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National Rural Health Association
Written Testimony
by

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for the
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Subcommittee on Specialty Crops, Rural Development, and Foreign Agriculture

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Chairman McIntyre, thank you for this opportunity to testify. I am Wayne Myers, M.D., Trustee of Maine Health Access Foundation and I am a Past-President of the National Rural Health Association (NRHA). Thank you for this opportunity to speak on behalf of the NRHA at this important hearing. I am pleased to tell you why quality health care in rural America is critical to both the community's citizens and the community's economy. I will also discuss the impact of Federal programs with a specific focus on USDA health programs.

The NRHA is a national nonprofit, non partisan, membership organization with approximately 18,000 members that provides leadership on rural health issues. The Association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

**Health Care in Rural America is a Vital Component of the Economy**

Health care is critical to the physical and mental well-being of the citizens of a community. In rural America, health care is also critical to the economic well-being of the community.

As factories and plants across the nation close due to outsourcing, many parts of rural America's economy are in flux. A vital health care system is often one of the few bright spots in the local economy.

Over the last decade, cities and towns across the nation lost manufacturing jobs, but gained heath care jobs. Last year the manufacturing industry lost 310,000 jobs and the health care industry gained 363,000 jobs. Rural manufacturing jobs declined at double the rate of urban manufacturing jobs. In fact, health care and education are the largest rural employers and added the most jobs to the rural economy in 2007. According to Health Resources and Services Administration (HRSA), health care services are consistently a top employer in rural America and if local health care should disappear, as much as 20 percent of a local economy could go with it. In brief, health care services provide skilled employment, abundant ancillary employment, and help retain young families and the elderly (who rely on quality health care) in the community.

My state of Maine is similar to the rest of America. Healthcare looms large in Maine's present day economy and in 2005 accounted for 15% of all rural jobs. The Maine Department of Labor forecasts that, statewide, 30% of all new jobs from now until 2014 will be health care jobs.

Between 1998 and 2007, the Bangor metropolitan area (population 150,000) lost about 3,700 jobs in manufacturing, but gained 3,500 jobs in health care. For many, the hospital is replacing the mill as the passport to the middle class. The shift to medicine is evident throughout Bangor. The local community college's most popular courses are no longer welding and pipe fitting; they are nursing and medical radiology. In 1990, 16% of the jobs in the Bangor area were in manufacturing, while 12% were in health care. In 2007, 6% of the jobs were in manufacturing and 20% were in health care.

In rural Maine, health facilities are the communities' lifeline, both literally and figuratively. Maine has 15 Critical Access Hospitals, 50 Federally Qualified Health Center sites and 39 Rural Health Clinics. Each of these facilities is vital to the betterment of the rural patients and the rural economy. Despite this, the disparities between rural and urban persist. Rural areas have a larger share of lower-paying health-care jobs such as nursing assistants and personal care

attendants. In 2005, the average health-care wage in Maine's rural counties was $26,841 a year, $10,000 less than in the urban counties. Statewide the average wage for all jobs was $32,393.

The *Wall Street Journal* recently outlined this concern with a feature on a 51-year paper mill worker in Millinocket, Maine who was told he would be laid off his job of 28 years. The mill worker quit his job, took classes at the local community college and became a certified surgical technologist. Today he makes $16 an hour, $5 less than what he made at the paper mill.

**Health Care's Influence on Other Sectors of the Rural Economy**

The ancillary economic impact of health care in rural America is significant. A typical rural hospital may employ 20 percent of the local workforce and possess a multimillion dollar payroll. Much of the money paid to health sector employees is then spent in the community, which generates additional local jobs and revenue.

Additionally, health care employers and employees are important purchasers of goods and services, supporting many local business establishments. The employees who in work in health care, such as hospital and nursing home workers, physicians, dentists and pharmacists, are important sources of income in the community, supporting services such as housing and construction, retail establishments, restaurants and other local services. The hospitals and other health care institutions are also important purchasers of local inputs such as food, laundry services, waste management and other resources.

An often-overlooked aspect of the health care system in economic development is its importance to communities' efforts to attract and recruit firms. Rural leaders across the nation are becoming increasingly aware that the presence of quality health care is a vital component of numerous economic development strategies. From a survey of community leaders, almost 90% indicated that health care is important to the local economy. Manufacturers and high tech industries are unlikely to locate in an area that does not have adequate access to health care. Health care is also a key factor in attracting and retaining retirees.

