

Rural Legal Deserts Are a Critical Health Determinant

We introduce “rural legal deserts,” or rural areas experiencing attorney shortages, as a meaningful health determinant. We demonstrate that the absence of rural attorneys has significant impacts on public health—impacts that are rapidly exacerbated by COVID-19.

Our work builds on recent scholarship that underscores the public health relevance of attorneys in civil and criminal contexts. It recognizes attorneys as crucial to interprofessional health care teams and to establishing equitable health-related laws and policies. Attorney interventions transform institutional practices and help facilitate the stability necessary for health maintenance and recovery. Yet, critically, many rural residents cannot access legal supports.

As more individuals experience unemployment, eviction, and insecure benefits amid the COVID-19 pandemic, there is a need for attorneys to address these social determinants of health as legal needs. Accordingly, the growing absence of attorneys in the rural United States proves particularly consequential—because of this pandemic context but also because of rural health disparities. We argue that unless a collaborative understanding of these interrelated phenomena is adopted, justice gaps will continue to compound rural health inequities. (*Am J Public Health*. 2020;110:1519–1522. doi:10.2105/AJPH.2020.305807)

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In 2017, the Legal Services Corporation, a federally established nonprofit organization, published *The Justice Gap: Measuring the Unmet Civil Legal Needs of Low-Income Americans*.¹ The report estimated that 10 million rural Americans have incomes below 125% of the federal poverty line. Three quarters of low-income rural residents experience at least one civil legal problem in a year, and nearly one quarter face six or more civil legal needs in a year. Critically, the most common type of legal issue low-income rural residents report is access to health care.¹

Despite the clear need, there is ample evidence that increasing numbers of rural individuals cannot access legal assistance in civil and criminal matters because of growing attorney shortages. Indeed, many rural US counties now have few attorneys, if any.² Defined as “rural legal deserts,” this phenomenon is accelerated by the “graying bar”—attorneys who are retiring but not being replaced because of declining law school enrollments and limited specialized training for students interested in rural practice. These rural justice gaps are further exacerbated by the challenge of recruiting and retaining attorneys in areas with struggling local economies and underresourced educational and health care systems.

What results, then, is that only 14% of rural individuals receive

assistance for their civil legal problems—a rate less than half the national average.¹ Rural residents do not necessarily fare better when it comes to criminal matters. For instance, because of a shortage in defense counsel, rural criminal defendants in Wisconsin have to wait as many as two months before receiving a public defender.³ In rural tribal courts, many of which cannot afford to provide public defenders to tribal litigants, individuals are nearly always self-represented.⁴ The absence of legal counsel renders individuals experiencing housing precarity, intimate partner violence, or opioid addiction further vulnerable. Access to critical supports and treatments is delayed, and family stress is compounded. Most simply, a lack of attorneys propagates a cycle of increased risk for further health problems.

Drawing on our work with rural patients and stakeholders, we identify this rural justice gap as a public health concern. Despite meaningful attention to social and structural determinants of health—many of which are intrinsically legal—and to physician–attorney collaboration, there has so far been little, if any,

formal recognition of this unique rural disparity among public health researchers. This is surprising, given that the same US regions experiencing hospital closures and physician shortages, often characterized as rural health care deserts,⁵ are largely also classified as rural legal deserts. Although increasing numbers of policymakers are attending to these so-called deserts, their efforts are largely exclusive to either health care or law: so far no one has formally identified rural health care gaps as justice gaps, or vice versa. The consequences of this siloed approach are vast, particularly as we consider the health and socioeconomic effects of the COVID-19 pandemic. In response, we argue for meaningful acknowledgment of rural justice gaps as critical determinants of health. A collaborative understanding of this legal context will lend necessary insights to mitigating urgent rural health needs.

THE HEALTH–LAW INTERFACE

Recent public health scholarship has importantly documented

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the health outcomes of exposure to the US criminal justice system.⁶ It has likewise underscored the need to advance research aimed at improving health outcomes for criminal justice-involved populations.⁷ Other work has highlighted the public health effects of what are generally understood as civil legal needs, among them substandard housing, benefits or wage disputes, food insecurity, and education and employment barriers.^{8–10} These issues are commonly identified as social and structural determinants of health and often discussed in the context of medical–legal partnerships (MLPs).

