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# Federal Regional Commissions and Authorities (FRCAs): Health-Related Programs

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## Federal Regional Commissions and Authorities (FRCAs): Health-Related Programs

Congress has maintained a long-standing interest in improving the health status of rural populations, particularly through increasing access to health services and health workforce training. Federal regional commissions and authorities (FRCAs) are state-federal partnerships that use congressionally-provided appropriations for economic development grants and related activities. FRCAs tend to be rural relative to the overall United States' population. There are eleven FRCAs (see map below); as of the date of publication, six are active.

FRCAs have used a range of program authorities to help economically distressed regions to address health-related concerns. For instance, FRCAs can provide grants for health care facility development, health care workforce development, substance use disorder treatment, and health care business technical assistance. In addition, some FRCAs oversee health advisory councils and J-1 visa waivers for foreign physicians who provide medical services in communities with shortages of health providers. Under P.L. 118-272, enacted in FY2025, Congress expanded FRCA authorities, including authorities for health care demonstration projects. In recent years, Congress has directed other federal agencies to partner with or provide funding to FRCAs for various health care initiatives.

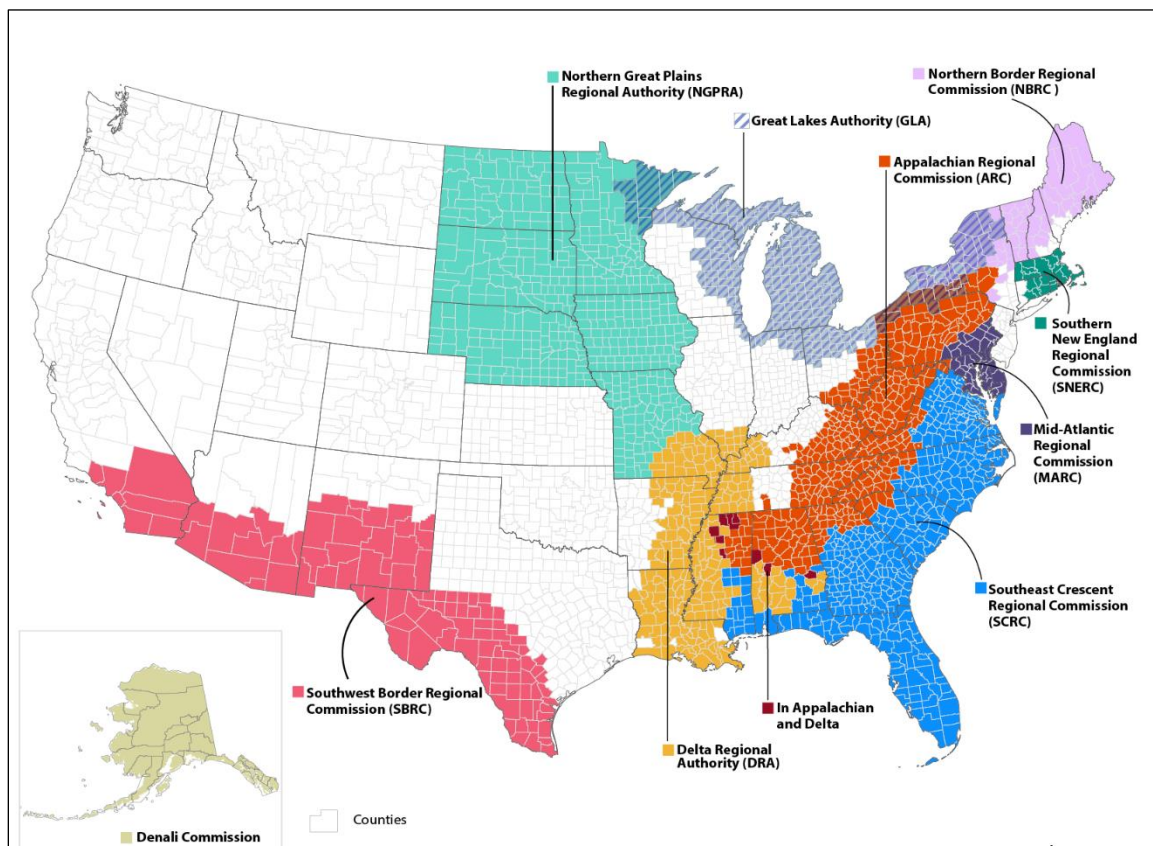
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**Regions of the Federal Regional Commissions and Authorities (FRCAs)  
(by county, parish, or borough)**



**Source:** CRS analysis of authorizing commission and authorities legislation and Esri Data and Maps.

**Notes:** There are no FRCAs in Hawaii. The Northwest Regional Commission is not included in the map above. P.L. 119-74 provided funding for this commission in Washington, Oregon, Idaho, and Montana, but did not provide further geographic information.

Efforts to improve individual and community health outcomes and expand health care access may align with a region's economic development objectives. Health care facilities and related businesses are often employers and may be a region's

largest source of jobs. They may also contribute to state and local economic development through their direct and indirect spending and may induce other jobs in their regions. Health resources and health care institutions also contribute to public health, and are amenities that workers and businesses may consider in their location and investment decisions.

FRCAs use community-driven approaches, convene cross-sector partnerships, and are statutorily authorized to facilitate projects informed by state and local priorities, some of which may also address individual and community health. For instance, FRCAs may support workforce development efforts, which are often designed to enhance regional employment opportunities, and employment is generally correlated with improved individual and community health. Employment is associated with lower mortality in certain circumstances and conditions, and employment may also affect the health of the larger community because of the relationship between employment opportunities, insurance status, health care access, and the financial viability of health providers. FRCAs may also provide a regionally-oriented framework for addressing certain factors that contribute to health. Health care funding often flows to states, but individuals may access health care in ways that cross state boundaries. FRCAs, most of which have multistate regions, may be able to work on the complicated issue of health care access using their experience in administering regional, multistate projects and collaborating with multiple levels of government entities, including regional development organizations.

Congress may wish to evaluate how FRCAs' health-related programs are implemented and how they may further the FRCAs' and FRCA members' economic development goals. Congress may also wish to evaluate whether these programs may serve as a way to expand the reach of federal funding in different or complementary ways or if there are areas of overlapping activity. Congress may consider options to change, integrate, or otherwise coordinate FRCAs' health-related activities with other federal funding programs. Recognizing the role of state and local decisions in health outcomes, policymakers could direct FRCAs to administer economic development programs that are tailored to specific health challenges or opportunities while continuing to integrate state and local input and priorities. Should Congress be supportive of expanded FRCA roles, Congress may wish to build on the existing state and local partnerships that are central to the FRCAs' structural, governance, and operational framework. Finally, Congress may wish to evaluate existing FRCA health activities and their partnerships with other federal, regional, state, and local entities.

