Journal of Law and Health

Volume 38 | Issue 1 Article

10-31-2024

COVID-19 and Access to Healthcare at the Crossing of Race, Poverty, and Rurality

Shavonnie R. Carthens
University of Kentucky J. David Rosenberg College of Law

COVID-19 AND ACCESS TO HEALTHCARE AT THE CROSSING OF RACE, POVERTY, AND RURALITY

By: Shavonnie R. Carthens*

ABSTRACT: *Black Americans make up 7.7 percent of the rural population in the United States.[1] During the COVID-19 pandemic many in this population found themselves at a unique intersection of inequity - being Black, poor, and residing in a rural area. Poverty is a known contributor to negative health outcomes and is a risk factor for death from coronavirus infection.[2] The association between race and poverty, when examining infectivity and mortality rates of COVID-19, have disproportionately devastated Black Americans and other minorities.[3] Further, research indicates the presence of a general "rural mortality penalty" wherein rural Black communities have higher death rates than similar communities in urban areas.[4] How does someone at the crossroads of these statuses fare when struggling with health care accessibility? The pandemic underscored a need for health equity discourse to continue exploring nuances within marginalized communities. This article argues that the COVID-19 public health crisis highlighted important omissions in public health discussions of healthcare access and health equity, notably that traditional ways of defining healthcare access falls short of capturing the lived experiences of Black, impoverished people living in rural communities. Instead law and policy responses, targeting healthcare access, must expand the definition of "access" to include "Healthcare Access+" factors that acknowledge the history, culture, and unique circumstances of rural Black communities.*

* Assistant Professor of Law, University of Kentucky, J. David Rosenberg College of Law. For helpful comments on an earlier draft of this article, I thank Professor Kimani Paul-Emile. I am also grateful to everyone cited within this piece who researched the impacts of the COVID-19 pandemic, during such a trying time for all.

[1] Kenneth Johnson & Daniel Lichter, *Growing Racial Diversity in Rural America: Results from the 2020 Census*, (May 2022), https://carsey.unh.edu/publication/growing-racial-diversity-in-rural-america.

[2] Maritza Vasques Reyes, *The Disproportional Impact of COVID-19 on African Americans*, HEALTH AND HUMAN RIGHTS JOURNAL (Dec. 2020).

[3] *Id*.

[4] Arthur Cosby, et al., *Growth and Persistence of Place-based Mortality in the United States: The Rural Mortality Penalty*, AMERICAN JOURNAL OF PUBLIC HEALTH (2019).

TABLE OF CONTENTS

INTRODUCTION

Although persons in rural communities often have worse health outcomes and less access to health care than those in urban communities, rural racial/ethnic minority populations have substantial health, access to care, and lifestyle challenges that can be overlooked when considering aggregated population data.[5]

On January 20, 2020 the Centers for Disease Control and Prevention ("CDC") reported the first confirmed case of the 2019 Novel Coronavirus (acute respiratory syndrome coronavirus 2(SARS-CoV-2))[6] in the United States.[7] On March 11, 2020, the World Health Organization ("WHO") declared the COVID-19 outbreak a Pandemic.[8] The next day, on March 12, 2020, a community in New Rochelle, New York, was declared to be a "containment area."[9] On March 16, 2020, a "shelter in place" order was issued for six counties in the San Francisco Bay Area.[10] States and local governments began to follow suit – closing schools, limiting grocery store occupancy, and preparing health systems to deal with quarantine and treatment measures. Many of us were glued to television screens and dealing with massive anxiety about the possibility of transmission, death rates, and the health of ourselves, our families, and friends.

We have learned many lessons from this life-changing event - from communicable disease awareness to healthcare access, and health inequities - the possibility of a pandemic still looms in our collective consciousness. Of the many lessons we learned during this event is an appreciation for the fact that although the COVID-19 Pandemic was a shared experience, distinct differences exist among U.S. residents around risk management and resilience depending upon where they were situated across geographic, racial, and economic strata. This post-Pandemic era affords us with a unique opportunity to assess lessons learned from these different experiences and evaluate the role that access to healthcare plays in one's ability to manage the COVID-19 virus, with specific attention given to the reality that a lack of access to healthcare drives health inequities. What many marginalized groups have always experienced, regarding healthcare access in America, was put on full display during the pandemic, with many groups enduring unequal health-related, economic, and social burdens. For example, individuals from poor, rural, and

---

[5] Cara V. James, et al., *Racial/Ethnic Health Disparities Among Rural Adults—US 2012–2015*, Centers for Disease Control and Prevention (2017).
[6] Quian Huang et al., *Urban-Rural Differences in COVID-19 Exposures and Outcomes in the South: A Preliminary Analysis of South Carolina*, PLOS ONE (2021).
[7] *COVID-19 Timeline*, DAVID J. SPENCER CDC MUSEUM, https://www.cdc.gov/museum/timeline/covid19.html.
[8] Lakshay Sood & Vanita Sood, *Being African American and Rural: A Double Jeopardy From COVID-19*, J. RURAL HEALTH (2021).
[9] Bill Chappell, *Coronavirus: New York Creates 'Containment Area' Around Cluster in New Rochelle*. NPR (March 10, 2020) https://www.npr.org/sections/healthshots/2020/03/10/814099444/new-york-creates-containment-area-around-cluster-in-new-rochelle.
[10] *See* Grant D. Jacobsen & Kathryn H. Jacobsen, *Statewide COVID-19 Stay-at-Home Orders and Population Mobility in the United States*, WORLD MED. & HEALTH POL'Y (2020).

minority backgrounds were disproportionately impacted by the virus.[11] As socio-economic status, race, gender, comorbidities,[12] geographic location, and other factors have long impacted health outcomes, so these factors also impacted one's ability to positively navigate the pandemic and rebound in its aftermath.[13] For example, in a study of urban-rural differences in South Carolina, researchers found that case rates and mortality rates were positively correlated with pre-existing social vulnerabilities.[14] Rural communities experienced compounding disparity factors such as limited health care,[15] fewer testing sites, transportation deficits, and cultural perceptions of health.[16]

Healthcare access challenges experienced by minorities in rural communities did not have their genesis in the pandemic. A closer look at rural, impoverished, and minority communities, reveals a history of inequities related to health and specifically the importance of healthcare access. Approximately one in five Americans live in rural America.[17] Individuals in rural communities have historically experienced poorer health than those living in urban areas.[18] Though a smaller swath of the rural landscape, there is also a growing minority population in rural America.[19] There are approximately 3.5 million non-Hispanic Black people living in rural America,[20] who faced worse health outcomes than their white rural counterparts during the COVID-19 pandemic.[21] Early in the pandemic the daily increase in the COVID-19 mortality rate was significantly higher in rural counties with the highest percent Black and percent Hispanic populations.[22]

To get to the heart of why Black residents have a history of health struggles, that both pre-date and extend beyond the COVID-19 pandemic, policy makers must be concerned with a wide range of health inequity data points from both academic and community-based research. From a health status perspective, some of these communities experienced poor health based on not only their proximity to healthcare services but also

---

[11] Don Bambino et al., *The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States*, CLINICAL & INFECTIOUS DISEASES (2021).
[12] John M. Carethers, *Insights into Disparities Observed With COVID-19*, J. OF INT'L MED. (2020).Underlying medical conditions that have been identified as risk factors for severe illness from the COVID-19 virus include hypertension, obesity, diabetes, and cardiovascular diseases.
[13] Bambino, *supra* note 12.
[14] *See* Huang, *supra* note 6.
[15] Gopal Singh and Mohammad Siahpush, *Widening Rural–Urban Disparities in Life Expectancy, U.S., 1969-2009*, AM. J. OF PREVENTATIVE MED. (2014).
[16] *See* Huang, *supra* note 6.
[17] *See What Is Rural America*? U.S. CENSUS BUREAU (2017). https://www.census.gov/library/stories/2017/08/rural-america.html. When using the term "rural" I am referring to census data via the United States Census Bureau. I also refer to studies that rely on census data and other sources.
[18]Jonathon P. Leider et al., *The State of Rural Public Health: Enduring Needs in a New Decade*, J. AM. J PUB. HEALTH (2020).
[19] *See generally* Kenneth Johnson & Daniel Lichter, *Growing Racial Diversity in Rural America: Results from the 2020 Census*, UNIVERSITY OF NEW HAMPSHIRE CARSEY SCHOOL OF PUBLIC POLICY 449 (2022), https://scholars.unh.edu/carsey/449.
[20] *Id*.
[21] Kent Jason G. Cheng et al., *COVID-19 Death Rates Are Higher in Rural Counties with Larger Shares of Blacks and Hispanics*, 36 J. OF RURAL HEALTH 602, 608 (2020).
[22] *Id*.

due to a history of racism and medical mistrust,[23] environmental hazards,[24] a lack of health literacy,[25] and history that are unique to this community.[26] As a result, it is important to continually engage in the process of evaluating how we collectively understand healthcare access as a socio-legal concept. Policymakers must take this broader look to address future public health emergencies. The need to consider the future, in terms of our ability to rebound from these events, is particularly important for Black, impoverished, rural communities that are most immediately and detrimentally impacted- those for whom collective resilience was lacking from the outset. Policymakers must be receptive of this complexity and understand that healthcare access remedies, in practice, may vary depending upon the convergency of different inequity markers.

This article introduces the concept of "Healthcare Access+," which addresses critical omissions in pandemic-era and current discussion of healthcare access, markedly the erasure of Black experiences in conversations that center rurality; and allows for more robust legal and policy responses that target healthcare access in a manner that is inclusive of rural Black communities. This article argues: (1) that the COVID-19 public health crisis highlighted important omissions in public health discussions of healthcare access and health equity, notably that traditional ways of defining healthcare access falls short of capturing the lived experiences of Black, impoverished people, living in rural communities; and (2) that law and policy responses targeting healthcare access, must expand the definition of "access "to include "Healthcare Access+" factors that uncover additional touchpoints important for developing policy that acknowledges health disparities that hinder the ability of some residents to survive public health crises, an d rebound in their aftermath.