This scholarship underscores the public health relevance of courts and court personnel in the context of both criminal and civil matters. It recognizes attorneys as valuable members of interprofessional health care teams, as MLP attorney interventions lower emergency room visits, decrease health care avoidance stemming from concerns about health insurance and costs, and reduce stress and increase personal well-being.^{11,12} Recent public health research also appreciates how attorneys' strategic litigation can improve or enforce laws that influence health.¹³ At a fundamental level, this awareness reflects a principle of medical ethics, namely that physicians respect the law and recognize their responsibility to seek changes to those requirements contrary to the best interest of patients.¹⁴

Even when not formally involved in the health care setting, legal assistance powerfully mitigates and even prevents health issues. Significantly, these complex needs are not deferred during a pandemic. Rather, rapidly growing numbers of individuals are facing unemployment,

eviction, insecure benefits, and limited or restricted access to health care systems. In rural regions already familiar with this precarity, the trajectory of COVID-19 has magnified deep sociospatial vulnerabilities. Presently, the rate of US cases and deaths appears to be increasing more rapidly in rural areas, with rural regions described as a tinderbox for SARS-CoV-2. Rural residents are older, experience more chronic conditions, and are more likely to be essential workers and at a greater risk for exposure.¹⁵ At a structural level, many rural communities also contend with underresourced or even shuttered hospitals; labs, grocery stores, and pharmacies “at the end of the supply chain”; and limited or absent infrastructure necessary for telehealth.¹⁶

RURAL HEALTH AND LEGAL DISPARITIES

As they pertain to the rural United States, the health and legal consequences of the COVID-19 pandemic must be situated within a broader context of poverty and structural vulnerability. Rural US poverty rates have exceeded urban poverty rates every year since 1959, and persistently high-poverty counties are overwhelmingly rural.² Migrant farm workers may endure substandard housing and abusive working conditions. The elderly, disabled, and veterans are all disproportionately represented in the rural United States, and all need diverse supports. American Indians and Alaska Natives are often rural and contend with high poverty rates, health inequities, and a complex interplay of state, federal, and tribal laws.² Rural communities also

disproportionately experience environmental hazards and degradation.²

It is perhaps unsurprising that rural regions exhibit marked health disparities, including poorer health outcomes than urban areas and what Cosby et al. describe as the “rural mortality penalty.”¹⁷ Rural communities also face significant legal disparities when compared with metropolitan areas. Not only is there a shortage of private practitioners, but low-income rural individuals are often at a significant distance from nonprofit legal aid organizations, which tend to be centered in urban areas. Metropolitan regions, additionally, offer larger firms that can take on pro bono or “low bono” cases, better resourced law libraries, courthouses accessible by public transit, consistent digital connectivity, and law schools that may provide specialized free legal assistance through housing and family law clinics. Simply put, the same sociospatial aspects that affect rural community members' access to health care—vast distances, professional shortages, insufficient or nonexistent public transit, a lack of reliable communication tools—also limit their access to justice. These challenges are further exposed and exacerbated by the pandemic, as social-distancing requirements result in curtailed or eliminated public supports (e.g., Internet access at a local library) just as the need for electronic communication, secure document transmission, and remote court appearances grows.

THE PUBLIC HEALTH COSTS OF RURAL DESERTS

If not resolved in an appropriately multifaceted way, legal

needs compound existing health issues, and health needs impede access to justice. Without rural attorneys, health care professionals cannot refer patients to civil legal aid or an immigrant advocacy organization. There are also fewer prospects for medical–legal partnerships—a reality reflected in the relative dearth of literature on rural MLPs.¹⁸ In rural legal deserts, there are fewer attorneys to advocate rural health at a policy level, either through local impact litigation or through systematic public health law.

Of course, the absence of rural health providers proves just as consequential to the justice system. For instance, the rural per capita opioid overdose rate is 45% higher in rural than in urban areas,¹⁹ and treatment of chemical dependency is often delayed if a rural individual is involved in the criminal justice system and must wait for months to get a public defender. Not only does this leave an individual addicted to opioids in a high-stress situation with a greater risk of reoffense, but she or he also has a lower likelihood of treatment options in a rural region. Many rural areas do not have a certified opioid treatment program, and only 3% of physicians with waivers to prescribe buprenorphine and methadone operate in rural communities.²⁰

Other justice supports, including drug or driving while intoxicated courts, family dependency treatment courts, and mental health courts, likewise rely on health care professionals for diagnoses, assessments, protocol development, and education. These interprofessional courts are invaluable, and yet there are geographical differences in who benefits the most from them. The effectiveness of rural drug courts arguably lags

behind urban courts, which may provide more culturally specific services, have larger program budgets, and are more likely to offer adjunct health, mental health, and social services.²¹

Just as the absence of rural attorneys influences the public's health, the absence of rural health care professionals uniquely impedes justice delivery. This is particularly significant now, as already limited health resources in the rural United States are redirected to other life-saving activities. These professional deserts add credence to the notion that disparities in access to justice and health care are a critical, deeply intertwined public health concern. With fewer opportunities for interprofessional advocacy on behalf of vulnerable community members, both individuals and systems are affected.

