues Unique to Minority Communities in Rural Areas
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND. Resolution 433-A-24 asked that our American Medical Association study health issues unique to minority communities in rural areas, such as access to care difficulties. Rural minority populations are not a homogeneous group of individuals and ethnic and racial diversity within rural America has increased significantly within the past twenty years. Despite limitations in available data and health studies, it has been well established that racial and ethnic minority populations in rural areas often experience disparities in health status, health insurance coverage, rates of chronic disease, life expectancy, and rates of unintentional injury compared to their White rural counterparts. This report provides a summary of the available evidence on health disparities within minority rural populations, with a focus on Black/African American, Hispanic/Latinx, American Indian/Alaskan Native (AI/AN), as well as the LGBTQ+ community. Additionally, the report explores the historical and current contributors to ongoing health disparities, such as the social determinants of health and structural racism.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “rural” AND “minority”; “rural” and “health disparities”, and “rural” and “health inequities.” Additional articles were identified by manual review of the reference lists of pertinent publications and as new areas of exploration were revealed through identified articles. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION. Many studies demonstrate that rural minority populations have poor health outcomes across multiple measures compared to their White rural counterparts. For example, as of 2017, close to 30 percent of AI/ANs, non-Hispanic blacks, and Hispanics self-reported poor or fair health compared to only about 18 percent of non-Hispanic Whites. While many rural racial minority populations suffer worse health outcomes and have poorer health care access compared to their White rural counterparts, each group experiences a unique set of challenges which are influenced by intersecting social determinants of health. Rural minorities are functionally impacted by two overlapping disparity processes - disparities associated with their rural geography and disparities associated with being a member of a particular minority group. Among the various social determinants of health, a lack of education, economic stagnation, and lack of investment within rural communities are notable as they have led to disproportionate rates of poverty in rural areas, leading to lower tax bases that limit the ability for educational and health systems to thrive. As a result, upstream social and economic determinants are negatively impacted, including housing, food security, access to places to be physically active, and health care access. Many of these social determinants are deeply rooted in centuries of discrimination, racism, violence, as well as disinvestment and injustice.

CONCLUSION. Rural minority populations suffer a disproportionate burden of adverse health outcomes compared to rural White populations or urban minority populations. Rural minority residents experience dual disparities and poor health outcomes are a result of intersecting structural and social determinants of health. Longstanding disparities in health care access within rural areas are compounded by additional and unique barriers experienced by rural minority populations.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 7-A-25

Subject: Addressing the Health Issues Unique to Minority Communities in Rural Areas

Presented by: John T. Carlo, MD, MS, Chair

Referred to: Reference Committee D

INTRODUCTION

Resolution 433 was adopted at the 2024 Annual Meeting resulting in policy H-350.937, "Improving Healthcare of Minority Communities in Rural Areas." Item five of this policy asks that "our American Medical Association (AMA) will research and study health issues unique to minority communities in rural areas, such as access to care difficulties."

BACKGROUND

As of 2020, around 46 million Americans, or 14 percent of the U.S. population, lived in rural areas.[1] Rural Americans face numerous health disparities compared with their urban counterparts. Rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts.[2] Unintentional injury deaths are approximately 50 percent higher in rural areas than in urban areas, partly due to greater risk of death from motor vehicle crashes and opioid overdoses.[3,4] In general, residents of rural areas in the U.S. tend to be older and sicker than their urban counterparts.[2,5]

While rural America is still overwhelmingly White (constituting about 76 percent of the rural population), it has become more ethnically and racially diverse over the last twenty years.[1] Despite limitations in available data and health studies, it has been well established that racial and ethnic minority populations in rural areas often experience disparities in health status, rates of chronic disease, life expectancy, and rates of unintentional injury compared to their White rural counterparts.[6–8] As an example, in a recent study, rural counties with a majority non-Hispanic Black or American Indian/Alaska Native (AI/AN) residents were found to have a higher premature death rate compared to rural counties with a majority of non-Hispanic White residents.[9] In places where race and ethnicity overlay with rural geography, residents often experience dual disparities and face some of the worst outcomes in the nation. Poor health outcomes for rural minority populations are a result of intersecting social determinants of health factors, which are further elucidated in this report.