Part I provides an overview of the health outcomes and disparities present in rural American pre-COVID-19 pandemic. Part II then offers a survey of outcomes of inequities experienced by rural communities during the pandemic, specifically using COVID-19

---

[23] Andrea Smith et al., *An Investigation of Associations Between Race, Ethnicity, and Past Experiences of Discrimination with Medical Mistrust and COVID-19 Protective Strategies*, J. OF RACIAL AND ETHNIC HEALTH DISPARITIES (2022). Medical mistrust is a general term that captures a range of mistrust of medical institutions generally or mistrust related to a specific context such as the COVID-19 pandemic. Studies show greater levels of medical mistrust among Black and Latinx communities as compared to white communities.; *see also* Ebony L. Boulware et al., *Race and Trust in the Health Care System*, PUB. HEALTH REP. (2003).

[24] Stuart McIntyre and Graeme Roy, *Revisiting the Dimensions of Rural Resilience: The COVID-19 Pandemic*, J. RURAL STUD. (2023). Rural communities may face difficulties in recovering from crises periods due to social, economic, and environmental resilience issues. Some of the environmental issues stem from relationships between rural communities and extractive industries in these communities.

[25] Barry D. Weiss & Michael K. Paasche-Orlow, *Disparities in Adherence to COVID-19 Public Health Recommendations*, HLRP: HEALTH LITERACY RSCH. & PRACTICE (2020). In addition, health messaging about COVID-19 was confusing and ever changing. This impacted the dissemination and use of health information.

[26] *See generally* Valire Carr Copeland, *African Americans: Disparities in Health Care Access and Utilization*, HEALTH & SOCIAL WORK (2005); see also Barbara Ann Graves et al., *Community-based Participatory research: Toward Eliminating Rural Health Disparities*, ONLINE J. RURAL NURSING & HEALTH CARE (2015).

outcomes to illustrate how the differences in healthcare access and outcomes among the general rural population often diverge from the experiences of Black rural residents during the pandemic. Part III critiques legal and policy solutions geared toward addressing healthcare access inequities and gaps in legal responses during the COVID-19 pandemic, along with limitations on those actions. Part IV identifies "Healthcare Access+" factors that contributed to the heighted inequities experienced by rural Black people during the pandemic and which should be considered as precursors to policymaking aimed at combating public health crises. This section argues that acknowledging "Healthcare Access+" enables law and policy to respond more effectively to healthcare access concerns among Black residents in rural America.

I. HEALTHCARE ACCESS AND INEQUITIES IN RURAL AMERICA PRE-COVID-19 PANDEMIC

Approximately 97% of the land in the U.S. is categorized as "non-metropolitan" areas[27] and 20% of these areas are considered "rural,"[28] containing roughly one-fifth of the U.S. population.[29] Studies show that prior to the pandemic, rural residents faced several health-related challenges, including opioid drug use,[30] long-term poverty,[31] lack of broadband access,[32] lack of housing[33] and transportation,[34]

---

[27] Alfred J. Anzalone et al., *Higher Hospitalization and Mortality Rates Among SARS-CoV-2-infected Persons in Rural America*, THE JOURNAL OF RURAL HEALTH 39.1 (2023).

[28] *Id*.

[29] *See generally* United States Government Accountability Office, *Health Care Capsule: Accessing Health Care in Rural America,* (May 16, 2023), https://www.gao.gov/products/gao-23-106651#:~:text=Fewer%20health%20care%20providers%2C%20which,limits%20access%20to%20telehealth%20services.

[30] Jamey J. Lister et al., *A Systematic Review of Rural-Specific Barriers to Medication Treatment for Opioid Use Disorder in the United States*, AM. J. DRUG & ALCOHOL ABUSE (2020). The authors discuss the opioid crises in rural communities noting a rise in deaths in rural communities. Further, there can be a lack of medical providers and other treatment delivery mechanisms in rural communities.

[31] *See generally* Jonathon P. Leider et al., *The State of Rural Public Health: Enduring Needs in a New Decade*, AM. J. PUB. HEALTH (2020). From 2005-2017 low-income rural areas had slower reductions in mortality than low-income urban areas.

[32] *See* Betsy Lawton, *COVID-19 Illustrates Need to Close the Digital Divide* (February 15, 2021). Scott Burris et al., *COVID-19 Policy Playbook: Legal Recommendations for a Safer, More Equitable Future*, BOSTON: PUB. HEALTH LAW WATCH (2021). The digital divide is a term that describes the reality that millions of individuals do not have broadband service at home. Some individuals cannot afford broadband access and in some areas broadband is not available. People without access are impacted in classrooms, jobs, social supports, and telehealth services.

[33] *See* Morgan Montañez, *Nowhere Else to Go: Housing Insecurity in a Hispanic-Majority Rural County During the Covid-19 Pandemic*, AM. RURAL SOCIOLOGICAL SOC'Y (2024).

[34] *See* Thomas A. Arcury et al., *Access to Transportation and Health Care Utilization in a Rural Region*, J. RURAL HEALTH (2005). This article examines the association between transportation and healthcare among 12 western North Carolina counties.

fewer hospitals and medical professionals,[35] and lower wages, among other ills, which can be attributed to a multitude of compounding factors that have increased health disparities within this population.[36] Before adding the layer of race to the healthcare access equation in rural America, this section offers an umbrella analysis of the greater picture of rural health outcomes.

A. General Health Outcomes for Residents in Rural America

Although "rurality" as a characteristic is not the only measure of the presence of health disparities among Americans, troubling health outcomes and inequities in rural communities have been well-documented since the early 20th century,[37] including infectious disease burdens, maternal and child heath, healthcare access, and racial inequities, present early in the literature.[38] Further, it is well documented that there are disparities in social determinants of health, health status, health care access, disease prevalence, morbidity, and mortality in rural America.[39] Indeed, rural residents have higher all-cause mortality rates than urban residents.[40]

Studies reveal that chronic disease and mortality differences between rural and urban populations shifted during the late 20th century.[41] Before 1990 the mortality differences between urban and rural communities, were similar, but today, mortality rates in the rural U.S. exceed such rates in urban communities, even after adjusting for age.[42] Known as the "nonmetropolitan penalty"[43] this divergence became most noticeable after the acceleration of this morality gap post-1999.[44] For example, coronary heart disease mortality rates decreased in urban areas from 1999-2009, yet they remained constant in rural areas.[45] There is also a widening gap with respect to higher rural preventable deaths.[46] Rural residents are more likely to die from highly preventable diseases than those in urban settings.[47] Various factors that have contributed to this "nonmetropolitan penalty" including, but not limited

---

[35] *See* Maura Kelly, *The Crisis in Rural America: Rural Hospitals Are Closing at an Unprecedented Rate—and Residents Are Dying for Lack of Access. Will Policymakers Step In?* ANNALS OF EMERGENCY MEDICINE (2020).
[36] *See* Leider, *supra* note 19; *see also* Shelia Mammen et al., *Rural Low-income Families' Quest for Economic Security: It Takes More Than a Paycheck*, FAMILY SCIENCE REVIEW (2017).
[37] *See* Anzalone, *supra* note 26.
[38] *See* Erika Ziller & Carly Milkowski, *A Century Later: Rural Public Health's Enduring Challenges and Opportunities*, AM. J. PUB. HEALTH HIST. (2020).
[39] *Id*.
[40] Jeralynn S. Cossman et al., *Underlying Causes of The Emerging Nonmetropolitan Mortality Penalty*, AM. J. PUB. HEALTH, 100 (2010).
[41] *Id*.
[42] *See* Anzalone, *supra*, note 26.
[43] *Id*.
[44] *Id*.
[45] Adam R. Roth, Justin T. Denney, et al., *Characteristics of Place and the Rural Disadvantage in Deaths from Highly Preventable Causes*, SOCIAL SCIENCE & MED., (2020) (citing Ambar Kulshreshtha et al., *Urban Rural Differences in Coronary Heart Disease Mortality in the United States: 1999–2009* PUB. HEALTH REP. 129 (2014)).
[46] Ziller, *supra* note 43 at 1 (citing Macarena Garcia et al., *Reducing Potentially Excess Deaths From the Five Leading Causes of Death in the Rural United States*, MMWR: SURVEILLANCE SUMMARIES (2017)).
[47] *See* Roth, *supra* note 51.

to, poverty, unemployment, lower education attainment levels, and limited access to healthcare.

B. Causes of Healthcare Access Deficits in Rural America

The many layered causes of health disparities among rural residents are too many to discuss in one article, thus this section highlights some of the interlocking factors contributing to these disparities, with a focus on healthcare access.

