Poverty in Rural America

By Jazmine Reagan

Poverty may be defined in simple terms as a state of being extremely poor. A real-world application of poverty translates to unmet physical needs for millions of people, including myself. Deprivation of unmet needs means weighing the importance and choosing between equally necessary critical needs, such as food or medicine, electric bills, or school shoes. Poverty is not an unusual or atypical phenomenon. According to the Census Bureau, the national poverty rate was 11.6% in 2021 (Creamer et al.). There are fewer resources and even fewer supports to access those resources compared to supports available to those in need living in metropolitan areas. In my small town in Kentucky called McCreary County, support is virtually non-existent. It is a region in which poverty is pervasive, and finding a path to success is challenging. The poverty rate in my hometown was 34.5% in 2019, an alarming rate by any measure. Per capita, McCreary County is one of the poorest areas in the nation, and my family is not unlike most of our neighbors. One might easily overlook the starkly contrasting experiences of impoverished lifestyles for rural sufferers such as food insecurity, medical assistance, and mental health.

Facing poverty in rural regions seems more arduous to navigate than dealing with poverty in resource-rich

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metropolitan areas. Many families in America face food insecurity and a lack of accessibility to adequate nutrition. "More than 14% of households in the United States were considered food insecure by the U.S. Department of Agriculture (USDA) in 2012, meaning that they did not have the money or resources for an adequate amount of food" (Piontak et al. 175). This percentage in hindsight may appear minute, but in reality, this "small" number amounts to roughly 17.3 million households in America. That is 17.3 million families, too many. Rural areas in southern America consist of the majority of that population as well. Therefore, after examining food insecurity and concluding that rural areas are at a spatial disadvantage, one begins to graze the surface of the economic differences between rural and metropolitan regions. As spatial disadvantages are prevalent in the United States, many people receive social program assistance or have low incomes in general. Jean Lloyd goes on to explain that with low income, food is sparse: "Many [people] live on fixed incomes, and wonder where their next meal will come from," (Lloyd 24). As the roots of food insecurity are embedded in economic status, other factors, such as unemployment and the lack of resources, play a role as well.

As metropolitan areas experience poverty alongside rural regions, urban areas tend to have access to adequate resources in comparison to rural communities. However, a resource to combat food insecurity that has been made available to all people is the Supplemental Nutrition Assistance Program (SNAP). According to Craig Gundersen, "SNAP is the largest food assistance program in the United States" (Gundersen et al. 114). Benefits from this program include the purchase of eligible food items in grocery stores, but in order to receive such assistance one must qualify for such. "To be eligible for

SNAP, households must first meet a monthly gross income test -the household income (before any deductions) typically cannot exceed 130 percent of the poverty line, though some states have set more lenient thresholds" (Gundersen et al. 114). Although many who need this type of assistance receive it, many do not. As states dictate, the program qualifications for resources vary, and social programs as such are not an exact way to alleviate food insecurity; meaning that no matter how much "leniency" states have, if you make 20 dollars over the qualifying amount, one does not receive SNAP. As many fall in the cracks of gaining resources to fight the battle of food insecurity, many other needs are unmet. With needs that are unmet nutritionally, one can expect other factors of one's health to be at risk as well.

Oftentimes, poverty poses many limitations to the accessibility of the various necessities of basic human survival. Healthcare services provided to poor rural Americans are very limited and the leading factor is low socioeconomic status. According to Lorraine Garkovich who researched rural communities and medical health, "Rural communities are three times more likely to be classified as medically underserved than are urban areas," (Garkovich et al. 10). As many people are put in positions where one must choose between one necessity over another, medical assistance is often disregarded. A study conducted by Donald Patrick points out lower health rates by explaining, "Decreased access and low level of health service use are, then, viewed as major reasons for poor health status outcomes observed among persons below the poverty level" (Patrick et al. 105). Donald furthers his claim by elaborating that since lower health rates are increased in impoverished communities, one can assume increased rates of medical care must be improved upon, but this simply is not the case. In fact, an upsurge in ill health and death rates has been

imposed on rural American citizens instead. However, efforts to alleviate this tragedy have been implemented for many years.