In 2022, the AMA's Council on Science and Public Health (CSAPH) authored a report on improving rural public health infrastructure, which found that rural local health departments are often limited by budgets, staffing, and capacity constraints in providing public health services, limiting their ability to respond to national public health and health care policy initiatives and emergencies. With less funding and fewer staff, rural local health departments are often not able to meet the needs of a sicker population over a larger geographical area, contributing to the lack of essential public health services offered in rural areas. Building from the previous CSAPH report,

Action of the AMA House of Delegates 2025 Annual Meeting: CSAPH Report 7
Recommendations Adopted, and Remainder of Report Filed.

this report provides a summary of the available evidence on health disparities within minority rural populations, with a focus on Black/African American, Hispanic/Latinx, AI/AN, as well as gender and sexual minority populations. Additionally, the report explores the historical and current contributors to ongoing health disparities, such as the social determinants of health and structural racism.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "rural" AND "minority"; "rural" and "health disparities", and "rural" and "health inequities." Additional articles were identified by manual review of the reference lists of pertinent publications and as new areas of exploration were revealed through identified articles. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION

Rural minority populations are not a homogeneous group of individuals and ethnic and racial diversity within rural America has increased significantly within the past twenty years.[1] For the purposes of this report, rural minority populations are grouped into four general categories: African American/Black, Hispanic/Latinx, AI/AN, and the LGBTQ+ community. To note, the non-Hispanic multiracial population has also increased in rural areas as of the 2020 Census, now representing 3.9 percent of the rural population.[1] However, due to the recency of this population increase and little information in the literature on the health issues of this population, this report focuses primarily on the four above noted categories.

Data from the Behavioral Risk Factor Surveillance System (BRFSS), an annual state-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. population aged 18 years or older, demonstrates that rural minority populations have poor health outcomes across multiple measures compared to their White rural counterparts.[6] For example, as of 2017, close to 30 percent of AI/ANs, non-Hispanic blacks, and Hispanics self-reported poor or fair health compared to only about 18 percent of non-Hispanic Whites.[6] While many rural racial minority populations suffer worse health outcomes and have poorer health care access compared to their White rural counterparts, each group experiences a unique set of challenges.[6] The following sections summarize health challenges unique to each of the four minority groups.

Non-Hispanic African American/Black. As of the 2020 Census, rural African Americans account for about 7.7 percent of nonmetropolitan inhabitants, with a concentrated population in the rural south.[1] This geographic concentration is an artifact of our countries' history of chattel slavery, as many black families stayed in the south following emancipation and the Civil War despite the large migration to other regions of the country in the early 20th century. The history of slavery in the U.S. is an important social determinant influencing the health disparities experienced by rural African Americans today (discussed further below). Rural African Americans have significantly lower rates of health care coverage (73.2 percent) compared to White populations (83.9 percent) and almost one in four (24.5 percent) have not seen a doctor in the past 12 months due to cost.[6] Based on BRFSS data, rural African Americans are significantly more likely to have two or more chronic health conditions (40.3 percent prevalence), are more likely to be severely obese (12.1 percent have a BMI greater than or equal to 40 kg/m2), and are more likely to get no leisure-time physical activity (38.2 percent prevalence) compared to non-Hispanic White populations (36.0 percent prevalence of two or more chronic conditions, 5.0 percent prevalence of severe obesity, and 27.7 percent prevalence of no leisure time physical activity).[6] As a result, rural African American communities are particularly impacted by cardiovascular disease, hypertension, stroke, and

diabetes.[7] Rural African Americans are 20 percent more likely to be diagnosed with diabetes compared to urban residents and also tend to have poorer diabetes disease control, leading to increased rates of complications that arise from diabetes.[7]

Poor control of hypertension among rural African American communities is also high, which may be linked to the high rates of stroke found in this population. The high rate of stroke is so stark that southern states where many rural African Americans reside have been nicknamed "The Stroke Belt."[7] Lastly, due to barriers faced in accessing preventive services in rural areas, cancer disparities are more acutely felt among rural African Americans.[7,10] For example, African American women in rural areas have the highest breast cancer mortality rate compared to other racial and ethnic populations in the U.S.[7] The high prevalence of poorly managed chronic disease, lack of access to preventive services and care, ultimately lead to higher mortality rates among rural African Americans. Based on one study, the age-adjusted mortality rates estimated across a five year period (2013-2017) were highest among rural African Americans compared to all other minority groups, in both rural and urban settings (981.3 deaths per 100,000).[8]