1. Geographic Proximity to Healthcare Facilities and Services

A lack of geographic access to healthcare is a chief contributor to health disparities among rural residents.[48] Having access to a hospital[49] or specialized care[50] is important for maintaining health or resolving health issues during a public health emergency.[51] Rural areas saw around 4% of their hospitals close from 2012 through 2020.[52] During the past decade over 128 rural hospitals have closed, and several others are not financially sound.[53] Some rural residents have to travel about 20 miles farther than their urban counterparts for common services like inpatient care.[54] Relatedly, a reduction in facilities naturally reduces the number of care providers. As of September 2022, 65.6% of primary care "Health Professional Shortage" areas were in rural areas.[55] Other services that are difficult to access in rural areas include preventive services, home health services, palliative care, and mental health services.[56] The COVID-19 pandemic only spotlighted deficits within these rural healthcare systems.[57] Location-based inequality has detrimental health impacts because lower healthcare supply leads to lower healthcare access and degraded health outcomes.[58]

Geography not only impacts rural residents, but it also impacts the surrounding healthcare workforce. Rural areas may not be able to attract qualified workers to serve this

---

[48] *Id*. One study found that having one or more specialist visits during the previous year was associated with 16.6% lower mortality for those with chronic conditions. Among counties with shortages in primary care 56% are in nonmetropolitan areas.
[49] United States Government Accountability Office, *supra* note 30.
[50] *Id*.
[51] *Id*.
[52] *Id*; *see Kenton* Johnston et al., *Lack of Access to Specialists Associated with Mortality and Preventable Hospitalizations of Rural Medicare Beneficiaries*, HEALTH AFFAIRS (2019); *see also* Gopal Singh & Mohammad Siahpush, *Widening Rural-Urban Disparities in All-Cause Mortality and Mortality from Major Causes of Death in the USA*, *1969-2009*, J. URBAN HEALTH (2014).
[53] Adrian Diaz, Karan R. Chhabra & John W. Scott, *The Covid-19 Pandemic and Rural Hospitals – Adding Insult to Injury*, HEALTH AFFAIRS, (May 3, 2020).
[54] *See* Erin Pullen & Carrie Oser, *Barriers to Substance Abuse Treatment in Rural and Urban Communities: Counselor Perspectives*, SUBSTANCE USE & MISUSE (2014). Rural residents travel farther to access services such as alcohol and drug misuse treatment.
[55] *See generally Healthcare Access in Rural Communities Overview*, RURAL HEALTH INFORMATION HUB, https://www.ruralhealthinfo.org/
[56] *Id*.
[57] *See* Anzalone, *supra* note 26 at 40.
[58] David Litaker, Sirian Koroukian, & Thomas Love et al., *Context and Healthcare Access: Looking Beyond the Individual*, MED CARE (2005); *see also* Barbara Starfield, Leiyu Shi, & James Macinko, *Contribution to Primary Health Systems and Health*, MILLBANK QUARTERLY (Oct. 3, 2005).

population[59] and therefore lack services provided by primary care physicians such as family doctors, pediatricians and internists.[60] Because there is a worker shortage rural nonuse of healthcare workforce is the best measure of staffing insufficiencies. [61] This nonuse measure that suggests that employment impacts not only relate to healthcare affordability, but also availability. Even residents able to afford care may be unable to access it due to their inability to secure care in an area that is generally impoverished and lacks a robust health care workforce.

2. Socio-economic Status

Poverty is married to health inequities among rural populations. Socio-economic status directly impacts health and mortality,[62] and rural counties, particularly in the South, have higher poverty rates than many urban counties .[63] Rural communities are also among the poorest in the nation, suffering from a lack of employment opportunities.[64] For example, in a study of poverty in rural and urban Pennsylvania counties, investigators noted that rural areas experienced 25% more poverty than urban ones in general. Pennsylvania was not exception to the rural-urban divide.[65] Ever-present financial barriers mean that rural residents do not have the financial capacity to pay for health services, even if they were available.[66]

Moreover, a lack of healthcare insurance among rural residents exacerbates access concerns. Uninsured rural residents face greater challenges when attempting to access care, due to limited supplies, when compared with urban residents due to the limited number of insurers operating in rural areas.[67] Studies show that rural populations are less likely to have insurance than urban populations.[68] Notably, in one study rural adults in Kentucky lacked insurance for specific categories of coverage including vision care, dental care, mental health, and drug abuse treatment.[69]

---

[59] Carole R. Berini, Heather S. Bonilha, & Annie N. Simpson, *Impact of Community Health Workers on Access to Care for Rural Populations in the United States: A Systematic Review*, CMTY HEALTH (2022).
[60] Nathan Douthit et al., *Exposing Some Important Barriers to Health Care Access in the Rural USA*, PUB. HEALTH (2015).
[61] Rural Health Information Hub, *supra* note 61.
[62] J. C. Phelan et al., *Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications*, J. HEALTH SOC. BEHAV. (2010).
[63] Yoshie Sano & Shelia Mammen, *Mitigating the Impact of the Coronavirus Pandemic on Rural Low-Income Families*, J. FAM & ECON. ISSUES (2022).
[64] Rural Health Information Hub *supra*, note 61.
[65] Angel Alcantara, Stephanie M. Brewer, & James J. Jozefowicz, *Rural-Urban Differences in Poverty: An Analysis of Pennsylvania Counties*, INT'L J. ECON. & FIN. ISSUES (2023).
[66] Rural Health Information Hub, *supra* note 61.
[67] Rural Health Information Hub (citing Kaiser Family Foundation, *Affordable Care Act Insurance Coverage in Rural Areas* (2014)).
[68] Ning Lu et al., *Rural-Urban Differences in Health Insurance Coverage and Patterns Among Working-Age Adults in Kentucky*, J. RURAL HEALTH (2010).
[69] Lu, *supra* note 74.

This lack of insurance coverage is directly impacted by affordability issues in rural areas,[70] with states that that did not expand Medicaid having higher levels of uninsured populations.[71] Average premiums from 2014 to 2018 were more expensive in rural communities, whose residents paid higher premiums than urban counties, and rural counties were more likely to have only one insurance issuer participating in the health insurance marketplace ("HIM").[72] A brief from the Department of Health and Human Services noted that 26.5% of uninsured rural residents delayed receiving healthcare in the previous year due to cost.[73] This directly effects the extent to which rural residents seek care. Further, rural residents may struggle to access health insurance and services due to having low health insurance literacy.[74] In rural communities, such as rural Appalachian communities, cultural and linguistic supports for health insurance decision-making may not be available.[75]

Transportation services may also be limited or located at a distance, adding additional costs to those seeking healthcare.[76] Transportation, as a part of one's neighborhood and built environment, is a social determinant of health,[77] and as an overall health matter, transportation habits impact one's health.[78] Residents of rural areas are often forced to travel long distances for healthcare services, especially specialist services.[79] A lack of transportation compounds financial challenges as illustrated when rural residents seek health services at long distances, incurring additional expenditures associated with the actual travel and missing work.[80]

---

[70] *See* Catherine A. Okoro et al., *Lack of Health Insurance Among Adults Aged 18 to 64 Years: Findings From the 2013 Behavioral Risk Factor Surveillance System*, U.S. Centers for Disease Control & Prevention (2015), https://www.cdc.gov/pcd/issues/2015/15_0328.htm.
[71] *Id*.
[72] Abigail R. Barker, et al., *Health Insurance Marketplaces: Issuer Participation and Premium Trends in Rural Places*, RURAL HEALTH INFORMATION HUB (2018), https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/HIM%202018%20Issuer%20Participation.pdf (citing RUPRI Center for Rural Health Policy Analysis Policy).
[73] Rural Health Information Hub, (citing United States Department of Health and Human Services, *Brief from the Assistant Secretary for Planning* (2024), https://www.ruralhealthinfo.org/topics/healthcareaccess#:~:text=The%20June%202016%20issue%20brief,than%20the%2052.6%25%20of%20uninsured.
[74] *See* Jean Edward, Robin Thompson, & Andrea Jaramillo, *Availability of Health Insurance Literacy Resources Fails to Meet Consumer Needs in Rural, Appalachian Communities: Implications for State Medicaid Waivers*, J. RURAL HEALTH (2020). Health insurance literacy is defined by an individual's ability to seek, obtain, and use health insurance. This type of literacy plays a role in one's ability to access coverage and health care. It is estimated that over half of the American population does not understand the basic health insurance terms such as "deductible," "copay," and premium."
[75] *Id*.
[76] Rural Health Information Hub, *supra* note 61.
[77] Carrie Henning-Smith et al., *Geographic Variation in Transportation Concerns and Adaptations to Travel-Limiting Health Conditions in the United States*, JOURNAL OF TRANSPORT & HEALTH (2018).
[78] *Id*.
[79] Rural Health Information Hub, *supra* note 61.
[80] *Id*.

Socio-economic status also diminishes access to services, such as broadband access. As a result, the rise of telehealth services[81] has not been a true salve for the lack of healthcare access in rural communities.[82] The use of telehealth services was on the rise prior to the COVID-19 pandemic and dependency on online services only grew at the beginning of 2020.[83] However, rural residents were and remain nearly two times more likely to lack broadband access than those living in urban areas.[84] In 2019, 7% of people in metropolitan areas did not have access to internet at home, but the percentage jumped to 13% of those in nonmetropolitan areas.[85] Even the small number of rural residents fortunate enough to enjoy broadband services may experience slow internet speeds,[86] which impedes their ability to take meaningful advantage of telehealth services.[87]

3. Lifestyle Factors and Education

Lifestyle and behavioral differences also contribute to negative health outcomes among rural communities. Compared to urban residents, including low-income urban residents, the inhabitants of rural areas are more likely to abuse alcohol and opioids resulting in alcohol-related behavior and overdose.[88] Rural areas have experienced overdose-related deaths passing the urban death rate in 2015.[89] This led the White House to declare a Public Health Emergency calling for expanded treatment for opioid use disorder (OUD) in rural communities.[90]

Rural residents also face higher levels of mental illness,[91] attributed, in part, to reduced access to mental health and emergency medical services,[92] and shortages of mental health specialists, hospitals and facilities located at great distances, and the social stigma attached

---

[81] *See* Kendall Cortelyou-Ward et al., *Navigating the Digital Divide: Barriers to Telehealth in Rural Areas*, J. HEALTH CARE FOR THE POOR & UNDERSERVED (2020).
[82] Government Accountability Office, *Why Health Care Is Harder to Access in Rural America* (2023), https://www.gao.gov/blog/why-health-care-harder-access-rural-america. As of 2019, at least 17% of people living in rural areas lacked broadband access. Only 1% of residents in urban areas lack broadband access.
[83] Rural Health Information Hub, *supra* note 61.
[84] Krutika Amin et al., *How Might Internet Connectivity Affect HealthCare Access?*, *Peterson* Center on Healthcare and Kaiser Family Foundation (2020), *https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access/*.
[85] *Id*.
[86] Rural Health Information Hub, *supra* note 61.
[87] *See* Lawton, *supra* note 36.
[88] John Gale et al., *Behavioral Health in Rural America: Challenges and Opportunities*, Rural Policy Research Institute (RUPRI) (2019), https://rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf.
[89] *See* Lister, *supra* note 34.
[90] Department of Health and Human Services, *HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis* (2017), https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html.
[91] Shelia Mamment & Yoshie Sano, *Rural, Low-Income Families and their Well-Being: Findings from 20 Years of Research*, FAMILY SCIENCE REVIEW (2018).
[92] M.S. Martin, et al., *Food Insecurity and Mental Illness: Disproportionate Impacts in the Context of Perceived Stress and Social Isolation*, PUB.HEALTH (2016).

