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The United States House Committee on Economic Disparity & Fairness in Growth

For the Roundtable Discussion:
"Roundtable on Building Inclusive Prosperity for Rural America"
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Carrie Henning-Smith, PhD, MPH, MSW
Associate Professor, Division of Health Policy and Management
Deputy Director, University of Minnesota Rural Health Research Center
Associate Director, University of Minnesota Rural Health Program
University of Minnesota School of Public Health

Chairman Himes, Representative Craig, Ranking Member Steil, and distinguished members of the Committee, thank you for the opportunity to participate in today's roundtable discussion. I am currently an Associate Professor in the Division of Health Policy and Management at the University of Minnesota School of Public Health, Deputy Director of the University of Minnesota Rural Health Research Center, and Associate Director of the University of Minnesota Rural Health Program.

My career has been focused ensuring that all people have the opportunity for good health and quality of life, regardless of where they live. We still have a long way to go to achieve geographic health equity, however. For many rural residents today, living in a rural area means fewer opportunities for good health, increased barriers to timely access to affordable and high-quality health care, and more limited access to the basic infrastructure necessary to participate in our current economic and social systems. Altogether, these rural-specific challenges are costing lives and limiting the prosperity of our entire nation.

Rural Health Disparities

As I noted in my testimony in March, 2022 to the U.S. Senate Committee on Agriculture, Nutrition, & Forestry,[1] rural residents have worse health and greater risks of mortality than urban residents. On average, residents of large metropolitan areas live 2.5 years longer than residents of rural areas,[2] and that disparity has gotten worse in the past two decades.[3,4] From 1999-2019, the rural-urban difference in mortality rates tripled.[3] Compared to urban residents, rural residents have higher death rates from all five leading causes of death: cancer, cardiovascular disease, chronic lower respiratory disease (COPD), stroke, and unintentional injury.[4,5]

Those grim statistics predate the COVID-19 pandemic, which only made rural health inequities worse. While the very beginning of the pandemic was a distinctly urban phenomenon in the United States, the situation quickly became worse for rural residents.[6–8] By September of 2020, the COVID-19 death rate was higher in rural places than in urban places, and it has remained

higher for most of the pandemic.[9,10] According to research from the RUPRI Center for Rural Health Policy Analysis, as of July 1, 2022 the cumulative mortality rate for COVID-19 in rural America was 394 per 100,000 people, compared with 296 per 100,000 people in urban America.[9]

These inequities in health and mortality are important in their own right. They also inhibit economic growth and prosperity,[11,12] which can then lead to additional health disparities in a vicious cycle of economic and health inequity.

Access to Health Care in Rural America

There are many reasons that rural residents experience health inequities, including differences in access to the social drivers of health, like housing, transportation, education, and job opportunities. However, when talking about rural health, it makes sense to start with a discussion of rural health care.

Since 2010, 140 rural hospitals have closed their doors.[13,14] For years, rural health care providers and patients have faced workforce challenges, low patient volumes, and long travel distances to obtain treatment. Unfortunately, these issues have only been exacerbated by the COVID-19 pandemic. Because of this, the Chartis Center for Rural Health also estimates that more than 450 rural hospitals are currently operating at margins like those that closed throughout the last decade, meaning that they are particularly vulnerable to closure.[14]

In addition to hospitals, rural areas have also seen a decline in other health care services in recent decades. These include nursing homes,[15–17] pharmacies,[18,19] and obstetric units.[20–23] Today, fewer than half of all rural counties have a hospital in which you can give birth. Ten percent of rural counties have no nursing home.[15] Between 2003-2018, 1,231 rural pharmacies closed, amounting to 16.1% of all rural pharmacies.[19] From birth to end of life, it is more difficult to access the care you need in rural areas.

There are many causes for the decline in rural health care services. In some cases, it is difficult to afford the necessary overhead costs of keeping the lights on and the staff employed and well-trained in low-volume settings. Reimbursement rates, uncompensated care, and access to health insurance are also large contributors to hospital and health services vulnerability.[24] There have fewer been hospital and unit closures in states that have expanded Medicaid,[13,21,24] and we have seen a particularly pernicious loss of services in the southeast.[13,22] As rural America wrestles with new and ongoing challenges two and a half years into the COVID-19 pandemic, addressing these longstanding issues is more urgent and important than ever.