Hispanic/Latinx. As of the 2020 census, Hispanics represent the largest share of the rural minority population, with a population of about 4.1 million or 9.0 percent.[1] Since 1980, Hispanics have been the fastest growing population in rural America, often relocating for employment opportunities in the agriculture, construction, and manufacturing sectors.[7] A result of the intersection of largely being immigrants (26.7 percent of rural Hispanics were born outside of the U.S.) and working in lower skilled jobs, rural Hispanics have the lowest prevalence of health care coverage among rural minority populations (61.1 percent) and nearly a quarter have not seen a doctor in the past 12 months due to cost (23.1 percent).[6] In terms of health conditions, rural Hispanics are impacted by a high prevalence of diabetes compared to rural White populations and urban Hispanic populations, as well as a higher burden of hypertension, heart disease, and stroke.[7] Rural Hispanics with diagnosed diabetes and/or hypertension are significantly less likely to be managing their conditions.[7] Significant barriers to accessing care unique to the rural Hispanic community are lack of bilingual staff or qualified medical interpreters within health care settings.[7] Despite higher prevalence and burden of some health conditions, rural Hispanics have a lower age-adjusted mortality rate compared to their African American, AI/AN, and White rural counterparts (580.7 per 100,000) but it is significantly higher than urban Hispanic populations (522.7 per 100,000).[8]

American Indian/Alaskan Native. AI/AN populations are largely rural in composition, with approximately 54 percent living in rural areas of small towns, and 68 percent living on or near their tribal homelands.[11] AI/AN communities have a significantly higher prevalence of depressive disorder (23.2 percent), obesity (38.5 percent), and are more likely to be current smokers (36.7 percent) compared to non-Hispanic Whites (20.3 percent prevalence of depressive disorders, 32.0 percent obese, and 24.7 percent are current smokers).[6] Rural AI/AN communities also have the highest rate of death by unintentional injury compared to all other racial/ethnic groups, both urban and rural (101.9 deaths per 100,000).[8] Notable health conditions of concern in AI/AN community include high rates of diabetes and hypertension, substance use, suicide, as well as respiratory health conditions such as tuberculosis, asthma, pneumonia, and more recently, COVID-19.[7,12] As a result of the numerous health disparities experienced by the AI/AN community, they have a lower life expectancy compared to all other racial groups in the U.S. population (65.2 years in 2021 compared to 76.4 for White populations).[12] While life expectancy declines from the COVID-19 pandemic were experienced among the entire population, AI/AN groups experienced the largest decline which is reflective of the disproportionate burden of excess deaths from COVID-19 experienced in this community.[12]

LGBTQ+ community. While exact numbers of the LGBTQ+ population in rural areas are difficult to assess compared to racial and ethnic minorities as there is no standardized method for collecting this information, (such as the Census) and ongoing stigma targeted at the LGBTQ+ community makes self-reporting unreliable, it is estimated that there are approximately three to four million LGBTQ+ individuals living in rural areas.[7,13] Data is limited in terms of unique health conditions experienced in this community. However, it has been documented that self-reported health among rural LGBTQ+ populations is more likely to be poor or fair and they are more likely to report having three or more chronic conditions compared to urban LGBTQ+ populations.[14] Sexual minority populations are at an elevated risk for substance use and substance use disorders compared to heterosexual populations, which has been associated with chronic stress and use of substances as a coping mechanism.[15] Rural LGBTQ+ populations may experience more stress due to continued stigmatization and prejudice, with reduced access to supportive communities, leading to higher levels of anxiety and depression.[13,14] It has also been estimated that rural sexual minorities have lower access to substance use disorder treatment, but few studies have evaluated this issue.[15]

Causes of Rural Minority Health Disparities: Intersecting Social Determinants of Health