MOVING FORWARD

Amid the rampant physical, financial, and emotional hardships wrought by the COVID-19 pandemic, Americans are asking, "If I can't afford to pay all of my health care bills, which should I pay first?" "If I am unable to work from home [a reality for many rural Americans experiencing technology deserts], will I still get paid?" "What if I can't pay my utilities?" "What if I don't feel safe in my home?" These questions demonstrate legal needs and personal values, and they intimately involve the health and well-being of individuals, families, and communities. In rural areas experiencing shortages of health and legal professionals, answers to such multidimensional questions are increasingly rare. We need to collaboratively address concomitant rural health care and legal

deserts—and now more than ever.

As a first step, we propose dismantling the professional boundaries implicit in desert designations. Rural public health and justice challenges are deeply intertwined and together must acknowledge the unique sociospatial and structural barriers rurality presents. Any professional initiative that neglects this complex rural context will be insufficient at best, impossible at worst. Consider, for instance, that the same legal scholarship that identifies public health as a key component of rural justice administration neglects growing rural attorney shortages.²² Although we commend the call for rural lawyers to incorporate public health law practices into their advocacy, rural lawyers must first be there. We accordingly encourage health and legal professionals to mindfully consider each other's presence and capacity. This requires conscious commitment: even in a small community, dwindling attorney numbers may not be evident to health professionals—especially if providers are overwhelmed or health systems are experiencing high turnover. We also firmly acknowledge the complex challenges that each sector individually confronts: declining law school enrollment, for instance, and prevailing payment models and prescription drug costs.

Merely expanding our conceptualization of rural deserts, however, necessarily grows a new professional rural spatial imaginary, or a new way of representing and talking about rural spaces. This is crucial for addressing both the immediate local and long-term structural consequences of health and justice gaps across the rural United States. What might this

look like? For one thing, public health could widen its scope of care to include justice gaps. This could be as basic as enhancing metrics, such as including the availability of attorneys as a social and economic factor in the "county health rankings & roadmaps" tool.²³ It might mean that the US Health Resources and Services Administration, which in 2014 recognized civil legal aid as an enabling service and allowed health centers to use funding for MLPs, additionally considers the presence of attorneys as relevant to health professional shortage areas. Most simply, we must broaden our conception of what—and who—makes a healthy public.

Relatedly, we must scale up our interprofessional partnerships in light of professional shortages. If an MLP is impossible owing to a dearth of local attorneys or clinic closures because of consolidation, then broader collaborations must be mobilized across regional legal aid organizations, community health clinics, firms willing to provide pro bono or low bono assistance, and state bar and primary care associations, as with the Montana Health Justice Partnership.²⁴ A potential drawback of this suggestion is that it demands more of already overburdened health care and legal professionals. Accordingly, we must extend this professional rural spatial imaginary far into the future and beyond the health care and legal professions. This is, after all, the ultimate goal: that we understand that the solutions to health services and justice gaps—and likewise to technology, mental health, dental, and other rural deserts—are as interrelated as the problems themselves.

This means advocating initiatives and policies that improve the health of a community and help recruit and retain

professionals. An immediate example of this is expanded rural broadband and cellular coverage. As the COVID-19 pandemic has demonstrated, rural residents are among the likeliest to need and benefit from telehealth and telelegal solutions—and yet are the least likely to have consistent access to broadband Internet or cellular service.²⁵ A longer-term example is the collective advancement of rural pipeline programs in which students engage law and health care as intrinsically related, observe the participation of attorneys and health care providers on equal justice committees and treatment courts, and find public health and legal professionals who reflect their identities and experiences. This is critical to innovating professional education and addressing complex, deeply interrelated needs.²⁵ Relatedly, more medical and law schools must generate pathways to rural practice by selecting students who understand rural communities and by developing sustained and immersive rural educational experiences.

We have introduced rural justice gaps as a critical social and structural determinant of rural health. This adds dimension to prevailing understandings of rurality and rural health care provision, and it contributes a novel, spatially specific interpretation of interprofessional care. We make this argument at a critical time; growing numbers of individuals urgently need health care and legal supports amid the COVID-19 pandemic. For rural health and justice systems that are under-resourced and over capacity, these supports were already lacking. Without a meaningful recognition of such interrelated phenomena, justice gaps will continue to compound rural

health inequities. Yet by correlating rural professional shortages, we demonstrate that acknowledging one rural gap—namely legal—provides critical context and a better understanding of other barriers to rural health care. This is a necessary first step, one that demands a collaborative approach to addressing urgent rural health disparities. **AJPH**

CONTRIBUTORS

M. Statz conceptualized and led the writing of the article. P. Termuhlen contributed to the writing. Both authors revised the article and reviewed and approved the final version.

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CONFLICTS OF INTEREST

The authors declare that they have no known competing financial interests or personal relationships that could have influenced the work reported in this article.

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