to mental illness.[93] According to the Health Resources & Services Administration data the majority of Mental Health Professional Shortage Areas are in rural communities.[94]

Education attainment is a social determinant of health and lower mortality rates are associated with higher education attainment.[95] Rural areas have lower levels of education attainment in general, which is linked to lower health outcomes.[96] For example, low educational attainment is associated with higher all-cause and cardiovascular mortality in United States adults.[97] Relatedly, rural residents often have not developed a workable level of health literacy. If "knowledge is power," then a lack of knowledge in the form of health literacy leaves rural residents at a disadvantage, making it difficult for them to understand health information, directives from their providers, or the risks associated with health conditions.[98] It may also be challenging for those with low health literacy to navigate healthcare systems.[99] The reception and digestion of information may also be difficult because the channels used to communicate information and explanation of content may not be sufficient for rural populations.[100] A two-part series published in a 2002 edition of the *Rural Monitor* identifies rural inequities around health literacy and information sharing, noting that the jargon associated with medicine and the terminology use by healthcare professionals may be foreign to rural patients, creating create barriers to understanding.[101]

II. HEALTHCARE ACCESS, OUTCOMES, AND INEQUITIES AMONG RURAL UNITED STATES RESIDENTS DURING COVID-19

Using the COVID-19 pandemic as a backdrop, this section explores health inequities in rural communities, including health outcomes for rural Black communities.

---

[93] Yoshie Sano, et al., *Maternal Depression and Family Health Context: Tracking Depression Trajectories of Rural, Low-income Mothers*, J. FAMILY SOC. WORK (2020), https://doi.org/10.1080/10522158.2019.1709244.
[94] *See e.g.* Michael Hendryx, *Mental Health Professional Shortage Areas in Rural Appalachia*, JOURNAL OF RURAL HEALTH (2008).
[95] Najah Khan et al., *Low Educational Attainment Is Associated With Higher All-Cause and Cardiovascular Mortality in the United States Adult Population*, BMC PUBLIC HEALTH (2023).
[96] *See generally* Rural Health Information Hub, *supra* note 61.
[97] Khan, *supra* note 101.
[98] *Id*.
[99] *Id*.
[100] *Id*.
[101] *Id.* (citing Kay M. Temple, *A New Era of Health Literacy? Expanded Definitions, Digital Influences and Rural Inequities* (Feb. 2, 2022), https://www.ruralhealthinfo.org/rural-monitor/digital-health-literacy); *see also* The Office of Disease Prevention and Health Promotion (ODPHP), *Health Literacy in Healthy People 2030*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030. The Health People 2023 Plan now divides "health literacy: into two definitions. The first definition is "personal health literacy," which is "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others". The second definition is that of "organizational health literacy," which is "the degree to which organizations *equitably enable* individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others."

A. Rural Health Outcomes During the COVID-19 Pandemic

The gap in mortality outcomes was particularly remarkable in the rural population during the COVID-19 pandemic.[102] Even when compared to pre-COVID rural gaps, one study showed that there was an even greater gap between rural and urban dwellers hospitalized for COVID-19 infection.[103] This data indicates that public health emergencies might heighten states of disparity among rural populations.

In retrospect, early findings from the pandemic suggested that metropolitan areas experienced higher mortality rates than rural areas, but later studies yielded different results.[104] Infection clustering and mortality rates were higher in rural areas of the United States.[105] The National COVID Cohort Collaborative (N3C) data, for example, illuminates the extent to which the pandemic increased the gap between rural and urban health outcomes,[106] observing that people in rural areas were significantly more likely than urban areas to be hospitalized with COVID, even after adjusting for geographic differences and comorbidities.[107] Proximity to urban areas significantly affected COVID-19 hospitalization and mortality rates.[108] Residents in rural communities near urban areas were 18% more likely to be hospitalized, while those who lived far away from urban areas were 29% more likely to be hospitalized.[109] Moreover, rural residents, of any geographic distance from urban areas, were 36% more likely to die within 90 days after Covid-19 hospitalization.[110]

There are many reasons for this widened emergency gap, including the ability of rural health care systems to respond to the COVID-19 pandemic,[111] and their limited access to intensive care beds, limited access to infectious disease providers and other specialty care providers.[112] Not surprisingly, this geographic distance also makes accessing health care more difficult.[113]

---

[102] Anzalone, *supra* note 26.
[103] Anzalone, *supra* note 26 at 48.
[104] *Id*.
[105] National Institutes of Health, *N3C Data Reveal More Severe COVID-19 Outcomes in Rural Communities*, NATIONAL CENTER FOR ADVANCING TRANSLATIONAL SCIENCES (last visited Nov. 29, 2023), https://ncats.nih.gov/news-events/news/n3c-data-reveal-more-severe-covid-19-outcomes-in-rural-communities. The authors relied on data from the National COVID Cohort Collaborative (N3C), a National Institute of Health-supported data enclave containing electronic health record information. The goal of this study was to (1) to estimate differences in hospitalization and mortality among rural and urban individuals within COVID-19 infection using data adjusted for underlying demographic differences, and comorbid burden and (2) quantify differences in rural outcomes based on region and degree of rurality. The cohort included patients diagnosed between January 1, 2020, and June 30, 2021.
[106] *Id*. The N3C researchers examined patient health records from every U.S. state, representing 44 health systems, between January 2020 and June 2021. They compared COVID-19 related hospitalization and mortality rates of people in rural areas compared to people in rural areas.
[107] *Id*.
[108] *Id*.
[109] *Id*.
[110] *Id*.
[111] Anzalone, *supra* note 26.
[112] Anzalone, *supra* note 26.
[113] *Id*.

Rural residents also struggled to secure needed medical care, during a time when 4.7 million rural residents lived in counties where there was no general medical or surgical hospital beds.[114] This was especially troubling during the COVID-19 pandemic when early intervention was critical for not only positively impacting individual outcomes, but also in spread to the community.[115]

The working and living environments of residents compounds the difficulties faced by rural populations during the pandemic. The labor for agriculture, meat processing, and other food processing industries was provided largely by rural residents.[116] The meat packing industry remained open during the pandemic but did not adjust to incorporate best health-based practices. Detrimentally, some states with Occupational Safety and Health Administration approved plans did not sufficiently equip plant workers with needed protections.[117] The meat packing industry also imposed penalties for missing work, and workers were encouraged to continue working despite risks.[118] Moreover, approximately 70% of prisons were also located in rural communities, and infection could spread quickly through this population.[119]

Consistent with pre-COVID evidence, rural populations entered with pandemic with significant health challenges as they were more likely to be older[120] poorer, and more likely to become sick if infected.[121] Rural residents were more likely to have conditions associated with severe COVID-19 and death,[122] and those with preexisting acute conditions suffered significantly more negative health effects.

In addition, rural residents were less likely to engage in behaviors that helped prevent COVID-19 infection and were more likely to have conditions associated with severe COVID-19 and death.[123] These comorbidities include obesity, age, and diabetes.[124] These residents have also experienced more disparity in life expectancy over the last 50 years.[125] Bleakly, rural residents' lower levels of educational attainment, poverty and unemployment,[126] and other social determinants of health aggravated their ability to

---

[114] Diego F. Cuadros et al., *Dynamics of the COVID-19 Epidemic in Urban and Rural Areas in the United States*, ANNALS OF EPIDEMIOLOGY (2021).
[115] Eva Clark et al., *Disproportionate Impact of the COVID-19 Pandemic on Immigrant Communities in the United States*, PLOS NEGLECTED TROPICAL DISEASES (2020).
[116] Sano, *supra* note 99.
[117] Shauhin A. Talesh, *Racial Inequality, COVID-19, and Health and Unemployment Insurance: Lessons Learned and Pathways Forward*, DEPAUL L. REV. (2022). Racial minorities contracted COVID-19 in disproportionately high rates in "hotspot" areas such as New York City, Milwaukee, Louisiana, and Chicago.
[118] *Id*.
[119] *Id*.
[120] Stacy Weiner, *Rural and at Risk for Covid-19*, AAMC News (May 14, 2020), https://www.aamc.org/news/rural-and-risk-covid-19.
[121] Sano & Mammen, *supra* note 47.
[122] Anzalone, *supra* note 26.
[123] *Id*.
[124] *Id*.
[125] *Id*. This study noted that the cohort noted that rural populations had higher rates of comorbidities across 14 of the 15 comorbidity categories and had higher rates of obesity.
[126] Anzalone, *supra* note 26 at 50.

experience positive COVID-19 health outcomes.[127]

B. Health Outcomes Among Black Residents in Rural America Pre-COVID-19 Pandemic

Why examine the cross-section between rurality, poverty, and race? The simple answer is that this nexus deserves more targeted attention if any progress is to be made in addressing healthcare access and other inequities experienced by this population. This simple answer, however, belies a more complex reality: while Black rural residents share the inequities experienced by the larger white rural population, race adds additional burdens when assessing health outcomes in the United States.[128] Consequently, strides in addressing health inequities among Black Americans in rural America have not yielded the progress that is needed. By way of illustration, studying the impact of COVID-19 among Black Americans in [the rural South] is particularly important because Southern states were among the last to shut down and the first to reopen and had fewer pandemic-related restrictions relative to other areas of the United States.[129]