Rural minorities are functionally impacted by two overlapping disparity processes - disparities associated with their rural geography and disparities associated with being a member of a particular minority group, which can be exponential, not just additive.[7] In other words, existing rural health disparities are a product of a complex intersection and interplay of many social and structural determinants of health. Among the various social determinants of health, a lack of education, economic stagnation, and lack of investment within rural communities are notable as they have led to disproportionate rates of poverty in rural areas, leading to lower tax bases that limit the ability for educational and health systems to thrive.[7] As a result, upstream social and economic determinants are negatively impacted, including housing, food security, access to places to be physically active, and health care access.[16,17]

While many consider housing shortages and affordability an urban issue, many rural areas are also facing similar challenges caused by an overall lack of housing development over many decades as well as the growth in seasonal and recreational use of available housing.[18,19] These issues were exacerbated by the COVID-19 pandemic, when urban dwellers and remote workers moved to rural areas.[20] Housing shortages and affordability not only impact low-income minority populations but also makes recruitment and retention of rural health care professionals even more challenging.[18,19] Multi-modal transportation infrastructure, such as public transportation, sidewalks, and biking-walking trails, is also lacking in rural areas compared to most urban and suburban municipalities.[21,22] Combined with long distances between destinations, this reduces the availability of daily opportunities for physical activity and creates a reliance on personal automobiles to access daily needs and services.

To understand how the current social determinants of health were created, it is useful to look from a structural and historical perspective. The relationship between rural minority groups and current poor health outcomes is rooted in centuries of discrimination, racism, violence, as well as disinvestment and injustice.[23] Structural racism in the U.S. is defined as "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems…These patterns and practices in turn reinforce discriminatory beliefs, values and distribution of resources."[24] Structural racism plays a critical role in the existing health disparities experienced by minority rural populations as it has influenced housing and lending discrimination, cultural stigma, forced migration, occupational inequalities, and xenophobic immigration policies.[25] For Black Americans in the rural South and AI/AN populations, the historical legacy of land dispossession is a critical structural determinant in understanding the current context of high poverty levels and poor health.

In the rural South, particularly the Mississippi Delta area (an area defined as the northwest section of the U.S. that lies between the Mississippi and Yazoo rivers), 98 percent of black agricultural landowners have lost ownership of their land, equating to a loss of 12 million acres over the last century.[26] Following the civil war and during the Reconstruction era, Black ownership of land increased and even outnumbered White landowners in some southern counties. At the beginning of the 20th century, it was estimated that African Americans owned as much as 14 million acres of farmland.[27] That changed starting during the Great Depression and through the 1960s when federal agencies and policy directives, implemented in a structurally discriminatory manner, transformed the nature of farm ownership and increased racial disparities in farm owner acreage. As an example, Black farmland in Mississippi totaled 2.2 million acres in 1910. Fifty years later, according to the Census of Agriculture, black farmers lost almost 800,000 acres of land over a fourteen-year period. This was largely a result of discriminatory loan servicing and loan denial practices by the USDA and other federal and financial institutions (as found by major audits and investigations).[26] Coupled with the onset of Jim Crow laws in the late nineteenth and early twentieth century, rural African American communities have struggled economically, with the long-term effects on health clear today.

Among indigenous communities in the U.S., the overall level of land dispossession is even more staggering. The colonization and imperial expansion by Western European countries of North America led to the displacement and forced migration of indigenous communities across the U.S., the erosion of their languages and culture, and dismantling of their social structures.[28,29] It is estimated that there has been an aggregate reduction in historical indigenous lands of about 98.9 percent.[29] The eviction of indigenous people from their ancestral lands has had long-term intergenerational impacts on indigenous families and community. For both the African American and AI/AN communities, the dispossession of their lands has led to an overwhelming loss of actual and potential net wealth that could have been passed on between generations. For African Americans, it has been estimated that as of 2013 the median net wealth of their households is $11,200, while it is thirteen times greater for White households.[30] For ancestral AI/AN lands, one study estimated that the total worth of the transfer of land resources was equivalent to approximately half a billion dollars.[30] Overall, loss of land has been found to have stemmed from "discrimination in federal and state programs, swindles by lawyers and speculators, unlawful denials of private loans, and even outright acts of violence or intimidation."[26] Considering the extreme level of poverty experienced by these rural minority communities today, the importance of this historical loss of wealth cannot be overstated. Additionally, current lands where indigenous populations have been relocated to are more exposed to climate change risks and hazards, including more extreme heat and less precipitation.[29]