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## Introduction

Policymakers have linked health and economic development for decades (see textbox on “ARC’s Health Demonstration Health Projects”). Efforts to improve health outcomes and expand health care access often align with economic development objectives for several reasons.<sup>1</sup> Resilient regional economies—with economic development and employment opportunities—are increasingly viewed as complementary to individual and community health. Social and economic policies, including economic development efforts (e.g., entrepreneurship, workforce training), are often designed to address certain factors, employment opportunities, and living conditions that—along with other determinants—contribute to individual and community health. Such factors are referred to broadly as social determinants of health (i.e., the conditions in which people are born, grow, work, live, worship, and age) and are separate from medical interventions that tend to occur in a clinical setting.<sup>2</sup> Individual health is also generally correlated with socioeconomic status; higher income and wealth levels are associated with greater life expectancy and improved health outcomes.<sup>3</sup>

Health care, as an industry, may also drive economic development. Health care facilities and related businesses are employers and may be a community’s largest source of jobs.<sup>4</sup> They may also contribute to state and local economic development through their direct and indirect spending and may induce other jobs in their regions. Additionally, for-profit (investor-owned) hospitals may provide regional revenue by paying state and local taxes.<sup>5</sup> Nonprofit hospitals are required to meet a “community benefit” standard to qualify for tax exemptions; these include community building activities that are designed to improve the health of the population that the hospital serves.<sup>6</sup> In addition to jobs, revenue, and other economic impacts, health resources and

<sup>1</sup> For examples of state perspectives on rural economic development and health care, see National Governors Association (NGA), “Governors and States Are Advancing Equitable Rural Economic Development and Healthcare,” summary of roundtable events, April 12, 2023, <https://www.nga.org/meetings/governors-and-states-are-advancing-equitable-rural-economic-development-and-healthcare>. For an example of private sector perspectives, see Nashville Healthcare Council, “Intersection of Economic Development and Health: Insights from Crucial Conversations,” March 5, 2025, <https://healthcarecouncil.com/intersection-of-economic-development-and-health-insights-from-crucial-conversations/>. For an example of philanthropic perspectives, see Georgia Health Policy Center, “Reimagining Rural Health: Landscape Analysis,” April 2025, pp. 39-40, <https://www.gih.org/wp-content/uploads/2026/01/Reimagining-Rural-Health-Landscape-Analysis.pdf>.

<sup>2</sup> Centers for Disease Control (CDC), “Social Determinants of Health (SDOH),” <https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html>.

<sup>3</sup> For a summary of recent research on life expectancy and income, see “The Growing Gap in Life Expectancy by Income: Recent Evidence,” in CRS Report R44846, *The Growing Gap in Life Expectancy by Income: Recent Evidence and Implications for the Social Security Retirement Age*, by Katelin P. Isaacs et al.

<sup>4</sup> News analysis of job growth in 2025-2026 has pointed to healthcare-related jobs as a significant driver of economic growth. See, for example, Abha Bhattarai and Luis Melgar, “If Not for This One Industry, the U.S. Labor Market Would Look a Lot Worse,” *The Washington Post*, February 14, 2026, <https://www.washingtonpost.com/business/2026/02/14/health-care-industry-fuels-employment/>; and Lydia DePillis, “Healthcare Has Become the Lifeblood of the Labor Market,” *New York Times*, March 6, 2026, <https://www.nytimes.com/2026/03/06/business/economy/health-care-hiring-labor-market.html>.

<sup>5</sup> In 2025, the share of hospitals that were for-profit (compared to nonprofit or government-run) was approximately 17—24% of all hospitals. See KFF (formerly the Kaiser Family Foundation), “The Hospital Industry—Hospital Characteristics,” <https://www.kff.org/health-costs/key-facts-about-hospitals/?entry=the-hospital-industry-hospital-characteristics>; and Christopher M. Whaley, “Reassessing the Value of Nonprofit Hospital Tax Exemptions: Community Benefit or Missed Opportunity?” Testimony for the U.S. Congress, House Committee on Ways and Means, Subcommittee on Oversight, September 16, 2025, p. 5, [https://waysandmeans.house.gov/wp-content/uploads/2025/09/Whaley\\_Ways-and-Means-Nonprofit-Hospitals-.pdf](https://waysandmeans.house.gov/wp-content/uploads/2025/09/Whaley_Ways-and-Means-Nonprofit-Hospitals-.pdf).

<sup>6</sup> Nonprofit hospitals are required to provide certain community benefits (e.g., free or reduced-cost care) and to meet (continued...)

health care institutions contribute to public health, and—as amenities—contribute to an area’s quality of place. Workers, retirees, and businesses generally consider proximity to and quality of amenities in location decisions.<sup>7</sup> In some regions, health care institutions also lead or facilitate community development, education, and innovation roles and provide telehealth and other services.<sup>8</sup>

For decades, Congress has authorized federal regional commissions and authorities (FRCAs) to address economic and social disparities in designated regions of the United States. FRCAs are quasi-governmental partnerships between the federal government and the constituent state or states of the given authority or commission. FRCAs are federally chartered, receive congressional appropriations for their administration and activities, and include an appointed federal representative.<sup>9</sup> FRCAs may award grants to further their economic goals. In addition to grant-making activities, FRCAs may partner with federal agencies on targeted health initiatives, convene public and private sector stakeholders, serve as Interested Government Agencies for J-1 visa waivers for physician recruitment (see “J-1 Visa Waiver Program for Physician Recruitment”), and coordinate research on health or health care challenges and opportunities (e.g., access to health care, workforce training).

Most FRCA regions also face health and health care challenges, which may impact economic development, health outcomes, and business location decisions in their regions.<sup>10</sup> Generally speaking for most FRCAs, over a third of the population lives in rural areas, exceeding the national average of 20% (see **Appendix A**). Federal policies have long recognized the health challenges that rural areas face—through targeted grants and technical assistance supported by the Federal Office of Rural Health Policy and through payments in federal health programs that target rural hospitals, among other efforts.<sup>11</sup>

This report summarizes research on the relationships between economic development and health as context for discussing health and health care programs facilitated by federal economic development policy—with an emphasis on the six active FRCAs. FRCAs address economic development as well as health and health care priorities as key components of their overall

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other requirements (e.g., to implement financial assistance and emergency medical care policies) in order to maintain their tax-exempt status. Nonprofit hospitals must also meet the general requirements applicable to all 501(c)(3) organizations. For additional information, see CRS Report R48027, *Legal Requirements for Section 501(c)(3) Hospitals*, by Edward C. Liu.