## The Challenges of Rural Health Care

Despite the growth of health care in rural America and its importance to the rural economy, many geographic and demographic challenges jeopardize its viability. Rural health systems are often facing severe budgetary restraints. Some rural facilities are on the verge of closing. In other cases, health care services are being cut. Recruitment and retention of physicians and other providers are often extremely difficult and expensive. Access to capital for facility improvements can be severely limited. Rural populations are older and poorer than urban. Younger, more prosperous rural citizens are more likely to seek care in larger, regional urban centers while relying on local rural resources for emergency care. Therefore, rural healthcare facilities are heavily reliant on the reimbursement rates of Medicare and Medicaid, which do not adequately cover the cost of care and are continually threatened by cuts. Indigent care burdens are increasing due to rising unemployment and a flagging economy, while states are struggling to meet their Medicaid budgets.

## Recommendations: Federal Investment and Partnership Vital to Rural Health and Economic Development

### A. Grants and Loans for Capital Improvements

Health care will only be an important economic component if rural facilities can maintain quality structures and equipment. A large portion of rural hospitals were built using funding provided through the Federal Hill-Burton Act, in force from 1946 through 1975. Unfortunately, many quality rural facilities continue to operate in obsolete and deteriorating buildings, or operate with sub-standard equipment, because of the difficulty in accessing capital. This does not have to continue.

According to a 2005 Rural Hospital Replacement Study conducted by Stroudwater Associates and Red Capital Group, investment in rural facilities:

- Helps physicians and staff recruitment and retention;
- Reduces facility expenses (due to improved efficiencies);
- Improves patient safety;
- Improves quality of care and continuity of care; and
- Increases patients use and utilization.

The USDA has a long history of bolstering the rural economy and its influence on rural health care has been both direct and indirect. The vehicle for much of the USDA efforts has been the Farm Bill, which generates about $100 billion in federal spending each year.

Rural Development Programs in the Farm Bill provide some amount of grant funding for hospital and clinic construction, and leverage much more through loan guarantees and interest rate subsidies. They help fund construction of a range of related facilities, including wellness centers, emergency medical services (EMS), and long-term care centers. The NRHA strongly supports these programs yet believes improvements can and should be implemented.

1. **Current Loan Guarantee Programs Must be Improved**. From our members who have utilized or attempted to utilize USDA loan programs, the concerns are consistent:

   - The process is long and complex.
   - The process often proves not cost-effective because of the costly application requirements.
   - Inter-creditor loan agreements are cumbersome.
   - The program is often limited to Critical Access Hospitals. Other rural health facilities are excluded.
   - The loan amount is typically insufficient to fund the entire project.
   - The process precludes facilities that are in true need of the program from qualifying for the program.

The NRHA often hears complaints from Critical Access Hospitals, who are in dire need of capital improvements or equipment improvements, which failed to meet the strict criteria of USDA guaranteed loan programs. The USDA's stringent lending criteria deserve credit for the low default rate of these loans. The NRHA commends a low default rate; however, the NRHA also strongly supports greater outreach to the facilities in true need.

The USDA guaranteed lending programs' mission is to improve economic development. That mission is best achieved if the USDA reaches facilities with significant needs. Since 1977, under the Community Reinvestment Act (CRA), Federal law has required private lending institutions to offer credit throughout their

entire market area. The purpose of the CRA is to provide credit to underserved populations and small businesses that may not have previously had access to such credit. USDA federal lending programs should have a similar mission. The NRHA strongly believes that this type of federal outreach is the most effective way to improve quality health care and improve local economies.

2. **Implement New Loan Program Per Recommendations of RUPRI**.

In March, 2008, the Rural Policy Research Institute (RUPRI) documented recommendations for implementing a new USDA Rural Development Program that strengthens rural health care delivery systems. RUPRI was established in 1990 to address a concern of members of the Senate Agriculture Committee that no objective non-government source of external data, information, and analysis, regarding the rural community was available for policy decision makers. NRHA finds RUPRI's recommendations for expansion of the USDA lending program to be sound and prudent. Attached to this testimony are RUPRI's complete recommendations.

3. **Grants for Capital Improvements are Needed**.

The NRHA applauds this Committee for including language in the 2008 Farm Bill that would have made grant monies available to a wide range of rural facilities and to improve health care quality and patient safety. We regret that this section was not included in the final Farm Bill.

4. **Increase Investment in Information Technology**

Health Information Technology (IT) is particularly important for rural people, yet difficult to secure. Rural people typically get their primary health care in their home communities, but travel to larger centers for specialty services. The dangers and inefficiencies related to moving paper and film record are great, as are the difficulties of having access to these records where and when they are needed across the region.