Many of the health disparities that existed among rural Black populations were noted in the early part of the 20th Century remain present today.[130] When speaking to the National Medical Association in 1917, D.W. Byrd noted that Black infant and maternal mortality was twice as that of whites.[131] Sadly, over 100 years later in 2020, researchers found that Black infants have the highest rates of adverse birth outcomes, including preterm birth and mortality.[132] Research has also shown that Black people experience lower life expectancy, experience elevated levels of high blood pressure, and receive fewer flu vaccines than white residents in rural areas.[133] Mortality rates signify further inequities experienced by Black rural populations. Data on mortality rates between 1999 and 2018 in rural and urban areas for Black and white people aged 25 and older,[134] show that for four conditions -- heart disease, diabetes, high blood pressure, and stroke --- Black adults in both rural and urban areas had consistently higher death rate for all four diseases when compared to white adults, with the highest mortality rates found in Black adults residing in rural areas.[135]

---

[127] *Id*.
[128] Shauhin, *supra* note 117.
[129] Olutosin Adesogan et al., *COVID-19 Stress and the Health of Black Americans in the Rural South*, CLIN PSYCHOL SCI. (2022).
[130] Veronica Gillispie-Bell, *The Contrast of Color: Why the Black Community Continues to Suffer Health Disparities*, OBSTETRICS & GYNECOLOGY (2021).
[131] *Id*. (citing D.W. Byrd, *Maternity and Infant Mortality*, J. NAT'L MED. ASSOCIATION (1917).
[132] Veni Kandasamy et al., *Regional Variation in Black Infant Mortality: The Contribution of Contextual Factors*, PLOS ONE (2020).
[133] Kimberly Drake, *Black People in Rural Areas Continue to Experience Health* Disparities, MEDICAL NEWS TODAY (APRIL 6, 2021), https://www.medicalnewstoday.com/articles/black-people-in-rural-areas-continue-toexperience-health-disparities. Drake cited researchers from the Beth Israel Deaconess Medical Center who used data from the Centers from Disease Control and Prevention. They used the CDC WONDER databases to compare annual mortality rates between Black and white adults.
[134] *Id*.
[135] *Id*.

C. Healthcare Outcomes for Rural Black Communities During the COVID-19 Pandemic

Although improvements have been made in health outcomes in recent decades, the progress is not as prominent in low-income, Black or Native American, or in certain areas of the country,[136] and this can be attributed, in part, to an emphasis in rural health policy and discourse on the white working class, which tends to erase the non-white rural population that accounts for approximately 25% of the rural population.[137] Not only has modern research been criticized for failing to acknowledge the complexities of rural communities, including differences in racial and ethnic characteristics and outcomes,[138] modern policy responses should be more informed by these equity-based subtleties as well.

Black populations inhabit the same spaces as rural white residents, but they bare an even greater healthcare disparity burden, including clear adverse consequences related to COVID-19 hospitalization and mortality. In the early days of the pandemic in 2020, COVID transmission rose in Black, Latinx, and Native American communities.[139] Members of these communities were three times more likely to be hospitalized and twice as likely to die from COVID-19 as white, non-Hispanic people.[140] In 2020, for example, Oklahoma, which is largely rural, documented the highest hospitalization rates for African Americans and the lowest for whites.[141] This data echoes nationwide data that revealed that 33% of hospitalizations nationwide (when race was known) were African American, even though the latter constitute only 13% of the country's population.[142]

In March of 2021, people of color were the largest share of those who contracted COVID-19 in almost all U.S states,[143] with Black Americans disproportionately impacted.[144] At that time Black Americans were 1.1 times greater risk for COVID-19 infection, 2.9 times greater risk for COVID-19 hospitalization, and 1.9 time greater risk of death when compared to white American residents.[145] Among Black populations in rural West Virginia were more likely to be admitted to the hospital.[146]

---

[136] Talesh, *supra* note 124.
[137] *See* Stacy Grundy & Beth Prusaczyk, *The Complex Intersection of Race and Rurality: The Detrimental Effects of Race-Neutral Rural Health Policies*, HEALTH EQUITY (2022).
[138] Katy B, Kozhiminnanil & Carrie Henning-Smith, *Racism and Health in Rural America*, J. HEALTH CARE FOR THE POOR & UNDERSERVED (2018).
[139] Kristen Underhill & Olatunde C.A. Johnson, *Vaccination Equity by Design*, 131 YALE L.J. F. 53 (2021).
[140] *Id*; *see also* Talesh, *supra* note 124.
[141] *See e.g. Coronavirus Was Slow to Spread to Rural America. Not Anymore*, N.Y. TIMES (April 8,2020), https://www.nytimes.com/interactive/2020/04/08/us/coronovirus-rural-america-cases.html.
[142] Sood, *supra* note 9; *see also* Owen Dyer, *Covid-19: Black People and Other Minorities are Hardest Hit in U.S.,* BMJ (2020).
[143] Talesh, *supra* note 124.
[144] Adesogan, *supra* note 136.
[145] Centers for Disease Control and Prevention, *Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity* (May 25, 2023), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.
[146] Jessica E. Johnson et al., *The Compounding Effect of Rurality on Health Disparities Among Black Patients with COVID-19*, J. APPALACHIAN HEALTH (2021).

D. Causes of Health Disparities in Among Rural Black Americans During the COVID-19 Pandemic

The disproportionate representation of Black COVID-19 patients presented largely in rural southern states.[147] At one point 70% of deaths in Louisiana occurred among Black patients underscoring a huge outcome disparity.[148] Alabama provides another example of this disparity. During the first few months of the pandemic, 43% of the deaths in Alabama were of African American patients, who only made up 26% of the population.[149] As recently as February of 2022, data revealed that Black and Hispanic people in rural areas died at higher rates than their white counterparts.[150]

If we more closely interrogate the reasons for the negative health status of Black rural America, compared to that of the greater rural population, we see systemic racism, poverty, geography, and an absence of the government interventions needed to increase these residents' ability to access healthcare. This is all part of the long, tragic, triumphant, and complicated history of Black people in rural America. Black people have resided on the land now known as the United States as indentured servants, enslaved persons, sharecroppers, and survivors of systemic racism and ongoing healthcare inequities.[151] Yet, there are additional factors that contribute to healthcare access disparities among the Black population. I call these "Healthcare Access+" factors, including race and poverty, which have a compounding effect on health disparities experienced by Black people living in rural locations compared to both white residents and individuals living in urban areas where healthcare is geographically more accessible.[152]African Americans have the highest poverty rate among racial/ethnic groups, with lower median incomes for rural than urban African American households.[153] Even Black Americans of higher socio-economic statuses have worse health outcomes than similarly situated wealthy white Americans.[154]

This section discusses how the health disparities that existed in Black rural communities prior to the COVID-19 pandemic persisted during and after the pandemic, contributing to worsened health effects among those in this population. This section sheds light on the plight of Black rural people during the pandemic and examines distinctions in the causes of the disparities that exist between the general rural and Black rural populations.

1. Access to Healthcare Facilities and Services

Black residents in rural areas are more impacted by healthcare facilities and professional shortages than other rural residents. According to recent data, 65.6% of

---

[147] *Id*.
[148] Govind Persad, *Allocating Medicine Fairly in an Unfair Pandemic*, U. ILL.. L. REV. (2021).
[149] Sharlene D. Newman et al., *The Health of Rural Black Communities During COVID: Some Affirmations, Some Surprises*, FRONTIERS IN PUB. HEALTH (2023).
[150] Benjamin Meuller, *In Rural America, Covid Hits Black and Hispanic People Hardest*, NEW YORK TIMES (July 28, 2022).

[152] Drake, *supra* note 141.
[153] Sood, *supra* note 9.
[154] Talesh, *supra* note 124.

primary care "Health Professional Shortage" areas were located in rural areas.[155] Areas with lower health care supply correspond with lower access to healthcare and degraded health outcomes,[156] with more damaging for the Black community. Case in point, 83% of African American majority rural counties were characterized as being within a "Health Professional Shortage" Area.[157] In terms of access to services, African Americans in rural areas had lower odds of receiving cholesterol screenings and cervical screenings than African Americans in urban areas.[158]

Moreover, access to healthcare, measured by proximity, has suffered due to hospital closures and decreased beds in African American neighborhoods,[159]and rural neighborhoods. An analysis of rural hospital closures found that they are more likely to occur in communities with higher percentages of Black and Hispanic residents.[160] Some suggest that Title VI offers a route to fighting the racial impacts of hospital closures, but this possibility has not been realized.[161]

To add insult to injury, the promise of the COVID-19 vaccination serving as an equity leveler never came to fruition due to lower vaccination rates among communities of color.[162] By mid-2021 data revealed these lower levels.[163] The Centers for Disease Control and Prevention (CDC) reported that of the vaccine recipients, for whom race was known, only 9% were Black, 61% were white, and 15% were Latinx..[164] Public health scholars have called this phenomenon an "inverse equity hypothesis."[165] In short, this theory suggests that inequities increase when new health innovations are adopted first by wealthy and resourced members of the population.[166] This underscores history which reveals that healthcare interventions, like vaccines, take time to reach all of society.[167]

2. Low Socio-economic Status

---

[155] Rural Health Information Hub, *supra* note 61.
[156] David Litaker et al., *Context and Healthcare Access: Looking Beyond the Individual*, MED. CARE (2005); *see also* Barbara Starfield et al., *Contribution to Primary Health Systems and Health*, MILLBANK QUARTERLY (2005).
[157] Julia Caldwell, Chandra Ford et al., *Intersection of Living in a Rural Verses Urban Area and Race/Ethnicity in Explaining Access to Health Care in the United States*, AJPH RESEARCH (2016).
[158] *Id*.
[159] See Talesh, *supra* note 124.
[160] Grundy, *supra* note 145.
[161] *Id*; see also Talesh, *supra* note 124.
[162] Underhill, *supra* note 147.
[163] *Id*.
[164] *Id*.
[165] *Id*.
[166] Underhill, *supra* note 147; *see also* Cesar Gomes Victoria, Gary Joseph et al., *The Inverse Equity Hypothesis: Analyses of Institutional Deliveries*, AM. J. PUB. HEALTH (2018); *see also* Adam Todd & Clare Bambra, *Learning from Past Mistakes? The COVID-19 Vaccine and the Inverse Equity Hypothesis*, EUR. J. PUBL. HEALTH (2021).
[167] Adam Todd & Clare Bambra, *Learning from Past Mistakes? The COVID-19 Vaccine and the Inverse Equity Hypothesis*, EUROPEAN J. PUB. HEALTH (February 2021).