Occupational Hazards

In the Hispanic/LatinX rural population, occupational health hazards represent an important and unique social determinant of health which intersects with low pay for the work they do, few regulatory protections, limited services, as well as discrimination and harassment.[16] Hispanic migrants make up an overwhelming majority of hired crop workers in the U.S. One estimate is that they account for around 83 percent of hired U.S. farm workers. Rural Hispanics are also overly represented in the workforce of large scale agricultural processing facilities (e.g., poultry processing).[31] Working in the agricultural sector, rural Hispanics face numerous environmental and physical threats, including chemical hazards from pesticides and air pollutants, physical hazards such as those from occupational injuries and the effects of extreme heat, as well as biological hazards from inadequate access to drinking water and basic sanitation.[32,33]

Pesticides are not only a source of injury and acute illness among farm workers, but long-term exposure is also linked to several chronic health effects. Acute, short-term health impacts of pesticide exposure depend on the type of chemicals used but can include eye and skin irritation, nausea, dizziness, and diarrhea.[34] Chronic health effects from pesticide exposure can include cancer, birth defects and reproductive harm, neurological and developmental impacts, and disruptions to the endocrine system.[34] Farm workers are also exposed to numerous air pollutants, including black carbon, particulate matter, carbon monoxide, nitrogen dioxide, sulfur dioxide, and diesel-related emissions from farm activities, such as tractor driving, maintenance and repair of machinery and equipment, and agricultural crop residue burning.[32] An emerging threat to farm worker health is exposure to smoke, dust, and poor air quality from wildfires, which are expected to increase in frequency and intensity in the coming years because of climate change.[35]

Machine related injuries are another top occupational risk for farm workers as well as musculoskeletal injuries from physical exertion and repetitive motions.[16,32,36] Bacterial and viral threats from working in agriculture are also unique to farm workers and there are several recent examples of this. During the COVID-19 pandemic, farm workers were considered essential and had to keep working, thus increasing their risk of COVID exposure.[32] Most recently with the spread of highly pathogenic avian influenza A (H5N1) in dairy cows, the small number of cases that have occurred in farm workers has affected primarily Latino migrants.[37] Despite working on farms and harvesting food, the combination of low wages and living in highly rural areas with a low density of available supermarkets means that food insecurity is especially high among migrant workers in the rural/agricultural sector.[5] Additionally, there is a lack of quality housing for migrant workers and available low-cost housing is limited. Reports have consistently found high rates of overcrowded and substandard housing among migrant workers.[32]

Environmental Conditions

Increased risk of exposure to hazardous environmental exposures and conditions are not limited to the rural Hispanic community. Rural Black and AI/IN populations also experience similar but unique environmental justice issues. For example, intensive livestock operations, such as large hog farms, are disproportionately located near rural, low-income African American communities, which results in wide range of adverse health impacts including eye irritations, respiratory ailments, cardiovascular issues, mental health issues, and noxious odors.[38] Additionally, low-income, African American communities are disproportionately exposed to toxic air pollution from the fossil fuel industry, with more than 1 million African Americans living within a half-mile of oil and natural gas wells, processing, transmission and storage facilities.[39] Abandoned hard rock mining operations in the Western U.S. are disproportionately located on American Indian lands, creating an increased likelihood that American Indians living near these mines are exposed to high levels of toxic metals, which are associated with increased risk of kidney disease, hypertension, and other chronic diseases.[40]