<sup>7</sup> James F. Oehmke et al., “Can Healthcare Services Attract Retirees and Contribute to the Economic Sustainability of Rural Places?” *Northeastern Agricultural and Resource Economics Association Agricultural and Resource Economics Review*, vol. 36, no. 1 (April 2007), pp. 1-12, <https://doi.org/10.22004/ag.econ.10155>; and Jeffrey Dorfman and Anne Mandich “Senior Migration: Spatial Considerations of Amenity and Health Access Drivers,” *Journal of Regional Science*, vol. 56, no. 1 (August 2016), pp. 96-133, <https://doi.org/10.1111/jors.12209>.

<sup>8</sup> National Association of Development Organizations (NADO), *Building Healthier Rural Communities: Economic Development Districts Address Social Determinants of Health*, August 2025, p. 13, [https://www.nado.org/wp-content/uploads/2025/08/Social-Determinants-of-Health\\_v6.pdf](https://www.nado.org/wp-content/uploads/2025/08/Social-Determinants-of-Health_v6.pdf).

<sup>9</sup> The appointment of a federal co-chair, unless otherwise provided, is essential for most federal regional commissions and authorities’ (FRCAs’) operations. With the exception of the Denali Commission, a federal co-chair is a presidentially nominated and Senate-confirmed position.

<sup>10</sup> Elizabeth Weeks, “Medicalization of Rural Poverty: Challenges for Access,” *Journal of Law, Medicine & Ethics*, vol. 46, iss. 3 (September 2018), p. 653, <https://journals.sagepub.com/doi/10.1177/1073110518804219>; and Shannon Monnat and Khary Rigg, “The Opioid Crisis in Rural and Small Town America,” *Carsey Research*, University of New Hampshire, June 19, 2018, <https://carsey.unh.edu/publication/opioid-crisis-rural-small-town-america>. See also Anne Case and Angus Deaton, *Deaths of Despair and the Future of Capitalism* (Princeton University Press: 2020).

<sup>11</sup> U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy (FORHP), <https://www.hrsa.gov/rural-health> and CRS Infographic IG10095, *Medicare Payment for Rural or Geographically Isolated Hospitals, 2026*, by Marco A. Villagrana.

missions to improve the economic conditions of the areas they serve. As such, Congress may consider examining, changing, or expanding the role of FRCAs in advancing health and health care objectives. It may also consider how FRCA activities complement or duplicate existing efforts undertaken by the Department of Health and Human Services (HHS), which is the lead federal health agency. This report considers some of the possible advantages of strong population health and health care resources on regional economic development, as well as the impacts of health care shortages and health-related challenges in place-making, workforce development, and business attraction. Congress may consider the federal role in addressing these challenges, as well as the value of a community- or state-led approach. This report summarizes research and program evaluations carried out by epidemiologists, health economists, social scientists, and policy analysts, where available. There is a vast literature on these topics and this report's review is not exhaustive. **Appendix B** provides additional sources that CRS consulted when developing its analysis.

This report focuses on the health-related initiatives carried out by place-based economic development entities and does not cover general economic policies, though these too may benefit an individual's health.<sup>12</sup> This report does not provide a comprehensive analysis of socioeconomic disparities, health care workforce shortages, or rural hospital closures in FRCA regions.<sup>13</sup>

## Why Health Is Considered a Regional Economic Development Issue

Health is multidimensional. Broadly, community and individual health conditions are linked with—and affected by—economic conditions and opportunities in a particular place.<sup>14</sup> Also, economic development policies are often place-based and focused on improving economic mobility, employment opportunities, conditions for private investment, as well as the quality of services and amenities in a specific place or region.<sup>15</sup> Place-based economic development considerations include, among other things, a community's health resources, human capital, and

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<sup>12</sup> For perspective on the relationships of economic policies on health, see Elizabeth Rigby, "Economic Policy: An Important (but Overlooked) Piece of 'Health in All Policies,'" Washington, DC: Institute of Medicine, 2013, <https://nam.edu/perspectives/economic-policy-an-important-but-overlooked-piece-of-health-in-all-policies/>.

<sup>13</sup> For additional information on rural hospital closures, see CRS Report R47526, *Closed, Converted, Merged, and New Hospitals with Medicare Rural Designations: January 2018–November 2022*, coordinated by Marco A. Villagrana.

<sup>14</sup> Manuel Pastor and Rachel Morello-Frosch, "Integrating Public Health and Community Development to Tackle Neighborhood Distress and Promote Well-Being," *Health Affairs*, vol. 33, no. 11 (November 2014), <https://doi.org/10.1377/hlthaff.2014.0640>.

<sup>15</sup> The definition of "economic development" often varies depending on the priorities, economy, and values of the communities involved. Generally, economic development includes two definitions: first, a general usage; and second, a more specific description of its application in a public policy context. For the former, economic development can be interpreted as the promotion of certain economic ends through site selection by companies, business expansion and development, and public spending (or tax incentives) that support these activities, particularly as they may relate to job creation. In a more public policy-specific context, the definition of economic development may include policy interventions that may support or shape economic activity. Broadly, policy options for economic development typically fall along a continuum between economic growth and social welfare. Growth-oriented policies tend to focus on maximizing top-line macroeconomic performance, whereas social welfare policies often emphasize ameliorating inequality and poverty. The U.S. Economic Development Administration (EDA) defines economic development as "creating the conditions for economic growth and improved quality of life by expanding the capacity of individuals, businesses, and communities to maximize the use of their talents and skills to support innovation, job creation, and private investment." See EDA, "Economic Development Glossary," <https://www.eda.gov/about/economic-development-glossary>.

health care employers and workforce, as well as its overall population health.<sup>16</sup> For instance, positive community health indicators are generally associated with strong regional economic conditions and vice versa.<sup>17</sup> Elevated mortality rates of certain conditions such as substance use disorder are associated with areas experiencing economic distress, including certain FRCA regions.<sup>18</sup> Economic development policies to expand employment opportunities, for example, may align with health policies because employment is correlated with positive individual- and community-level health outcomes.<sup>19</sup> It is important to consider that, while certain aspects of a community's economic and population-level health are intertwined, the relationships are multifaceted, and effects vary by population, location, context, and other factors.<sup>20</sup>

Just as community health outcomes are impacted by many factors, multiple non-medical factors also affect individual health. Certain economic and social factors may influence individual health including health behaviors, socioeconomic factors, and physical and environmental conditions.<sup>21</sup> Some of these factors may be referred to as social determinants of health (see text box).

### Social Determinants of Health

Factors that affect individual and population health are known as *determinants of health*. Determinants of individual health are varied and multifaceted. The U.S. Department of Health and Human Services (HHS) defines social determinants of health (SDOH), as “the conditions in which people are born, grow, live, work and age, and people’s access to power, money and resources.” When weighing all of the factors that may impact an individual’s health, HHS has found that the SDOH contribute approximately 50% to health outcomes. These determinants include factors “such as housing, food and nutrition, transportation, social and economic mobility, education, and environmental conditions.” In addition to clinical care and SDOH, other factors that contribute to health outcomes include genetics and health behaviors.