The introduction of The Affordable Care Act was put in place in 2010 to combat poor health across America. This Act is known as the "most significant reform of the American healthcare system since the passage of Medicare and Medicaid a half-century earlier," (Campbell and Shore-Sheppard 1). Campbell Shore-Sheppard further explain that The Affordable Care Act (ACA) was intended to make more affordable health insurance for people, allow for more coverage of medical care, and implement more preventative care. This allowed for broader eligibility for health insurance such as Medicaid and Medicare to be provided as well. The benefits of the ACA are expanded on by James W. Buehler: "by requiring that insurers cover certain preventive services without a copayment, the Affordable Care Act advances both personal health and public health," (Buehler et al. 36). However, as lawmakers change policies, health care in recent years has become a not so "social" program. Since policies have changed since 2010, eligibility and access to affordable health insurance have since decreased and many Americans lost insurance entirely. Rural communities are mostly affected due to the lack of funds provided to assist one's medical needs, and I too can attest. As qualifications for Medicaid and Medicare have tightened, I also lost my health insurance at a young age. The economic impact that has been imposed on many rural citizens, such as myself, has taken a toll on communities. This toll is no easy feat to overcome, and as physical health is declining, people also face mental health issues in the midst of battling the war on poverty.

The association between rural poverty and mental health is woven through the fact that statistically families that suffer

from poverty are at higher risk of mental health issues. According to Lisa Strohschein, "Children whose families are poor perform lower on cognitive tests, report more physical and mental health conditions, and are at greater risk for grade failure and early school leaving than children from more advantaged households," (Strohschein et al. 1). The many traumas associated with poverty are a few of the many factors contributing to the effects listed by Strohschein. "Persistently poor children may be at risk for mental health problems because their lives unfold against a backdrop of deficits," (Strohschein et al. 3). Some deficits Strohschein further explains are food insecurity, lack of medical care, and unsustainable living conditions. This further iterates that not only are the contributing factors of poverty interwoven, but it is also the circumstances individuals are brought into that affect sufferers physically and mentally. Many studies have shown that after living a childhood of rural poverty, the impacts are carried with them throughout their adult life as well. After conducting research about mental health and the connection of rural impoverishment, Gary Evans has concluded that "Rural poverty tends to be more persistent and deeper than urban poverty, which likely has implications for impacts over the life course" (Evans 14951). Many can infer that seeking mental health care is a viable solution if one is experiencing such mental health issues, but residing in rural poverty presents many limitations on having assistance be an option.

As many people may search to conquer and overcome mental health issues in impoverished rural communities, doing so is no easy battle to win. Much like the lack of accessibility to adequate food resources and medical care, mental health falls in that same category. However, a financial barrier is not the only obstacle being faced within rural regions. The cultural

stigmas surrounding mental health care or health care in general, impose many implications on the statistical decrease of care received by individuals in such areas. As James Kirby conducted studies on health care and rural impoverishment, he found that these communities "report higher levels of distrust towards physicians and have lower expectations of the care received" (Kirby 330). As many southerners have limited access to health care overall, when one does seek assistance, one questions the efficacy of care. This occurs because many impoverished people are dealt bottom-of-the-barrel assistance, therefore, any assistance must be of little if any sufficiency. Southern cultural stigmas surrounding mental health care are not limited to efficacy, and many southerners do not seek assistance in any manner. Growing up in a rural southern community, many folks believe that asking for help from mental health providers is a key factor in being weak. Rural folk tend to depend on themselves, and considering the deficiency in assistance, this only makes sense. Therefore, depending on someone else is a sign of weakness, and no one wants to be viewed as weak among their peers. All of these factors contribute to poor mental and physical health, and poor ways of overcoming poverty.

Throughout my childhood and young adult life, I have experienced the pervasiveness of poverty. This war on poverty is unlike most when residing in rural southern America. Embedded in my experience, I have encountered food insecurity, SNAP, poor medical health, Medicaid, Medicare, mental health issues, and a lack of accessibility to resources. Cultural stigmas within rural communities like McCreary County are reflected in my experiences as well. While growing up and facing such, the war against poverty is often lost. However, as I am entering my adult life, I notice that not many

people are aware of the spatial disadvantages that hail in America. Many people are blind to the truth that lies within the depths of poverty. This blindness is rooted in statistics of rural impoverishment, as one may be able to comprehend statistics one cannot understand poverty simply through comprehension. As witnessing such battles among myself, my family, and my neighbors, the awareness of rural poverty is held within. As many of my folk face unseen battles, awareness is step one to finding solutions to generational impoverishment. However, all of these sufferers have many tales of hardships left unheard. Researchers, including myself, strive to not only be listened to but to be heard. Although my story may appear as if I am making efforts to pull one's heartstrings into a cry for action, I am not. I write to you in hopes that you will become aware, not just to read the words and comprehend sentences, but to truly hear my story.

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