The COVID-19 pandemic's impact on Black households was quite damaging.[168] Generally, systemic racism and oppression have elevated poverty rates in the South,[169] where most of the rural Black population resides.[170] The COVID-19 pandemic exacerbated this impact via its injurious economic impact on households. African Americans with low socio-economic status were at great risk for infection and mortality.[171] A study conducted by National Public Radio, the Harvard T.H. Chan School of Public Health, and the Robert Wood Johnson foundation found that 40% of households faced serious financial problems in 2020.[172] This financial impact was more damaging for Black and Latinx households in rural areas.[173] Around 80% of these households faced financial problems as compared to 36% of white households.[174]

Racial minorities also shouldered the burden of continuing to work as essential workers putting them at greater risk.[175] Further, individuals in minority, rural, and poor communities also disproportionately worked as essential workers who were at significant risk for COVID-19 exposure.[176] Minority workers are overrepresented in front-line jobs, with Black workers making up about one-sixth of all front-line-industry workers.[177] These front-line jobs include minority representation in low-wage jobs in convenience stores, grocery, and drug stores, public transit, trucking, warehouse and postal services, health care, child care, and social services.[178] These are all industries that put these essential workers at greater risk of contracting COVID-19 in the workplace given that they were unable to shelter in place.[179]

---

[168] *See generally* Saira Naseer et al., *COVID-19 Outbreak: Impact on Global Economy*, FRONTIERS IN PUBLIC HEALTH (2023).
[169] Linda M. Burton, Marybeth Mattingly et al., *State of the Union 2017: Poverty*, The Stanford Center on Poverty and Equality (2017), https://inequality.stanford.edu/sites/default/files/Pathways_SOTU_2017_poverty.pdf.
[170] *Id*.
[171] Elena Cyrus et al., *The Impact of COVID-19 on African American Communities in the United States*, HEALTH EQUITY (2020); see generally Emily Benfer, Seema Mohapatra et al., *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. OF HEALTH POL'Y, L., AND ETHICS 122 (2020).
[172] Mary G. Findling et al., *Serious Financial Burdens Facing U.S. Households with Employment loss during COVID-19*, CHALLENGE (2021).
[173] Giselle Corbie-Smith, Mary K. Wolfe et al., *Centering Equity and Community in the Recovery of the COVID 19 Pandemic*, NCMJ N.C. J. MED. (2021).
[174] *See* T.H. Chan, *The Impact of Coronavirus on Households in Rural America*, Robert Wood Johnson Foundation (Sept. 9, 2020), https://www.rwjf.org/en/insights/our-research/2020/09/the-impact-of-coronavirus-on-households-across-america.html.
[175] Corbie-Smith, *supra* note 191.
[176] *Id*.
[177] Talesh, *supra* note 124.
[178] *Id*.
[179] *Id*. Racial minorities contracted COVID-19 in disproportionately high rates in "hotspot" areas such as New York City, Milwaukee, Louisiana, and Chicago as well as in specific industries.

III. LAW AND POLICY RESPONSES TO HEALTHCARE ACCESS AND INEQUITIES IN RURAL AMERICA IN RESPONSE TO THE COVID-19 PANDEMIC

Policy actions have been taken to address issues of healthcare access and inequity among rural communities in general, and among minority populations, in particular, including efforts to acknowledge health inequities during the pandemic period.[180] However, the realities of health disparities remained a blight on what was a difficult public health period for Black people in rural communities. Another lesson learned from the pandemic-era is that the mere presence of a federal program does not mean that the distribution of its resources or its impact is equitably experienced among all social demographics. This section briefly identifies some of those policy changes and highlights benefits and equity deficits. It also highlights the normative question of how future policy actions should reconsider the impact of the COVID-19 pandemic on Black rural communities to reframe the way we define "access to healthcare."

A. Economy-based Government Programs

Rural residents, who already experience greater levels of poverty, were more economically strained during the pandemic. The pandemic only increased the income inequality experienced by this community.[181] For example, rural residents faced higher levels of unemployment exacerbating their ability to maintain their households. During the COVID-19 pandemic there were several economic-based policy actions taken to combat the financial toll of the pandemic. For example, The Coronavirus Aid, Relief, and Economic Security Act ("CARES Act")[182] created unemployment insurance programs including Pandemic Emergency Unemployment Compensation ("PEUC"), Pandemic Unemployment Assistance (PUA), and Pandemic Unemployment Compensation ("PUC").[183]

Unfortunately, the presence of these programs did not equally reach all potential beneficiaries.[184] From its inception the CARES Act did not cover most agricultural and home healthcare workers.[185] Also, a national study revealed that only 13% of Black Americans out of work from April to June of 2020 received unemployment benefits, as compared to 24% of white workers, 22% of Latinx workers, and 18% of workers of other races.[186] Many of these Black workers were in southern states which made significant cuts to their unemployment programs.[187] Even when Black workers did receive unemployment,

---

[180] See Ichiro Kawachi, *COVID-19 and the 'Rediscovery' of Health Inequities*, INT'L J. EPIDEMIOLOGY (2020).
[181] *See* Sano, *supra* note 99.
[182] CARES Act, Pub. L. No. 116-136. H.R. 748 (2020).
[183] *Id*.
[184] Talesh, *supra* note 124.
[185] Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, J. L. & BIOSCIENCES (2020).
[186] *Id*.
[187] *Id.*

because benefit levels are determined by salary, they received smaller payments that white workers across every education level. Black workers also stayed unemployed longer and were therefore more likely to exhaust their benefits.[188] Although the CARES ACT II extended economic programs through March 14, 2021, Black people faced increased economic insecurity. One study found that some landlords disregarded the initial eviction moratorium, making 23% of Black people and 20% of Latinx people unable to pay their rent. This was double the amount for whites and Asians.[189]

The inequity in one's ability to participate in economic-based COVID-19 programs did not stop with the individual. Research from the Brookings Institute reveals that small businesses in communities of color had unequal access to federal COVID-19 relief.[190] With large amounts of Paycheck Protection Program (PPP) loans going to larger commercial banks, many small businesses were excluded from funding due to race-based lending practices.[191] This was especially true in the beginning of the pandemic given that PPP loans reached minority communities better in the second half than the first half of the program.[192] Economic help often did not reach rural and minority communities, or it reached them later than others.[193] To avoid this type of delay in the future, legislators and policy makers should consider policies that include mechanisms for equitable distribution. This suggestion is in line with the U.S. Government Accountability Office (GOA) which suggests that policy respond by putting financial incentives at the forefront when developing programs to assist rural populations.[194]

B. Health-Based Government Programs

Government programs also extended to health-specific programs. Even prior to the pandemic, in response to rural hospital shortages, many federal programs in hospitals across the United States were aimed at alleviating health disparities among Black populations.[195] Programs through the Department of Health and Human Services ("HHS") targets healthcare access through its Health Resources and Services Administration.[196] In addition, HHS's Office of Minority Health was established in 1986 to improve the health of racial and ethnic minorities by developing program to eliminate health disparities.[197]

---

[188] *Id*.
[189] *Id*.
[190] Sifan Liu & Joseph Parilla, *New Data Shows Small Businesses in Communities of Color Had Unequal Access to Federal COVI-19 Relief*, The Brookings Institution (Sept. 17, 2020), https://www.brookings.edu/research/new-data-shows-small-businesses-in-communities-of-color-had-unequal-access-to-federal-covid-19-relief/.
[191] Talesh, *supra note* 124.
[192] Robert Fairlie & Frank M. Fossen, *Did the Paycheck Protection Program and Economic Injury Disaster Loan Program Get Disbursed to Minority Communities in the Early Stages of COVID-19?*, SMALL BUSINESS ECONOMICS (May 5, 2021), https://doi.org/10.1007/s11187-021-00501-9.
[193] Jeffrey Wang & David Hao Zhang, *The Cost of Banking Deserts: Racial Disparities in Access to PPP Lenders and their Equilibrium Implications*, SSRN ELEC. J. (2021).
[194] United States Government Accountability Office, *supra* note 30.
[195] Talesh, *supra* note 124.
[196] National Academies of Sciences, Engineering, and Medicine, *Federal policy to advance racial, ethnic, and tribal health equity* (2023).
[197] *Id*.

These programs may have addressed access to healthcare but the United States Government Accountability Office debates whether they have had a positive impact on remedying health disparities.[198]

During the pandemic the public eagerly anticipated the availability of the COVID-19 vaccine. Vaccine availability and programming was important for reducing both impacts of COVID-19 infection and mortality.[199] In recognition of the significant equity concerns the CDC included the goal of reducing disparities via its Advisory Committee on Immunization Practice ("ACIP").[200] This aim was supported by data on the racial and ethnic distribution of those particularly vulnerable to the negative health effects of COVID-19.[201] Yet, racial and ethnic minorities in rural communities faced challenges in receiving the vaccine, including reduced or nonexistent access to health care in rural areas.[202]

Although many rural low-income families lacked insurance during the pandemic, the Affordable Care Act enabled states to expand Medicaid to help cover many of the uninsured.[203] However, this expansion has not offered a clear path toward addressing inequities among poor population, particularly minority populations in rural areas. States that chose to expand Medicaid eligibility were able to offer coverage to residents who might not have been covered prior[204] affording those residents with some protection during the first year of the pandemic.[205] States that chose to expand Medicaid eligibility were able to provide insurance coverage to residents who might not have been previously covered.[206] Those states that did not expand were disproportionately located in the South,[207] and limited financial resources that could have allowed low-income, rural, and minority people access to medical care.[208]

---

[198] Drake, *supra* note 141 (citing Rahul Aggarwal et al., *Association Between the Proportion of Black Patients Cared for at Hospitals and Financial Penalties Under Value-Based Payment Programs,* JAMA (Mar. 23, 2021).

