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USDA RURAL DEVELOPMENT

Statement of Thomas Dorr, USDA Under Secretary for Rural Development, before the Subcommittee on Specialty Crops, Rural Development, and Foreign Agriculture

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to discuss the role of USDA Rural Development in improving access to quality health care in rural America.

This is a high priority for the Administration and, I know, for the Members of this Subcommittee as well. We are appreciative of the support that the Congress continues to provide in this area.

At the Federal level, several agencies share responsibility for this effort. We work closely with our colleagues at the Department of Health and Human Services, The Department of Housing and Urban Development, the Indian Health Service, and the Department of Veterans Affairs to identify and meet the heath care needs of rural communities.

As an example of this inter-agency coordination, in cooperation with the Department of Housing and Urban Development and the Department of Health and Human Service's Health Resources and Services Administration (HRSA), we have developed a prototype of a rural critical access hospital, which we have made available to rural communities to aid in the development of efficient, cost-effective hospitals.

We are continuing to participate in a Rural Hospital Working Group with HRSA and others in an effort to create a how-to manual for rural communities undertaking the construction of a replacement hospital.

In addition, in the private sector we have developed a close partnership with the National Rural Health Association (NRHA) and with larger lenders, such as the Farm Credit System, which can handle loans that many local banks are unable to make. We are committed to forming additional partnerships which will enable all parties to strengthen the services we provide to rural America.

While several Federal agencies collaborate to provide rural health care services, our perspectives may sometimes vary. The mission of USDA Rural Development is to increase economic opportunity and improve the quality of life in rural communities. From this perspective, investments in rural health care are a triple play.

First and foremost, we of course recognize the inherent importance of quality health care to rural residents.

In addition, major health care facilities -- clinics, hospitals, and a wide variety of specialized care facilities -- are intrinsically high-value assets to rural communities. They provide jobs, generate economic activity, support a wide range of ancillary services, and bring to town highly skilled professional people who are likely to make valuable contributions across the entire spectrum of civic life.

Finally, access to quality health care is clearly an important condition for many business and institutional site decisions. In this respect, quality health care is essentially an infrastructure issue like transportation, adequate electric capacity, water and wastewater treatment capacity, and

broadband access. Communities that lack these attributes may be effectively redlined for many types of developmental opportunities. It is therefore an important part of our mission to help ensure that these gaps are filled.

In considering Rural Development's role in this area, it is important to note that we are community-driven. We administer over 40 programs which we are prepared to use flexibly to solve problems identified by rural communities themselves. Since 2001, we have worked hard to build synergies among programs, break down stove-piping, and encourage both our own staff and our partners in the communities we serve to work across traditional program boundaries.

Traditionally the bulk of USDA Rural Development's investment in rural health care has been provided through the Community Facilities Program, and in dollar terms this continues to be the case.

Since 2001, we have supported investments of more than $1.75 billion in Community Facilities to help rural communities develop or improve more than 1,000 health care facilities. Of this total, 144 facilities were

hospitals while 262 were health clinics. Other health care investments in this period included assisted living facilities, nursing homes, vocational and medical rehabilitation centers, and mental health centers.

The Community Facilities Program, however, does not stand alone. In the health care sector, from FY 2001 through FY 2007, no fewer than six separate Rural Development programs have invested or supported investments in a total of over $2.2 billion in more than 1,800 health care-related projects:

	Projects	Funding
• **Community Facilities**		
Loans	**795**	**$1,152,420,669**
Guaranteed Loans	**284**	**648,953,654**
Grants	**363**	**32,950,541**
• **Distance Learning and Telemedicine/ Medical**		
100% Grants	**245**	**80,789,842**
Loans and loan combos	**17**	**78,409,821**
• **Business and Industry Guaranteed Loans**	**82**	**202,897,348**
• **Rural Business Enterprise Grants**	**28**	**3,553,287**

- **Rural Economic Dev. Loans and Grants** **27** **10,929,833**

- **Renewable Energy Guaranteed Loans And Grants** **5** **59,386**

During the same period, our Community Facilities Program also supported investments of over $831 million in 5,201 fire, rescue, and public safety projects. Many of these, including rescue and ambulance services, communications facilities, storm warning systems, and fire equipment, directly support the public health mission.

Looking forward, demand for these programs is growing and we expect that this will continue. Anticipating this demand, the Administration proposed in its 2007 Farm Bill submission $85 million in mandatory funding to support an additional $1.6 billion in guaranteed loans and $5 million in grants to support the reconstruction and rehabilitation of Rural Critical Access Hospitals.

Although Congress did not choose to fund this initiative, we will continue to invest in rural health care as funds are available. We also anticipate that growing demand coupled with new technologies and a stringent budget environment are likely to drive changes in program delivery.

The Distance Learning and Telemedicine program is already in high demand. It is administered as a nationally competitive program with scoring based on (a) the rural nature of the service area; (b) economic need; (c) leveraging, through matching funds; (d) project location in USDA Enterprise Zones; (e) the need for services and benefits; (f) innovativeness; and (g) cost effectiveness. In 2008, we anticipate making approximately $24 million in grants and $28 million in loans and combos.

Health care investments through the Community Facilities Program, in contrast, have historically been community and demand driven. And we continue to fund rural health care infrastructure through this program as the current resources allow.

In closing, let me express again my thanks for the support of this Subcommittee for rural health care. These investments are critical to rural residents and to the long-term health of rural communities. We look forward to working with you to ensure that these needs are met.