**Sources:** CRS Infographic IG10083, *Public Health Prevention and the Determinants of Health*, by Johnathan H. Duff et al.; Centers for Disease Control (CDC), “Social Determinants of Health (SDOH),” <https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html>; U.S. Department of Health and Human Services (HHS), “Social Determinants of Health,” <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health>; and Amelia Whitman et al., “Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts,” 2022, p. 2, <https://aspe.hhs.gov/reports/sdoh-evidence-review>.

<sup>16</sup> For additional information, see CRS In Focus IF12409, *What Is Place-Based Economic Development?*, by Adam G. Levin. For a review of changing approaches to economic development, see Steven S. Deller, “Are We at an Inflection Point in Community Economic Development? The 4<sup>th</sup> Wave,” *Economic Development Quarterly*, vol. 39, iss. 4 (May 28, 2025), <https://doi.org/10.1177/08912424251339139>.

<sup>17</sup> Steven H. Wolf et al., “How Are Income and Wealth Linked to Health and Longevity?” April 2015, pp. 6, 11-12, <https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf>; and Atheendar S. Venkataramani et al., “Economic Influences on Population Health in the United States: Toward Policymaking Driven by Data and Evidence,” *PLOS Medicine*, vol. 17, iss. 9 (September 2, 2020) <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003319>. See also “Impact of Health on Economic Growth” in Alison F. Davis et al., *The Program Evaluation of the ARC’s Health Projects, 2004-2010*, prepared for ARC, pp. 6-10, <https://www.arc.gov/wp-content/uploads/2020/06/ProgramEvaluationofARCsHealthProjects2004-2010.pdf>.

<sup>18</sup> For instance, deaths by suicide, drug use, and alcohol abuse are commonly referred to as “deaths of despair.” See Anne Case and Angus Deaton, *Deaths of Despair and the Future of Capitalism* (Princeton University Press: 2020); and Andrew Goodman-Bacon, “‘Deaths of Despair’ and Economic Opportunity,” Federal Reserve Bank of Minneapolis, February 24, 2023, <https://www.minneapolisfed.org/article/2023/deaths-of-despair-and-economic-opportunity>.

<sup>19</sup> See the “Economic Stability” section in HHS, Office of Disease Prevention and Health Promotion (ODPHP), “Social Determinants of Health Literature Summaries,” <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries>.

<sup>20</sup> Andrew Goodman-Bacon, “‘Deaths of Despair’ and Economic Opportunity,” Federal Reserve Bank of Minneapolis, February 24, 2023, <https://www.minneapolisfed.org/article/2023/deaths-of-despair-and-economic-opportunity>.

<sup>21</sup> Carlyn M. Hood et al., “County Health Rankings: Relationships Between Determinant Factors and Health Outcomes,” *American Journal of Preventive Medicine*, vol. 50, no. 2 (February 2016), pp. 129–135; <https://www.sciencedirect.com/science/article/abs/pii/S0749379715005140>.

The cumulative impact of living in places with limited financial and educational resources or under persistent poverty conditions is linked to health in complex ways. Economic Research Service researchers have observed that, “the cumulative effect of being poor may lead to poor health, limited education, and other negative outcomes.”<sup>22</sup> An HHS summary of the literature on poverty notes that

Unmet social needs, environmental factors, and barriers to accessing health care contribute to worse health outcomes for people with lower incomes. For example, people with limited finances may have more difficulty obtaining health insurance or paying for expensive procedures and medications. In addition, neighborhood factors, such as limited access to healthy foods and higher instances of violence, can affect health by influencing health behaviors and stress.<sup>23</sup>

The following sections summarize select health-related opportunities and challenges and how they may be linked with regional economic development and growth. They also provide context for FRCA investments in health. Additional information on FRCAs is provided later in the report. The challenges and opportunities discussed below do not uniformly apply to all FRCA regions, but are generally relevant to many of the FRCAs’ economic development priorities and activities, and particularly for rural areas in FRCA regions (see **Appendix A**).

## Employment and Health

Employment and health are linked.<sup>24</sup> For instance, employment is associated with lower mortality in certain circumstances and conditions.<sup>25</sup> Unemployment is generally correlated with negative health consequences, particularly for mental health.<sup>26</sup> Authors of a 2018 review of research found that, rather than a bidirectional causal relationship (i.e., employment causes improved health and vice versa), the relationships between employment and health are correlational and complex and depend on social contexts, such as the nature of jobs that workers occupy.<sup>27</sup>

Employment and health are often directly linked because jobs provide income and other benefits that support health.<sup>28</sup> Depending on the rate of compensation, having a job enables individuals to

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<sup>22</sup> U.S. Department of Agriculture (USDA), Economic Research Services (ERS), “Rural Poverty & Well-Being,” updated January 14, 2025, <https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being>.

<sup>23</sup> As part of developing national population health goals, HHS’s Office of Disease Prevention and Health Promotion (ODPHP), reviews the literature on various health priority areas. For more information, see HHS ODPHP, “Poverty,” <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty>.

<sup>24</sup> For a summary of the literature on the association between health and employment, see Jerome M. Adams, “Improving Individual and Community Health Through Better Employment Opportunities,” *Health Affairs Blog*, May 8, 2018, <https://www.healthaffairs.org/content/forefront/improving-individual-and-community-health-through-better-employment-opportunities>; and HHS, “Employment,” <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/employment>.

<sup>25</sup> An analysis of health and economic literature noted that in the United States, minimum- and medium-skilled workers had higher mortality, compared to higher income workers, if they were unemployed—likely because they had “less access to support services.” See Steven H. Wolf et al., “How Are Income and Wealth Linked to Health and Longevity?” April 2015, p. 11, <https://www.urban.org/research/publication/how-are-income-and-wealth-linked-health-and-longevity>.

<sup>26</sup> HHS, ODPHP, “Employment,” <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/employment>.

<sup>27</sup> Larisa Antonisse and Rachel Garfield, “The Relationship Between Work and Health: Findings from a Literature Review,” KFF Issue Brief, August 2018, pp. 5-6, <https://files.kff.org/attachment/Issue-Brief-The-Relationship-Between-Work-and-Health-Findings-from-a-Literature%20Review>.