Therefore, the importance of a usable and interoperable health IT infrastructure and equipment in rural America is critical to patient safety, quality and facility sustainability. Additionally, technology can increase access to care, provide remote diagnostic services, and provide education and training for health care workers who otherwise have limited access to professional colleagues and continuing education. Development funds through the Farm Bill and other programs have

been used to establish telemedicine and support broadband construction for rural communities. Such funding must continue and expand.

In it's 2004 report, Quality through Collaboration: The Future of Rural Health Care, the Institute of Medicine (IOM) stated that the acceleration of health knowledge is "pivotal" to patient safety and quality health care improvement in rural America. The report calls for a stronger health care quality improvement support structure to assist rural health systems and professions, and recognizes the importance of "investing in an information and communications technology infrastructure.

Health IT in rural America faces challenges far more significant than their urban counterparts. Both the 2004 IOM and Medicare Payment Advisory Commission (MedPAC) highlight problems with health IT in rural communities because of the relative scarcity of professional, technical and financial resources and interoperability issues which arise among numerous small independent health agencies.

Of these concerns, finance is the overriding challenge. Rural health facilities are small businesses who struggle to keep their doors open and meet their mission of providing care to their community. Investment in health IT or continued operation of the equipment is prohibitively expensive. (Often in rural areas, there is only a single telecommunications service provider - - which limits competition and increases costs.)

Additionally, rural hospitals often depend on the Critical Access Hospital designations and the Universal Services Funds to maintain operations and access technology. This tenuous existence, however, doesn't allow for any financial cushion in invest in technology. Current payment rates are insufficient to cover the costs associated with overcoming challenges of acquiring hardware and software, implementing community-based communications networks and obtaining training and ongoing support.

Investment in health IT can drive the expansion of telecommunication technologies to rural communities. Other rural businesses have similar investment and infrastructure issues. Successful projects driven by health providers such as hospitals, community health centers, or training facilities have demonstrated how the entire community can benefit when it is "wired." NRHA strongly supports provisions in the Farm Bill to expand broadband services in rural areas and hopes that more can be done.

## Health Insurance Coverage in Rural America

While health insurance is outside the scope of this committee and this summit, I would be remiss to not mention this important issue and help highlight how difficult and complex rural economic development can be. On this issue, rural America lags behind its urban counterparts and has disproportionately higher rates of the uninsured and underinsured. This is true of both adults and children.

As already highlighted, a healthy workforce is vital to having a vibrant economy. Without insurance coverage of the local populace, most people cannot afford routine health checkups and must rely on more expensive emergency care. This is both more costly for the community and leads to poorer health outcomes. In addition, health insurance coverage can help provide the monies necessary to keep health providers in rural communities driving further economic development.

For the future of our rural communities, we cannot continue to see increasing rates of uninsured adults and children. Nationwide, the trend has been decreasing employer sponsored health coverage. This trend has been more acute in our rural communities that tend to have smaller-sized businesses and more small business owners that cannot afford to insure their own family. We must find ways to provide insurance coverage.

Already, rural citizens disproportionately rely more on Medicare, Medicaid and the State's Children Health Insurance Program (SCHIP) than their urban counterparts. However, in providing this coverage, we must be cognizant that health insurance does not equal health care. Federal insurance programs such as the ones mentioned have a responsibility to make sure that our rural citizens can access care in their own communities and that the care they receive is of high quality. Without it, rural America may lack a productive workforce in the future.

Congress has attempted to pass meaningful SCHIP legislation only to have it vetoed. This program has been a significant source of health coverage for rural children. If additional SCHIP legislation is debated in this Congress, the NRHA asks that considerable improvements in health insurance coverage and outreach for children in rural communities be included. For those that care about the future of rural America, the reauthorization and expansion of SCHIP is of the utmost importance.

## Conclusion

Health care is a vital segment of the rural economy. Quality health care in rural America not only provides for the health of the community, but creates jobs, infuses capital into the local economy, attracts businesses and encourages families and seniors to maintain residency within the community. Federal, state, and local partnerships must be formed to protect this critical yet fragile component of the local economy. Grants and loans must be accessible for both capital improvements and IT infrastructure and development. Insurance programs such as SCHIP, Medicare and Medicaid must take into account their responsibility in providing health insurance for rural beneficiaries and in making sure those same people can access their care in their community. And finally, the USDA must continue to establish policies that help rural health care flourish - - for both the sake of the health of rural Americans and for the economy of rural America.