Concerns over water quality and waste management in rural African American and AI/AN communities are also prevalent, as many of these communities are not connected to larger municipal water and sewage treatment systems but rather rely on wells and septic systems.[41] One report estimates that 48 percent of households on American Indian reservations lack clean water or adequate sanitation.[42] Another study found that American Indians, Black, and Hispanic households are much more likely to live in a household without indoor plumbing and running water and "plumbing poverty" is geographically clustered in Alaska, the U.S. Southwest, the Upper Midwest, the Northeast (especially northern Maine and New Hampshire), and the Allegheny and Appalachian regions of Pennsylvania and West Virginia.[43] Moreover, for those with access, particularly well water, they are still at risk of contamination. The Hopi Tribe estimates 75 percent

of its community members are drinking contaminated water.[44] Similarly, multiple studies documented home well contamination with the Navajo nation exposed to uranium and arsenic in their well water and 39 percent of Tribal families' wells on the Crow Reservation showing unsafe levels of metals and/or nitrate.[45]

Fear of Deportation

Lastly, for migrant and immigrant Hispanic communities, the fear of and experience of deportation is an ongoing concern with both mental and physical health consequences, to the individuals themselves, their families, and their communities. If arrested and targeted for deportation, a person is held within an immigration detention center. In recent years, U.S. immigration detention centers have seen increasing reports of civil and human rights abuses as well as preventable in-custody deaths.[46] One study of detained immigrants in California found that greater exposure to confinement conditions within detention facilities increased the likelihood of one or more negative health conditions, but researchers also found a cumulative negative effect on their overall health.[47] Not only are the conditions of detention centers inhumane, but immigrants may fear what sort of conditions and punishment they will face upon return to their home country.[48]

Deportation efforts also separate individuals from their families and social support networks, often breaking up families that may have mixed immigration status. Large scale deportation efforts can be economically devastating for families, potentially plunging millions of families into poverty, increasing housing instability and food insecurity.[49] Mass deportation efforts also negatively impact communities. After deportation raids, communities are often more fearful and less trusting of public institutions, are less likely to participate in social and cultural activities, are less likely to seek health care, and are more reluctant to report crime to the police.[48]

Health Care Access

There are longstanding disparities in health care access within rural areas, which suffer from a shortage of health care professionals, the need to travel long distances to health care facilities and a lack of public transportation options for those who do not own cars, lower rates of health insurance coverage, as well as an increase in rural hospital closures.[5,50–55] Intersecting with these longstanding challenges, racial and ethnic segregation also impact access to health care in rural areas. While rural areas have lower proportions of racial and ethnic minorities compared to urban areas, estimates of residential segregation patterns are similar.[56] Segregation can perpetuate existing disparities by restricting various health promoting opportunities, such as education, employment, concentrating poverty, as well as access to health care resources. More than half of rural counties are estimated to be either whole or partially within a health primary shortage area, and those in this designation are more likely to be in counties that are majority Hispanic and/or African American.[56] In a study assessing residential segregation and health care access, both African American and Hispanic segregation were negatively associated with having a usual source of care but higher levels of segregation were also positively associated with health care needs being reported as met.[56] This second finding, as the study authors note, "underscores the need to identify assets and sources of resilience on which racial/ ethnic minority communities rely," in order to meet health care needs.[56]

Southern states, which have the highest populations of rural Black populations, were less likely to accept Medicaid expansion following the Affordable Care Act (ACA), therefore limiting the ability for lower-income minority rural patients to have access to health insurance coverage.[10] Medicaid plays an important role in rural areas for those who are low-income and unemployed (or underemployed). Medicaid coverage rates tend to be higher in rural areas versus urban areas and

the expansion of Medicaid under the ACA has been instrumental in expanding insurance coverage in rural America. It has also been demonstrated that Medicaid expansion decisions have been racialized as there are large differences in support for Medicaid expansion across different races. For example, state adoption decisions have been positively related to White opinion and do not respond to non-White support levels. Additionally, evidence indicates that when the size of the Black population increases and White support levels are low, states were significantly less likely to expand Medicaid.[57]

Outside of hospital settings, community health centers play an important role in providing primary care in rural areas that have a shortage of health care professionals. There are two federal programs which help to meet this gap – the Rural Health Clinics program and the Federally Qualified Health Centers program.[58] In terms of distance to health care facilities, one study found that rural zip code tabulation areas with a high proportion of Black or Hispanic residents tended to have better geographic access, defined as shorter distances, to both Rural Health Centers and Federally Qualified Health Centers compared to White populations, but those distances were still longer than urban minority populations.[55] However, in this study AI/AN populations had the poorest geographic access to Rural Health Centers and Federally Qualified Health Centers, with the longest distances, and areas with higher minority populations have been found to be more likely to have experienced a decline in Rural Health Centers compared to low-minority communities.[55,58]