<sup>28</sup> Research supports positive *correlational* relationships between health and income. Experts continue to examine potential causal relationships between income and health and related effects. For a summary of select studies, see (continued...)

pay for housing, food, and health care, which contribute to health. Jobs may provide benefits such as health insurance. They may also provide other benefits such as retirement funding and paid leave, which may also facilitate health and well-being. Jobs may also be a source of structure, social connection, and meaning, which benefit individual health.<sup>29</sup> The nature and quality of the job may affect how employment influences individual health. Certain jobs with low security, high stress, or long hours may negatively impact health.<sup>30</sup>

One of the mechanisms through which employment may affect health is through health insurance coverage. The predominant method of health insurance coverage in the United States is employer-sponsored insurance.<sup>31</sup> Thus employment status is directly linked to the ability to access health services as some health providers require health insurance as a condition of seeing a patient. Being uninsured generally reduces access to care and increases out of pocket costs for care.<sup>32</sup> Individuals with concerns about cost may be less likely to seek necessary care.<sup>33</sup> General access to health care in a given geographic area may also be influenced by the insurance coverage of the population of that area. In general, a medical facility's payer mix—its percentage of patients with private health insurance—affect the facility's financial health.<sup>34</sup> Facilities that serve more people with private health insurance and fewer people who are uninsured are less likely to experience financial distress, and financial distress is associated with health facility closures.<sup>35</sup> Thus, employment generally both improves individual health, but may also affect the health of the larger community because of the relationship between employment, insurance status, health care access, and the financial viability of health providers.

Health also affects employment and is correlated with income levels. Physical and mental health conditions impact individuals' ability to learn and work, which, in turn, affects their productivity, earnings, and quality of life. When individuals are healthy, they are generally able to obtain and keep jobs.<sup>36</sup> When individuals are in poor health, they have a higher risk of job loss or

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Angus Deaton, "Health, Inequality, and Economic Development," *Journal of Economic Literature*, vol. XLI (March 2003), [https://www.princeton.edu/~deaton/downloads/Health\\_Inequality\\_and\\_Economic\\_Development.pdf](https://www.princeton.edu/~deaton/downloads/Health_Inequality_and_Economic_Development.pdf).

<sup>29</sup> HHS, ODPHP, "Employment," [https://odphp.health.gov/sites/default/files/2023-05/SDOH%20Infographic\\_Employment.pdf](https://odphp.health.gov/sites/default/files/2023-05/SDOH%20Infographic_Employment.pdf).

<sup>30</sup> Jerome M. Adams, "Improving Individual and Community Health Through Better Employment Opportunities," May 8, 2018, <https://www.healthaffairs.org/content/forefront/improving-individual-and-community-health-through-better-employment-opportunities>. There are exceptions to the correlation between unemployment and poor health consequences. See Sarah A. Burgard and Katherine Y. Lin, "Bad Jobs, Bad Health? How Work and Working Conditions Contribute to Health Disparities," *The American Behavioral Scientist*, vol. 57, no. 8 (August 2013), pp. 10-11, <https://journals.sagepub.com/doi/10.1177/0002764213487347>.

<sup>31</sup> CRS In Focus IF10830, *U.S. Health Care Coverage and Spending*, by Ryan J. Rosso and Sylvia L. Bryan.

<sup>32</sup> Jennifer Tolbert et al., "The Uninsured Population and Health Coverage," KFF, Health Policy 101, Washington, DC, October 8, 2025, <https://www.kff.org/uninsured/health-policy-101-the-uninsured-population-and-health-coverage/?entry=table-of-contents-introduction>.

<sup>33</sup> Shameek Rakshit, "Access & Affordability: How Does Cost Affect Access to Healthcare?," Peterson KFF Health System Tracker, Washington, DC, March 10, 2026, <https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#Percent%20of%20adults%20who%20reported%20barriers%20to%20accessing%20healthcare,%202024>.

<sup>34</sup> Matthew Manary et al., "Payer Mix & Financial Health Drive Hospital Quality: Implications for Value-Based Reimbursement Policies," *Behavioral Science & Policy*, Spring 2015, pp. 78-84, <https://journals.sagepub.com/doi/10.1177/237946151500100110>.

<sup>35</sup> George M. Holmes et al., "Predicting Financial Distress and Closure in Rural Hospitals," *The Journal of Rural Health*, vol. 33, no. 3 (Summer 2017), pp. 239-249, <https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12187?msocid=12085c83de2365cf2bf44bfbd846454>.

<sup>36</sup> Jerome M. Adams, "The Value of Worker Well-Being," *Public Health Reports*, vol. 134, iss. 6 (2019), pp. 83-586, <https://journals.sagepub.com/doi/10.1177/0033354919878434>.

unemployment.<sup>37</sup> At the aggregate level, when workers are healthy, they are also able to be productive and thereby contribute to gross domestic product (GDP).<sup>38</sup> In the United States, higher incomes are correlated with longer life expectancy.<sup>39</sup> In a 2016 study researchers analyzed 1.4 billion tax records for individuals for every year from 1999 through 2014 and observed that longer life expectancies were generally associated with higher income levels.<sup>40</sup>

Relationships between education and individual health are also multifaceted. A considerable body of research has identified the relationship between health and education. However, researchers do not have a single theory or explanation for the relationships between education and health. Numerous studies point to the overall positive impact that education has on individual health outcomes. Adults with higher levels of education generally have better health.<sup>41</sup> Education that leads to better jobs and higher income is one of several likely pathways that contribute to improved health. In other words, greater educational attainment may improve individual economic outcomes, which may, in turn, improve health through better access to health services,<sup>42</sup> better access to healthy food, among other benefits.<sup>43</sup>

## Health Care Industry Employment

Health care and health-related businesses and institutions can be a major source of employment and may generate other beneficial economic activity in certain regions. Health care employment is often considered in regional economic development strategies for several reasons: (1) the industry's often high share of overall employment; (2) the industry's growth trend and resilience; and (3) the nature of health care wages, which tend to be higher than average than other industries.

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<sup>37</sup> For a summary of the literature on health and employment, see Larisa Antonisse and Rachel Garfield, "The Relationship Between Work and Health: Findings from a Literature Review," KFF Issue Brief, August 2018, pp. 2-3, <https://files.kff.org/attachment/Issue-Brief-The-Relationship-Between-Work-and-Health-Findings-from-a-Literature%20Review>.

<sup>38</sup> David E. Bloom et al., "The Effect of Health on Economic Growth: a Production Function Approach," *World Development*, vol. 32, iss. 1 (2014), pp. 1-13, <https://doi.org/10.1016/j.worlddev.2003.07.002>.

<sup>39</sup> For a summary of recent research, see "The Growing Gap in Life Expectancy by Income: Recent Evidence," in CRS Report R44846, *The Growing Gap in Life Expectancy by Income: Recent Evidence and Implications for the Social Security Retirement Age*, by Katelin P. Isaacs et al.

<sup>40</sup> Raj Chetty et al., "The Association Between Income and Life Expectancy in the United States, 2001-2014," *JAMA*, vol. 315, no. 16 (April 26, 2016), pp. 1751, 1762, <https://jamanetwork.com/journals/jama/fullarticle/2513561>.