In addition to the issues mentioned above, health care workforce availability is a huge contributor to the challenge of maintaining rural health care services, and is one that has been amplified by the COVID-19 pandemic. Health professional shortage areas (HPSAs) are disproportionately located in rural areas.[25,26] According to the Bureau of Health Workforce, as of the first quarter of this year (2022), 68.3% of all primary care HPSAs are in completely or

partially rural areas, as are 68.5% of all dental HSPAs and 66.4% of all mental health HPSAs.[26] Solutions for this may include training and pipeline programs, as well as financial incentives for providers. However, solutions must also focus on the overall vitality and appeal of rural communities, including strong infrastructure, job opportunities, housing, child care, and educational opportunities.[27]

Over the last few years, hospitals in rural communities have been tested to their limits. Often, they were providing crisis care in dated facilities. In fact, one in ten Critical Access Hospitals is more than 25 years old.[24] This means that rural providers are working with an influx of patients in dated buildings, and are often not equipped with the best technology and devices. The United States Department of Agriculture's Community Facilities Programs is a key source of infrastructure funding for rural communities and their health care providers. The program offers direct loans, loan guarantees, and grants to improve essential public services across rural America. Many rural health care providers have taken advantage of this program.

As the House Committee on Economic Disparity & Fairness in Growth continues to consider ways to enhance access to and quality of health care in rural America, Rural Development programs like Community Facilities and the Rural Business-Cooperative Service programs have been essential programs for resources, as well as associated technical assistance and trainings, all of which should be used as a blueprint. These have been successful. They have improved health care infrastructure and as we prepare for future public health emergencies, these programs should be part of our public health response for rural communities.

Above and beyond the issues laid out above, access to health care is not only about health outcomes, but about the broader economic prosperity of a community. The closure of a rural hospital, especially if it is the only hospital in the area, is associated with a decline in community population size, labor force participation, housing prices, income, and other negative economic indicators.[28–30] Rural hospital closures are also more likely to happen in areas that already experience economic deprevation,[31] which may be indicative of a vicious cycle of economic and health care losses. While research into the exact economic implications of rural health care losses is ongoing, the fact remains that lack of health care may make it more difficult for those same rural areas to attract new residents and loss of health care may make it more difficult to maintain other employers, talent, and economic opportunity.

Rural Infrastructure and Health

The issue of rural health and quality of life is not limited to health care services, facilities, and providers. Infrastructure policy is health policy. For example, transportation infrastructure poses long-standing and complex challenges in rural areas, including quality of roads and bridges, access to personal vehicles, fuel and vehicle maintenance affordability, and availability of public transportation, especially for people with physical limitations.[32] In our work at the University of Minnesota Rural Health Research Center, we found that rural residents who develop a medical condition that makes driving difficult – or dangerous – are less likely than urban residents with similar conditions to give up driving.[33] This is likely reflective of fewer available alternatives, and may also be associated with the overall higher rates of motor vehicle fatalities in rural areas.[34]

To support rural health and quality of life, infrastructure policy also needs to include access to reliable and affordable broadband Internet.[35–37] At the beginning of the COVID-19 pandemic, both Congress and the executive branch took decisive actions to ensure that health care was continued throughout the pandemic. The result was an unprecedented increase in utilization of telehealth services, which rural communities uniquely benefit from.[38] The advent of telehealth creates a new option for health care delivery that is essential beyond the duration of the public health emergency. Therefore, I was pleased to see Congress include an extension of these provisions until the end of the year in the appropriations package earlier this year. Ensuring that rural providers and their patients can utilize this health care delivery system into the future will increase patient access, satisfaction, and quality of life. Additional legislation, such as H.R. 8169, To Establish a Rural Telehealth Access Task Force, introduced by Representative Craig, and H.R. 7353, Telehealth Benefit Expansion for Workers Act of 2022; H.R. 6202, Telehealth Extension Act of 2021; and H.R. 2903, CONNECT for Health Act of 2021 are all examples of additional federal policy actions that would expand and solidify access to telehealth services into the future.