The growing use of telemedicine has been hailed as a potential solution to help improve health care access and utilization, but evidence of a rural/urban and ethnic/racial digital divide has made equitable access to telemedicine challenging.[59] One study looking at the utilization of telemedicine amid the COVID-19 pandemic found that both adults living in rural areas and minority race/ethnicity groups were less likely to use telemedicine.[60] This may be due to the fact that ethnic minorities, particularly rural African Americans, report less access to a computer or laptop with high-speed internet, smartphone with a data plan, or any digital access compared to non-Hispanic Whites based on 2019 American Community Survey data.[61,62] According to one estimate, there are approximately 3 million people living in rural areas without adequate broadband access or healthcare, and these populations are geographically concentrated in the rural South, Appalachia, and the remote West.[63] In addition to the challenges of internet access in rural areas, telemedicine has limits in terms of the types of medical issues that can be addressed, such as physical exams or medical testing. Thus, if accessing health care in-person is too far or expensive for rural minority communities, then telemedicine can only do so much to meet the existing health care needs.

Other barriers to accessing health care include stigma and cultural practices inherent to the current health care system.[59] Among LGBTQ+ populations in rural areas, stigma around seeking mental health care was a concern.[59] In particular, transgender and gender-diverse individuals living in rural areas face numerous barriers to accessing health care, including systemic transphobia and lack of health care professionals with sufficient training in gender-affirming care.[64] Another instance where stigma around gender and sexual identity intersects with health care access is the current epidemic of HIV in the South which has shifted towards rural areas.[65,66] Rurality has been associated with lower availability of HIV testing, prevention education, and Pre-Exposure Prophylaxis, which leads to later HIV diagnosis, later adoption of antiretroviral therapy, and increased HIV-related mortality.[66,67] To give an example, in one national study, HIV testing rates were 66 percent for nonurban participants versus 88 percent for urban participants.[66] Additionally, on top of all the other challenges in health care access, there is also a lack of access to clinicians with HIV expertise.[66] Based on the most recent data from the Centers for Disease Control and Prevention (CDC), nearly half of all new HIV infections were in the Southern region of the U.S., and the most affected subpopulations were Hispanic/LatinX men and African American men who had male-to-male sexual contact.[65] Thus, individuals who have multiple minority identities coupled

with HIV diagnoses may experience even more significant stigma and discrimination in their interactions with the health care system, which may negatively impact their willingness to seek treatment or manage their health conditions.

Reproductive Health Care Access

The impacts of the reversal of *Roe v. Wade*, in terms of limiting access to reproductive health care, may be especially acute for minority women in rural areas. Pregnant and postpartum women in rural areas already experience worse health outcomes, with one study finding that rural women had a 9 percent greater probability of severe maternal morbidity and mortality compared to urban residents.[53] State abortion bans exacerbate existing workforce shortages based on location and specialty, with OB/GYN, trauma and emergency medicine, and primary care in rural areas being most adversely impacted.[68] Consequently, an increasing number of rural women travel long distances to see health care professionals and have more nonindicated induction and C-sections.[69] Moreover, areas with more abortion restrictions also have fewer social safety net and maternal and child health resources.[70,71] Minority women are thus seriously impacted by intersecting barriers to care including long travel distances and maternity care deserts, waiting periods, parental consent, and financial burden.[69,72,73]

Strategies to Improve Rural Minority Health

The challenges facing rural minority populations are immense, multigenerational and multifactorial, and as such require targeted investment and resources across multiple sectors. Reversing the health care professional shortages and trends in hospital closures in high minority rural areas would be an initial step but bolstering public health and preventive services would need to occur simultaneously. However, due to the historical and entrenched poverty in many rural minority communities, changes in available economic and housing opportunities, investment in education, improved environmental regulation and clean-up, as well as stronger occupational regulations would also be needed to reverse the historical and ongoing trauma of disinvestment and injustice.