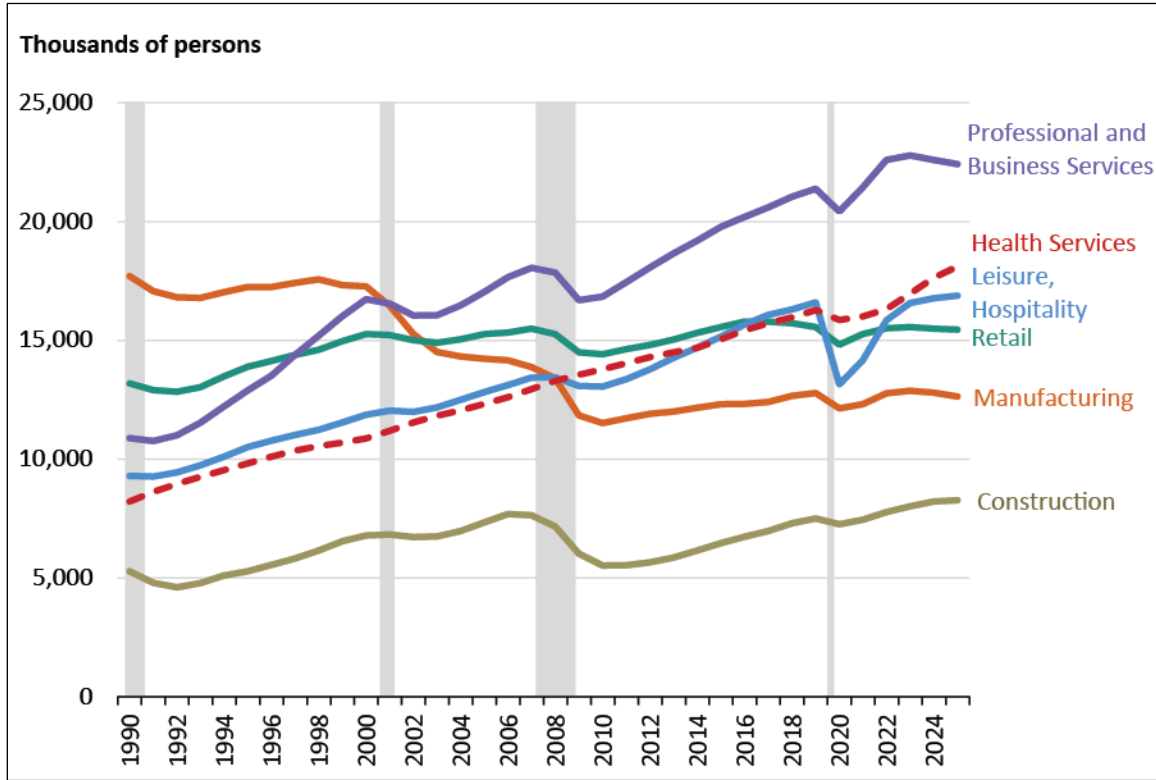
<sup>41</sup> For a summary of the relationship between education and health, see David M. Cutler and Adriana Lleras-Muney, "Education and Health," in Robert F. Schoeni, et. al, eds., *Making Americans Healthier* (Russell Sage Foundation Press, 2008), pp. 29-60; and See Steven H. Wolf et al., "How Are Income and Wealth Linked to Health and Longevity?" April 2015, p. 1, <https://www.urban.org/research/publication/how-are-income-and-wealth-linked-health-and-longevity>.

<sup>42</sup> Access to health care is impacted by the availability of health care services in a particular place, as well as the affordability of health care, including insurance coverage and other factors. See Agency for Healthcare Research and Quality, "Access to Healthcare and Disparities in Access," *2021 National Healthcare Quality and Disparities Report*, December 2021, <https://www.ncbi.nlm.nih.gov/books/NBK578537/>.

<sup>43</sup> Research findings suggest that education facilitates better-paying jobs, which supports wealth creation, and income and/or wealth can be used to improve health. See Anna Zajacova and Elizabeth M. Lawrence, "The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach," *Annual Review of Public Health*, vol. 39 (April 1, 2018), pp. 273-289, <https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-031816-044628>.

For several decades, health care has been one of largest industries in the United States.<sup>44</sup> Beginning in 2009, employment in health care surpassed employment in manufacturing, and in 2018, employment in health care surpassed employment in retail (see **Figure 1**).<sup>45</sup>

**Figure 1. U.S. Employment by Selected Industry, 1990-2025**



**Source:** CRS with data from the following U.S. Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) data series IDs: CES2000000001 (construction), CES6562000101 (health services), CES7000000001 (leisure, hospitality), CES3000000001 (manufacturing), CES6000000001 (professional and business services), and CES4200000001 (retail). Retrieved February 20, 2026, from <https://data.bls.gov/PDQWeb/ce>.

**Notes:** Data are seasonally adjusted. Each line corresponds to a major industry, by North American Industry Classification System (NAICS) industry codes. This figure displays Health Services (NAICS 62 [621, 622, 623]) and does not include Social Assistance (NAICS 624). For additional information about NAICS 62, see <https://www.bls.gov/iag/tgs/iag62.htm>. Periods of economic recession are shaded in gray.

<sup>44</sup> For a comparison of employment by industry sectors in 2014 and 2024, see U.S. Bureau of Labor Statistics (BLS), “Employment by Major Industry Sector,” <https://www.bls.gov/emp/tables/employment-by-major-industry-sector.htm>. For data on employment and earnings for the past six months, see BLS, “Employment and Earnings Table B-1a,” <https://www.bls.gov/web/empsit/cese1a.htm>. See also Lydia DePillis and Christine Zhang, “How Healthcare Remade the U.S. Economy,” *New York Times*, July 3, 2025, <https://www.nytimes.com/interactive/2025/07/03/business/economy/healthcare-jobs.html>; and Kristen Stiegler et al., “Healthcare Employment Projections, 2019–2029: An Analysis of Bureau of Labor Statistics Projections by Setting and by Occupation,” Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; August 2021, <https://www.chwsny.org/wp-content/uploads/2021/08/Health-Care-Employment-Projections-2019%E2%80%932029.pdf>.

<sup>45</sup> CRS calculations based on the industry’s annual average employment using BLS Current Employment Statistics (CES) data series. See also Joshua D. Gottlieb et al., “Rise of Healthcare Jobs,” National Bureau of Economic Research (NBER) Working Paper No. 33583, March 2025, <https://www.gottlieb.ca/papers/HealthCareJobs.pdf>. For a comparison of average annual job growth by industry for selected periods (January 2014–July 2024), see **Figure 10** in CRS Report R48468, *Recent Wages Trends and Issues*, by Sarah A. Donovan.