Despite gains in telehealth, ongoing issues remain related to the need for sufficient broadband connectivity. Inclusion of $65 billion in funding for broadband connectivity buildout in the Bipartisan Infrastructure Law was needed, but equitable implementation will be critical. Federal agencies, including the United States Department of Agriculture, the Federal Communications Commission, and the National Information and Telecommunications Administration (NITA) have a role to play to ensure that broadband connectivity is built out equitably, particularly in rural communities. While broadband is important to all things rural: farms, commerce, schools, and work, it has special importance for rural health care. Efficient connectivity will allow rural health care providers to have the ability to communicate with other health systems, have sufficient and up-to-date electronic health records, and the ability to provide telehealth services to their patients.

As the House Committee works to strengthen rural communities, broadband must be front of mind. Society is increasingly reliant on technology for every facet of life and as an economic driver, which is particularly true with health care. To ensure rural communities are capable of being part of the health care delivery system of the 21st century, effective broadband build out is critical. Such a build out must also be coupled with an emphasis on affordability and equitable access to devises with which to use broadband.

Within-Rural Disparities in Health and Health Care

No discussion of rural health should go without mentioning that rural areas and rural residents are not monolithic.[39] One in five rural residents today is Black, Indigenous, or a person of color (BIPOC). Health outcomes for rural BIPOC residents are significantly worse than for rural white residents and for all urban residents.[40,41] In my research, I've found that rural counties with a majority of Black or Indigenous residents are especially vulnerable to poor health outcomes, with the highest premature death rates of any counties in the country.[40,41]

Looking at individual-level data, research shows higher premature death rates among communities of color in rural communities compared to their urban counterparts.[14] In Georgia,

for example, a black individual living in a rural community is 30 percent more likely to die prematurely than their urban counterpart.[14] In Mississippi, a black rural resident is 20 percent more likely to die prematurely. The same statistics are prevalent in the Hispanic community.[14] In Texas, a Hispanic rural resident is 30 percent more likely to die prematurely than their urban counterpart.[14] In Arizona, a Hispanic rural resident is ten percent more likely to die prematurely.[14]

Disparities at the intersection of race and rurality are just as devastating for maternal mortality. According to data from the Center for Disease Control and Prevention, rural areas have a pregnancy-related mortality rate of 29.4 per 100,000 live births versus 18.2 in urban areas, but inequities are more severe if you look among rural residents, especially Black and American Indian/Alaska Native rural residents.[42] In Georgia for example, "rural Black women have a 30 percent higher maternal mortality rate than urban Black women."[42] The Biden-Harris Administration included these issues directly in the first-ever federal Maternal Health Day of Action in December 2021, and the recently enacted Rural Maternal and Obstetric Modernization of Services (Rural MOMS Act), championed by Under Secretary Torres Small in Congress, is an important step toward addressing rural maternal health inequities, although more still needs to be done.

In research from the University of Minnesota Rural Health Research Center released just in the past month, we also show inequities in health at the intersection of rurality and sexual orientation. For example, we find that rural lesbian, gay, and bisexual report higher rates of chronic conditions, anxiety disorder, and depression, and lower self-rated health than their heterosexual or urban counterparts.[43–45] Altogether, these statistics serve as a reminder that rural residents are not monolithic; instead, they face intersecting risks of poorer health outcomes based on their socio-demographic characteristics and social position.

Rural places are also heterogeneous. Rural land areas cover the vast majority of the country (>90%, depending on the measure used) and the challenges that people have around distance, transportation, connectivity, and climate vary considerably from place to place. As such, programs and funding for rural areas need to have built-in flexibility to adapt to the particular needs of specific rural places, which will vary by region and demographic composition.

Building on Rural Strengths

Despite the challenges I've laid out in rural health and health care, rural areas also have considerable strengths. Whether because of size or necessity, rural residents and organizations can be incredibly resourceful and innovative.[46] Many rural areas also have particularly strong social capital and social cohesion.[47] In research I've done, I've found that rural older adults report larger social networks – both more family members and more close friends – than urban older adults.[48] This social fabric provides a tapestry on which strong health and health can be built, given the right support through investment in infrastructure and resources.