[199] Underhill, *supra* note 147.

[200] *Id*.

[201] *Id*.; *see also* Nancy McClung, Mary Chamberland et al., *The Advisory Committee on Immunization Practices' Ethical Principles for Allocating Initial Supplies of COVID-19 Vaccine--United States,* MMWR. MORBIDITY AND MORTALITY WEEKLY REPORT 69 (2020), http://dx.doi.org/10.15585/mmwr.mm6947e3.

[202] Underhill, *supra* note 147.

[203] Alexandra Rakus & Aparna Soni, *Association Between State Medicaid Expansion Status and Health Outcomes During the COVID-19 Pandemic*, HEALTH SERV. RSCH. (2022).

[204] *See generally* Nathalie Huguet et al., *Medicaid Expansion Produces Long-Term Impact on Insurance Coverage Rates in Community Health Centers*, J. OF PRIMARY CARE & CMTY. HEALTH (2017).

[205] *See* Rakus, *supra* note 224. Studies identify the positive health impacts of Medicaid expansion prompted by the Affordable Care Act. Data from this study uses nationally representative data to empirically access the correlation between Medicaid expansion and changes in health outcomes and risk behavior during the pandemic.

[206] Huguet, *supra* note 225.

[207] Jose Figueroa et al., *COVID-19–Related Insurance Coverage Changes and Disparities in Access to Care Among Low-Income US Adults in 4 Southern States*, JAMA HEALTH FORUM (2021).

[208] *See generally* Nathalie Huguet et al., *Medicaid Expansion Produces Long-Term Impact on Insurance Coverage Rates in Community Health Centers*, J. OF PRIMARY CARE & CMTY. HEALTH (2017).

Many rural families faced increased food insecurity during the pandemic particularly among minority groups[209] and older residents.[210] Among Black and Hispanic households there was an insecurity rate of 21.2% and 16.2% respectively compared with the national average of 11.1%.[211] Residents tried to account for these struggles with shifts in behaviors with 26% of adults - including 30% of those who lost income, 30% of Black individuals, and 26% Latinx individuals - skipping meals or relying on community or government programs.[212] Strained community support systems and food banks struggled to keep up with demand.[213] Due to this insecurity, applications for Supplemental Nutrition Assistance Program (SNAP) increased dramatically, with 14.9% more Americans receiving SNAP benefits in April of 2020 verses April of 2019.[214] Policymakers, including the United States Department of Agriculture, responded by offering more flexibility in the administration of SNAP benefits,[215] such as such as by modifying the SNAP application process to make it easier for families to participate in or apply for benefits, and most states adjusted to these changes.[216] Making the application easier was especially important for rural residents, many of whom did not apply for SNAP prior to the pandemic due to lack of information, the difficulty of the application and recertification process, and lack of transportation.[217] This modification resulted in an increase of rural families participating in SNAP.[218]

Government actors took action to combat health impacts including the use of emergency powers laws which were deployed during the pandemic.[219] However, these policies were not structured with intent to address a large public health crisis like the COVID-19 pandemic, as such their efficacy was limited because they were designed to

---

[209] Danielle Xiaodan Morales et al., *Racial/Ethnic Disparities in Household Food Insecurity During the COVID-19 Pandemic: A Nationally Representative Study*, JOURNAL OF RACIAL AND ETHNIC DISPARITIES (2021).

[210] *See* Katherine Kent et al., *The Impact of the COVID-19 Pandemic on Rural Food Security in High Income Countries: A Systematic Literature Review*, J. OF ENV'T RSCH. & PUB. HEALTH (2022). This study explored the intersection among poverty, rurality, and age during the pandemic. Compared to those living in urban areas, rural older adults are more likely to face food insecurity and increased loneliness.

[211] Morales, *supra* note 230.

[212] Liz Hamel et al., *Impact of Coronavirus on Personal Health, Economic and Food Security, and Medicaid*, KAISER FAMILY FOUNDATION (May 27, 2020), https://www.kff.org/report-section/kff-health-tracking-poll-may-2020-health-and-economic-impacts/.

[213] Melissa G. Bublitz et al., *Pandemic Reveals Vulnerabilities in Food Access: Confronting Hunger Amidst a Crisis*, J. PUB. POL'Y & MKTG. (2021).

[214] Laura Tiehen, *The Food Assistance Landscape: Fiscal Year 2019 Annual Report*, ERS, USDA (2020), www.ers.usda.gov/webdocs/publications/99026/eib218_summary.pdf.

[215] Sano, *supra* note 97.

[216] *Id*.

[217] *Id*.

[218] Peggy Lowe, *Rural Americans are Now the Largest Slice of Federal Food Aid Recipients*, IOWA PUB. RADIO (Oct. 17, 2019), https://www.iowapublicradio.org/2018-10-17/rural-americans-are-now-the-largest-slice-of-federal-food-aid-recipients.

[219] See Lawrence O. Gostin, James G. Hodge, & Lindsay F. Wiley, *Presidential Powers and Response to COVID-19*, JAMA (2020).

address bioterrorism and not a pandemic.[220] Still, there is promise for future refinement of pandemic-era policies, that reference health disparities. Below I address some "Healthcare Access+" factors that should be introduced into the policy-framing process that might help to bridge the divide between the law and the complexity of healthcare access realities of Black rural residents.

IV. A CALL FOR A REVISED FRAMING OF HEALTHCARE ACCESS IN RURAL BLACK AMERICA

The beginning of this piece refers to "lessons learned" during the pandemic. One glaring lesson is that we as a legal collective of students, scholars, and policy makers should have a great appreciation for the complex nature of the rural health crisis. Similarly, we should be clear that it is imperative that legal responses during an emergency public health crisis must consider with particularity whether those plans deepen inequities. We should also be clear that inequities related to access to healthcare during the pandemic should not be considered as singular factors. In truth, these factors converge to layer inequity upon inequity upon inequity, such as inequities based on poverty, Black racial identity, and rural residence. Therefore, it is insufficient to only assess inequity based on "rurality" in practice and in policy creation. This section calls for a more nuanced look at the policy notion of "rurality" and its many race-based manifestations. I refer to these additional factors as "Healthcare Access+" factors, which give context to the role that race plays in placing Black people at greater risk during public health crises.[221]

A. Limitations of Healthcare Access Definitions in Policymaking

Some argue that law and policymakers should shift from place-intentional policies to race-conscious policies.[222] The point being that policies that solely focus on geography may fail to consider the nuance and differences between the health experiences of white and Black rural residents.[223] The impetus towards race-based considerations is likely motivated by the reality that rural residents may all also struggle with similar health challenges, but the severity of those challenges may differ based on race and ethnicity.[224]

For example, when considering how to prioritize vaccine allocation, physicians and ethicists argued for the use of individual race in allocation when discussing a draft of the National Academics of Sciences, Engineering, and Medicine draft COVID-19 vaccine allocation guidance.[225] However, several scholars have noted the dangers of racializing health outcomes [226] and the constitutional challenges attendant to using race in

[220] Michelle M. Mellow & Lawrence O. Gostin, *Public Health Modernization 2.0: Rebalancing Public Health Powers and Individual Liberty in the Age of COVID-19*, HEALTH AFFAIRS (2023), https://doi.org/10.1377/hlthaff.2022.01292.
[221] *Id*.
[222] Grundy, *supra* note 145.
[223] *Id*.
[224] *Id*.
[225] *Id*.
[226] *See* Benfer, *supra* note 189.

policymaking.[227] Yet, as history and public health data show, public health crises like the recent pandemic, will likely visit America again, exacerbating present inequities and health vulnerabilities.[228] History supports this possibility.[229] Studies of innovation in surgery, immunizations, HIV treatment, hospital births, and safe water flowed first to wealthy people deepening inequities.[230] Consistent with this pattern, the impact of those crises will not be equally distributed and the Black rural community will likely continue to be erased in the discourse of inequities.

Many polices address access to healthcare by relying on the traditional definitions of "access" within healthcare access discourse. Current legal/policy conceptualization of "access" are limited because they generalize health outcomes without considering the reality that healthcare access is not simply a function of proximity, but it is also a function of history, socio-graphic placement, and race-based experience. Policymakers must be more intentional about legislating/policymaking in a way that appreciates the multi-layered disparities that present themselves during public health emergencies. A broader look at the many indicators of inequities may ease fears regarding elevating race a sole factor in government decision-making.[231]

B. "Healthcare Access+" Factors for Rural Black Residents

The failure to acknowledge the complexities of rural communities, including differences in racial and ethnic characteristics and health outcomes, can be addressed through consideration of what I call "Healthcare Access+" factors. This concept recognizes that healthcare access works in conjunction with several social determinants of health,[232] including structural racism and medical mistrust, comorbidities and lifestyle differences, and environmental health and vulnerability. The factors noted here are in no way all-inclusive, but representative of the type of considerations needed to reframe discussions of access to healthcare. These Healthcare Access+ factors are necessary considerations in any public health emergency, allowing for more nuanced, equity-informed legal and policy solutions to rural healthcare access disparities.[233]

---

[227] Persad, *supra* note 158.
[228] *Id*.
[229] *See* Underhill, *supra* note 147.
[230] *Id*.
[231] *See generally* Kimani Paul-Emile, *The Regulation of Race in Science*, 80 GEO. WASH. L. REV. 1115, 1148 (2012).
[232] *See* Lisa Grow et al., *Disaster* Vulnerability, B.C. L. REV. (2022).
[233] Katy B. Kozhimannil & Carrie Henning-Smith, *Racism and Health in Rural* America, J. OF HEALTHCARE FOR THE POOR & UNDERSERVED (2018), https://doi.org/10.1353/hpu.2018.0004.