Health care employment is also an important share of all employment in rural areas.<sup>46</sup> Since 2001, health care and social assistance has been one of the top four industries in rural areas in terms of employment.<sup>47</sup> In addition, a Federal Reserve analysis noted that health care is one of the industries with the most significant employment gains in nonmetro areas in recent years.<sup>48</sup>

Health care jobs appear to be resilient to economic downturns. Analysts observe that health sector jobs—with some exceptions—are typically “recession-proof” because many health services, unlike other purchases, cannot be delayed.<sup>49</sup>

Lastly, jobs in the health care industry generally have wages that are higher than the median annual wages for jobs in other industries.<sup>50</sup> Health care workers include a wide range of positions and training requirements. While median wages for health care practitioners and technical occupations (e.g., dental hygienists, physicians and surgeons, registered nurses) are generally higher than the national median wage, median wages are lower than the national median wage for health care support occupations (e.g., home health and personal care aides, medical transcriptionists, and occupational therapy assistants).<sup>51</sup>

## Health Care Spending and Regional Economic Effects

Health care spending is a significant and growing portion of U.S. gross domestic product (GDP).<sup>52</sup> At the subnational level, health care spending is often an important economic factor in

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<sup>46</sup> James C. Davis, “Rural Job Growth Has Shifted Toward High-Skill Workers Since 2001,” January 17, 2023, USDA, ERS, <https://www.ers.usda.gov/data-products/charts-of-note/chart-detail?chartId=105587>; and Anne M. Mandich and Jeffrey H. Dorfman, “The Wage and Job Impacts of Hospitals on Local Labor Markets,” *Economic Development Quarterly*, vol. 31, iss. 2 (February 1, 2017), <https://doi.org/10.1177/0891242417691609>.

<sup>47</sup> James C. Davis et al., “Rural America at a Glance: 2022 Edition,” USDA, ERS, Economic Information Bulletin Number 246, November 2022, pp. 8-10, [https://ers.usda.gov/sites/default/files/\\_laserfiche/publications/105155/EIB-246.pdf?v=13453](https://ers.usda.gov/sites/default/files/_laserfiche/publications/105155/EIB-246.pdf?v=13453).

<sup>48</sup> Andrew Dumont, “Changes in the U.S. Economy and Rural-Urban Employment Disparities,” FEDS Notes (Washington: Board of Governors of the Federal Reserve System, January 19, 2024), <https://doi.org/10.17016/2380-7172.3428>. See also James C. Davis et al., “Rural America at a Glance: 2022 Edition,” USDA, ERS, Economic Information Bulletin Number 246, November 2022, p. 12, [https://ers.usda.gov/sites/default/files/\\_laserfiche/publications/105155/EIB-246.pdf?v=13453](https://ers.usda.gov/sites/default/files/_laserfiche/publications/105155/EIB-246.pdf?v=13453).

<sup>49</sup> In 2020, the COVID-19 recession impacted job growth in most employment industries—including health care. During the COVID-19 recession, health care jobs dropped significantly between January and April 2020 compared to jobs from the same period in the prior year. See Imani Telesford et al., “What Are the Recent Trends in Health Sector Employment?” Peterson Center on Healthcare and KFF, March 27, 2024, <https://www.healthsystemtracker.org/chart-collection/what-are-the-recent-trends-health-sector-employment/>; Joshua D. Gottlieb et al., “Rise of Healthcare Jobs,” NBER Working Paper No. 33583, March 2025, p. 2, <https://www.gottlieb.ca/papers/HealthCareJobs.pdf>; and Anne M. Mandich and Jeffrey H. Dorfman, “The Wage and Job Impacts of Hospitals on Local Labor Markets,” *Economic Development Quarterly*, vol. 31, iss. 2 (February 1, 2017), p. 144, <https://doi.org/10.1177/0891242417691609> (Original work published 2017).

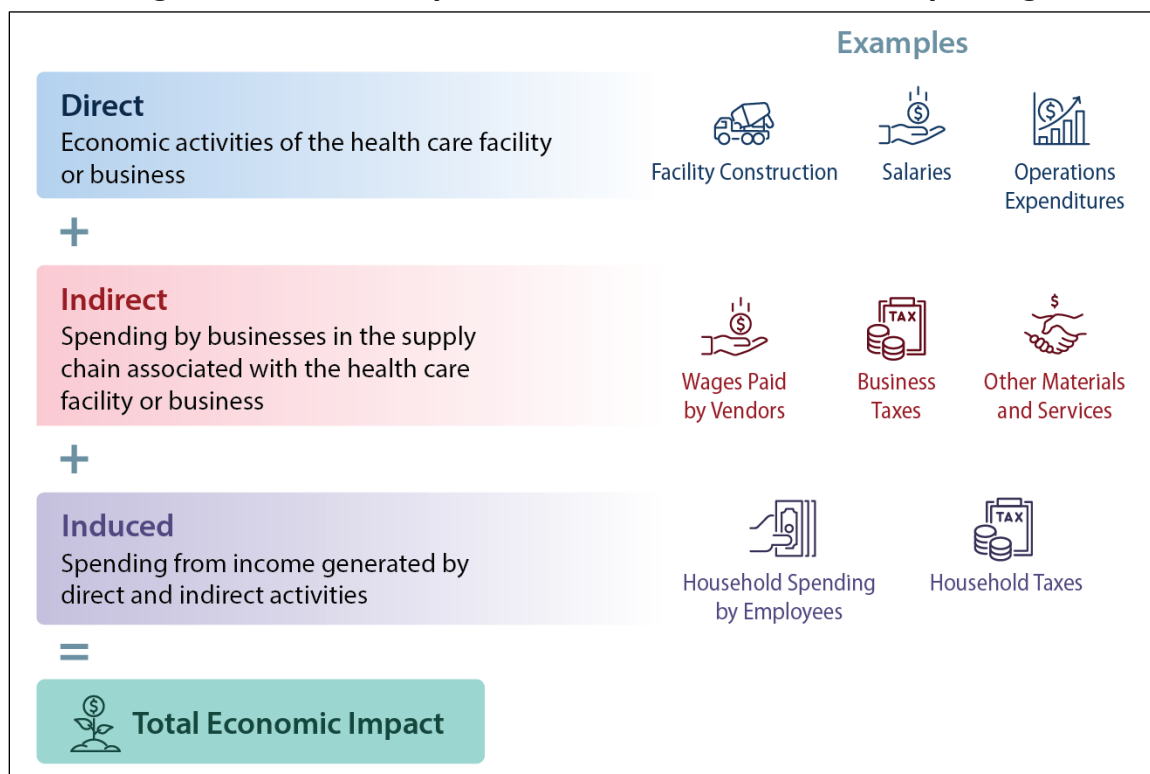
<sup>50</sup> According to the BLS, “The median annual wage for healthcare practitioners and technical occupations (such as dental hygienists, physicians and surgeons, and registered nurses) was \$83,090 in May 2024, which was higher than the median annual wage for all occupations of \$49,500.” See BLS, “Healthcare Occupations,” <https://www.bls.gov/ooh/healthcare/>; and Joshua D. Gottlieb et al., “Rise of Healthcare Jobs,” NBER Working Paper No. 33583, March 2025, p. 8, <https://www.gottlieb.ca/papers/HealthCareJobs.pdf>.