The last few years have tested rural residents and rural health care providers. While the challenges facing rural communities are different from those facing their urban counterparts, so

are the innovation opportunities. I appreciate the House Committee on Economic Disparity & Fairness in Growth shedding light on ways to improve rural economic prosperity and well-being. Ultimately, a strong rural economy starts with good health. Good rural health outcomes cannot be achieved without supporting the vitality of rural communities, including strong, modern infrastructure, a robust economy, and a thriving health care system.

Recommendations

There are various policy actions that can be taken to build on the strength inherent in rural areas and to move toward rural health equity. These include:

Broadband Connectivity:

- Thus far in the 117th Congress there has been significant investment in bridging the urban-rural divide when it comes to broadband connectivity access. However, going forward, it is imperative that Congress works with the Biden Administration to ensure that broadband connectivity is built out to areas of most need, particularly in rural communities.
- Not only is broadband critical to ensuring economic growth in rural communities, but it plays an integral role in rural health care. The growth in telehealth utilization at the onset of the COVID-19 pandemic was welcomed in our rural communities, but utilization is tied directly to connectivity in those communities. To ensure utilization, we must ensure connectivity.
- Further, efficient connectivity will allow rural health providers the ability to communicate with other health systems, have sufficient and up-to-date electronic health records, and the ability provide 21st century health care delivery options.

Social Determinants of Health:

- Throughout the COVID-19 pandemic, numerous disparities facing rural communities have been exacerbated. Rural communities are frequently a place of intersection between geographic, socioeconomic, and racial/ethnic disparities.
- As we move forward, data is critical. The United States Department of Agriculture is a trusted source of research and data collection in our rural communities. Proper data must be collected if we hope to understand the full impact the last several years have had on our residents. To improve the health outcomes of residents we must know the statistics; the United States Department of Agriculture should have a hand in this collection effort.
- Also included in this data collection effort should be the Centers for Disease Control and Prevention. To do so, Congress should work to set up an Office of Rural Health within the agency to ensure rural representation in health data moving forward.
- Further, to address the social and structural determinants of health in rural communities and stimulate the rural economy, Congress should fully fund programs that support it (Medicare and Medicaid, school lunch program and SNAP, child care subsidies, behavioral health, and maternal health).

Workforce:

- Ensuring a sustainable rural health workforce as the nation comes out of the COVID-19 pandemic is critical. Congress should take steps to lessen burdens on rural providers, while providing necessary funding to ensure adequate resources to recruit and obtain health professionals.
- Congress should extend the Conrad 30 J-1 Visa Program set to expire September 30, 2022, to ensure rural providers have continued access to this important program.
- Congress should also look to fully fund programs like the National Health Service Corps and Nurse Corps Loan Repayment Program to ensure rural providers can obtain a qualified workforce.
- Lastly, Congress should explore legislative options to make recruiting doctors and nurses easier for rural communities. This includes making rural friendly tweaks to Medicare's Graduate Medical Education (GME) program so that rural providers are able to train physicians. As we've seen historically, if you train in a rural community you're more likely to reside in a rural community later in life. We should be exploring options to make training in rural communities easier.

Rural Hospital, Facility, and Provider Stability:

- The last few years, providers in rural communities have been tested to their limits. Often, they were providing crisis care in dated communities. In fact, one in ten Critical Access Hospitals are more than 25 years old.
- The USDA Community Facilities Program is a key source of infrastructure funding for rural communities and their providers. The program provides direct loans, loan guarantees, and grants to improve essential public services across rural America. Most rural health care providers have taken advantage of this program.
- Further, the USDA Rural Hospital Technical Assistance program, funded each year through the appropriations process, is critical to providing needed technical assistance to struggling, at-risk rural providers.
- USDA, through the Rural Development branch, has provided necessary assistance to rural providers and the communities they serve. Ensuring continued support for these necessary programs will help rural communities thrive.

Thank you again for the opportunity to participate in today's roundtable discussion. I look forward to any questions you might have.

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