1. Structural Racism and Medical Mistrust

Difficulties for racial and ethnic minorities in rural communities were particularly challenging during the pandemic when combined with racism and discrimination. Structural racism has created a certain level of medical mistrust between medical institutions and the Black community in America.[234] These vestiges of racism and mistrust negatively impacted the many Black rural residents' ability to access healthcare during the pandemic.[235] Consider the troubling and well-documented history of systemic racism and discrimination that tarnished the relationship between Black people and the health system in America. One of many historical instances of racism in the medical profession that contributed to medical distrust is the Tuskegee Syphilis Study, which involved government-funded scientists withholding penicillin from low-income Black men in order to observe the long-term effects of syphilis infection.[236] Another example that directly points to medical racism is the forced sterilization of Black women in the South.[237] The U.S. medical system has also offered sub-par care to African American patients stemming from instances of racial bias.[238] Poor treatment of Black people by health providers, in the form of implicit bias by medical students and physicians, has caused delayed provisions of care and interruption in continuity of care.[239] For example, studies show that lower death rates are noted in prompt administration of antibiotics and collection of blood cultures, but these interventions have been withheld from African Americans.[240] Similarly, in a study of Medicare beneficiaries who suffered from congestive heart failure and pneumonias from 1991 to 1992, it was found that 53% of pneumonia patients with Medicare were given antibiotics within six hours of admission, while only 32% of African American patients with pneumonia received antibiotics within this same time period.[241] The full body of these instances has fueled a culture of suspicion[242] and mistrust between the Black community and the medical profession. This medical distrust could explain some of the cultural hesitancy of the Black rural community to take the opportunity to access care[243] during the pandemic, including hesitancy to receive vaccinations.[244] In a study among African Americans living in the southern U.S, almost one-third of the study participants were hesitant to receive the COVID-19 vaccine.[245]

---

[234] Lorraine T. Dean & Genee S. Smith, *Examining the Role of Family History of US Enslavement in Health Care System Distrust Today*, ETHNICITY & DISEASE (2021).
[235] Kozhimannil, *supra* note 261.
[236] *See* Underhill, *supra* note 147; *see also* Vickie L. Shavers et al., *Knowledge of the Tuskegee Study and Its Impact on the Willingness to Participate in Medical Research Studies*, J. NAT'L. MED. ASSOC. (2000). The authors of this article call for medical researchers to confront the role of the African American community's knowledge of the Tuskegee study as a deterrent from participating in medical research.
[237] Grundy, *supra* note 145.
[238] Sood, *supra* note 9.
[239] Talesh, *supra* note 124.
[240] *Id*.
[241] *Id*.
[242] Vicki S. Freimuth et al., *African Americans' Views on Research and the Tuskegee Syphilis Study*, SOC. SCI. & MED. (2001).
[243] Underhill, *supra* note 147.
[244] Justin Xavier Moore et al., *Correlates of COVID-19 Vaccine Hesitancy Among a Community Sample of African Americans Living in the Southern United States*., VACCINES (2021).
[245] *Id*.

Not only does structural racism allow for medical mistrust, experiences of racial discrimination have also been associated with detrimental impacts during the COVID-19 pandemic.[246] Researchers posit that Black people should be assisted through culturally component interventions that consider factors such as discrimination, medical mistrust, and trauma rooted in a history of discrimination.[247] Clearly, the COVID-19 pandemic is not exempt from the legacy of medical mistrust, creating an additional barrier to accessing healthcare that might have proven beneficial and lifesaving.[248] As such, definitions used for evaluating "access to healthcare" in policymaking, during public health crises, must absorb considerations of systemic racism and medical mistrust.

2. Comorbidities and Lifestyle Differences

Those who craft legislation and policies should also consider the Healthcare Access+ factors of comorbidities and lifestyle differences, given that many rural Black people entered the pandemic in a state of health disparity. These differences may be lost in general discussions of rurality. When reporting from 2012-2015 the CDC noted, "Although persons in rural communities often have worse health outcomes and less access to health care than those in urban communities, rural racial/ethnic minority populations have substantial health, access to care, and lifestyle challenges that can be overlooked when considering aggregated population data."[249]

The disproportionate risk of morbidity and mortality among racial minorities is a result of years of structural inequalities that increased the risk of chronic conditions.[250] For example, in North Carolina the history of inequities caused by structural racism were on full display during the pandemic, exacerbating the impacts of infection and mortality.[251] At one point Black individuals in North Carolina represented 29% of deaths but only made up 22% of the population.[252] Similarly, the Georgia Black Belt, known for its high concentration of African American residents, demonstrated health inequities during the COVID-19 period tied to structural elements including a lack of resources, lower socio-economic status, and a concentration of comorbidities.[253] In short, Black people have higher rates of untreated respiratory disease and cardiovascular disease, which are risk factors for COVID-19, and further compounded by a lack of access to treatment.[254]

---

[246] *See generally* Derek Novacek et al., *Mental Health Ramifications of the COVID-19 Pandemic for Black Americans: Clinical and Research Recommendations*, PSYCHOLOGICAL TRAUMA: THEORY, RSCH., PRACTICE, AND POL'Y (2020), https://doi.org/10.1037/tra0000796.
[247] *Id*.
[248] Underhill, *supra* note 147.
[249] Cara V. James, et al., *Racial/Ethnic Health Disparities Among Rural Adults—US 2012–2015*, Centers for Disease Control and Prevention (2017).
[250] Corbie-Smith, *supra* note 191.
[251] *Id*.
[252] *Id*.
[253] Moore, *supra* note 272.
[254] Talesh, *supra* note 124.

However, comorbidities cannot be completely disassociated from lifestyle. As noted by in many areas, "race determines home."[255] We cannot ignore the social determinants of health and the reality that Black residents my reside in poorer communities where there may be limited access to healthy foods.[256] This vulnerability is apparent in Black rural communities, geographic location places them at increased health risk – and different COVID-19 risk.[257] Geographic location can create lifestyles disparities driven by a lack of access to social and economic resources. For example, because of resource limitations rural African Americans may consume fewer fruits and vegetables and engage in less exercise.[258] Rural residents are more likely to have less education, with those who are employed working more frequently in production and manufacturing.[259] Crisis-responses policymaking must consider inequities such as comorbidities that are precursors to pandemic-related outcomes.

3. Environmental Health and Vulnerability

Environmental health and vulnerability are a significant Healthcare Access+ factor as well. Black and low-income communities disproportionately shoulder risks associated with environmentally unhealthy conditions as well.[260] These communities are more likely to be located near chemical plants and municipal waste facilities.[261] Black populations, particularly those in rural areas in greater proximity to environmental risk, struggled to be resilient during the COVID-19 pandemic.[262]

One recent study highlighted the troubling link between COVID-19 outcomes and certain segments of our country including people living in polluted neighborhoods.[263] The study notes that one contributor to the higher risk of mortality when one has COVID-19 infection and asthmas is the reduced lung capacity.[264] Further, research from Harvard University suggests an association between long-term exposures to air pollution, particularly fine particulate matter (PM2.5) and increased COVID-19 death rates.[265] Even

---

[255] *See* Clyde W. Yancy, *COVID-19 and African Americans*, JAMA (2020). Yancy notes that low socioeconomic status is independently a risk factor
for total mortality, without the inclusion of other risk factors.
[256] *Id*.
[257] Grow, *supra* note 260.
[258] *Id*.
[259] Rebecca Glauber & Andrew Schafer, *Employment, Poverty, and Public Assistance in the Rural United States*, The Carsey School of Public Policy at the Scholars' Repository (2017), https://carsey.unh.edu/publication/rural-us-assistance.
[260] Talesh, *supra* note 124.
[261] *Id*.; *see also* Robert Bullard, DUMPING IN DIXIE: RACE, CLASS & ENV'T QUALITY (3d ed. 2000). Dr. Robert Bullard writes that air pollution around schools is linked to poorer student health and academic performance, particularly among African American children.
[262] Robert Bullard, et al., *Roundtable on the Pandemics of Racism, Environmental Injustice, and COVID-19 in America,* ENV'T JUST. (2020).
[263] *See generally* Katherine Bagley, Interview: Connecting the Dots Between Environmental Injustice and the Coronavirus, YALE SCHOOL OF ENV'T (May 7, 2020), https://e360.yale.edu/features/connecting-the-dots-between-environmental-injustice-and-the-coronavirus.
[264] *Id*.
[265] *See* Xaio Wu et al., *Fine Particulate Matter and COVID-19 Mortality in the United States: A*

discussions about the higher prevalence and preexisting conditions among the Black populations should be qualified by exposure to long-term pollution. Many of the pre-existing conditions that increase risk of death from COVID-19 infection are similarly affected by long-term exposure to air pollution.[266] A more pointed look at how environmental risk factors impact troubling COVID-19 outcomes is a topic that warrants continued and intentional clinical and policy-based research as a Healthcare Access+ factor.

CONCLUSION

Much public health discourse on the COVID-19 pandemic focuses on the health of the general population impacted, however similar emphasis should be placed on groups that were particularly vulnerable to negative health impacts, beginning even prior to the outbreak. The question of how to improve access to healthcare for these populations must be addressed prior to the next national or world-wide health crisis emerges. Indeed, it is time for policymakers to devise solutions that are not only important for the many, but also important for the statistical few. We cannot afford to ignore the reality that recovery from contagious disease crises is not the same for all: everyone is not similarly situated, particularly those in rural communities. Yet, we must also come to grips with the fact that "rural health" does not fully capture the experiences of rural Black populations.

By combining an accounting of contemporary and historical race discrimination, structural health inequities, rural public health outcomes, and COVID-19 infections and death, my Healthcare Access+ concept allows us to not only better understand and predict the effect of future public health emergencies, but to also deploy law and policy in ways that best respond to the potential health challenges experienced by marginalized communities. Healthcare Access+ factors, like racism, rurality, poverty, history, lifestyle challenges, and environmental vulnerability effectively captures the experience of Black rural communities in America and thus should guide legal and policy solutions aimed at addressing the complex problem of reduced healthcare access for some of our most vulnerable U.S. residents.

National Study on Long-term Exposure to Air Pollution and COVID-19 Mortality in the United States, NAT'L LIB. OF MED. (2020).

[266] *Id.*