There have been federal agency initiatives aimed at improving rural minority health disparities. In 2023, the National Institute on Minority Health and Health Disparities in the National Institutes of Health started an initiative to address gaps in scientific knowledge and support research that addresses multilevel and multiple domains influences related to health disparities experienced by people who live in rural communities.[74] In 2022, the Centers for Medicare & Medicaid Services published their Framework for Advancing Health Care in Rural, Tribal and Geographically Isolated Communities, which has six priority areas that aim to support, strengthen, and improve data collection efforts, health care professionals, health care coverage, as well as medical and communication technology in these communities.[75] Additionally, in 2023 the CDC established the Office of Rural Health and in 2024 published its Rural Public Health Strategic Plan, FY 2024-2029. The Strategic Plan has four key priorities: (1) advance results-based engagement with partners and communities to address rural public health challenges, (2) strengthen rural public health infrastructure and workforce, (3) advance rural public health science, and (4) improve rural public health preparedness and response capacity.[76] With all that being said, changes to federal priorities with the election of a new administration in 2024 may impact the existence or scope of these initiatives moving forward.

CURRENT AMA POLICY

There are over 20 existing AMA policies pertinent to rural health and health care. The most relevant, AMA Policy H-350.937, "Improving Healthcare of Minority Communities in Rural Areas," was adopted in parallel with this request for study. In addition to a study, the policy (1) encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to minority communities in rural areas; (2) encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas to improve their quality of life; (3) encourages the collection of vital statistics and other relevant demographic data of minority communities in rural areas; (4) states AMA will advise organizations of the importance of minority health in rural areas; (5) states AMA will channel existing policy for telehealth to support minority communities in rural areas, and lastly (6) encourages AMA's Center for Health Equity to support minority health in rural areas through programming, equity initiatives, and other representation efforts. AMA also recently adopted policy in 2024 (D-135.963) supporting access to water and adequate sanitation, water treatment, and environmental support and health services in AI/AN communities.[77]

CONCLUSION

Despite more limited data compared to urban minority populations, it is clear rural minority populations experience a disproportionate burden of adverse health outcomes compared to rural White populations or urban minority populations. Rural minority residents experience dual disparities and poor health outcomes as a result of intersecting structural and social determinants of health. There are also longstanding disparities in health care access within rural areas in general, which are compounded by additional barriers experienced by rural minority populations, including racial and ethnic segregation, limited transportation options, lower rates of health insurance coverage, poor internet and broadband coverage which limits the ability for expanded telemedicine, as well as stigma and discrimination.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That Policy H-350.937, "Improving Healthcare of Minority Communities in Rural Areas" be amended by addition and deletion to read as follows:

    1. Our American Medical Association encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to minority communities in rural areas.
    2. Our AMA encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life.
    3. Our AMA encourages the collection of vital statistics and other relevant demographic data of minority communities in rural areas.
    4. Our AMA will advise organizations of the importance of minority health in rural areas.
    ~~5. Our AMA will research and study health issues unique to minority communities in rural areas, such as access to care difficulties.~~

~~6.~~ 5. Our AMA will channel existing policy for telehealth to support improved broadband internet access in minority communities in rural areas to increase the availability of telemedicine where clinically appropriate.

~~7.~~ 6. Our AMA ~~encourages our Center for Health Equity to~~ supports minority health in rural areas through programming, equity initiatives, and other representation efforts.

7. Our AMA encourages the development of strategies and mechanisms for communities to share resources and best practices to serve their rural minority populations. (Modify Current HOD Policy)

2. That Policy H-135.905, "Furthering Environmental Justice and Equity H-135.905" be amended by addition and deletion to read as follows:

1. Our American Medical Association supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or those that have been impacted by other discriminatory development, loan servicing, and building practices with full participation by the community residents in these decisions.
2. Our AMA supports measures to protect frontline communities from the health harms of proximity to historical and current harmful industrial and mining operations, including fossil fuel extraction, refining and combustion, and large-scale agriculture, such as using the best available technology to reduce local pollution exposure ~~from oil refineries~~, or health safety buffers from ~~oil extraction~~ industrial operations.

Fiscal Note: less than $1,000

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