<sup>51</sup> BLS, “Healthcare Occupations,” <https://www.bls.gov/ooh/healthcare/>.

<sup>52</sup> Health care spending comprised 5% of gross domestic product (GDP) in the 1950s and was approximately 18% of GDP in 2024. See U.S. Centers for Medicare & Medicaid Services, “National Health Expenditures (NHE) Fact Sheet,” updated January 14, 2026, <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>; and Aaron C. Catlin and Cathy A. Cowan, “History of Health Spending in the United States, 1960-2013,” November 19, 2015, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/historicalnhepaper.pdf>.

local and regional economies where health care businesses contribute to direct, indirect, and induced economic impacts (see **Figure 2**). Direct impacts include wages (employment) and operations expenses. The indirect impacts include business spending on local suppliers' goods and services, which may spin off additional jobs. Induced impacts occur when workers (and their households) spend money in the region.<sup>53</sup>

**Figure 2. Economic Impacts Associated with Health Care Spending**



**Source:** CRS. Figure based on examples of economic impact analysis provided in Federal Reserve Bank of Philadelphia, *Rural Economic Development Summit: Health Ecosystems and Workforce Pipelines* (presentation), June 3, 2025, <https://www.philadelphiafed.org/calendar-of-events/rural-economic-development-summit-health-ecosystems-and-workforce-pipelines>; Patrick T. Harker et al., “Anchor Impact: Understanding the Role of Higher Education and Hospitals in Regional Economies,” Federal Reserve Bank of Philadelphia, September 2022, <https://www.philadelphiafed.org/-/media/FRBP/Assets/Community-Development/Reports/anchor-economy-report-92022.pdf>; and Patricia Oslund et al., “The Importance of the Health Care Sector to the Barber County Economy,” Institute for Policy & Social Research, University of Kansas, May 2025.

Direct, indirect, and induced economic impacts, when present, vary by geography (e.g., location, degree of economic distress and/or rurality), type of businesses (e.g., inpatient facilities, outpatient facilities), and other factors and considerations, which may affect the degree or scale of their impacts.<sup>54</sup>

<sup>53</sup> Cristina Miller et al., “Employment Spillover Effects of Rural Inpatient Healthcare Facilities,” ERR-241, USDA ERS, December 2017, p. 10, [https://ers.usda.gov/sites/default/files/\\_laserfiche/publications/86254/ERR-241.pdf?v=88835](https://ers.usda.gov/sites/default/files/_laserfiche/publications/86254/ERR-241.pdf?v=88835).

<sup>54</sup> Researchers and economic development practitioners estimate local job (employment) multiplier effects as a means of measuring the economic impacts associated with an employment or output shift (e.g., a particular investment, policy or industry shift, development project) on the broader regional or local economy. Researchers use a range of approaches or models for estimating the impacts (e.g. input-output, econometric), which generally account for the size (continued...)

### Anchor Institutions: Eds and Meds

In many regions, health care facilities, along with educational institutions (“eds and meds”), are considered key drivers of regional economic activity. Eds and meds are referred to as anchor institutions due to their direct impacts on local and regional economies as employers and purchasers of goods and services. Anchor institutions may provide indirect and induced effects when other companies do business with the institutions and when employees spend earnings.

There are risks to having a regional economy that is primarily focused on health care—or on any other singular industry. Analysts note that potential economic and community benefits associated with anchor institutions may be impacted by disruptions caused by pandemics (e.g., COVID-19), technology (e.g., telehealth), demographic shifts (e.g., declining populations), or public policy changes (e.g., insurance coverage). These changes are relevant to regions with eds and meds as anchor institutions because the business practices of these entities often involve significant volume of transfer payments from the government and/or insurance industry. Policy changes that seek to constrain health care spending may be particularly challenging to areas with health care anchor institutions. For example, some hospitals are planning to reduce or cut services because of concerns about reductions in federal health payments included in the FY2025 Reconciliation Law (P.L. 119-21).

**Sources:** Andrew Cass, “32 Hospitals Closing Departments or Ending Services,” May 1, 2026, Becker’s Hospital Review, <https://www.beckershospitalreview.com/finance/32-hospitals-closing-departments-or-ending-services>; Patrick T. Harker et al. “Anchor Impact: Understanding the Role of Higher Education and Hospitals in Regional Economies,” Federal Reserve Bank of Philadelphia, September 2022, p.3, <https://www.philadelphiafed.org/-/media/FRBP/Assets/Community-Development/Reports/anchor-economy-report-92022.pdf>; and CRS Report R48633, *Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law*, coordinated by Alison Mitchell.

## Talent Attraction, Human Capital, and Place-Making

Strong regional economies feature amenities that help attract and retain businesses, workers, and residents.<sup>55</sup> For certain businesses, locating their facilities in areas with access to health care amenities may help recruit and retain employees.<sup>56</sup> Businesses generally benefit from lower costs and higher productivity by having a healthy workforce.<sup>57</sup> The quality of health care services and

and type of the labor market, labor supply conditions, and industry factors, among other considerations. The effects may be positive or negative. When positive, the multiplier effect is occasionally referred to as an indicator of “spillover” jobs that may be created when a job is created in a particular area. See Timothy J. Bartik and Nathan Sotherland, “Realistic Local Job Multipliers,” W.E. Upjohn Institute Policy Brief, April 2019, [https://research.upjohn.org/cgi/viewcontent.cgi?article=1007&context=up\\_policybriefs](https://research.upjohn.org/cgi/viewcontent.cgi?article=1007&context=up_policybriefs).

A 2017 analysis by the USDA ERS described the multiplier in the inpatient health care context as

the total number of jobs in the county in all industries that result from the addition of one inpatient healthcare job. A multiplier equal to 1 implies that there is only a direct impact of that healthcare job. A multiplier greater than one implies that the inpatient healthcare job generated additional jobs in the county in other industries.

The report noted that a county’s degree of rurality influenced whether there were positive multiplier effects from rural inpatient health care facilities (e.g., hospitals, nursing homes, other residential care facilities). The study found that rural inpatient health care facilities have direct employment effects (i.e., jobs associated with the facility) and estimated a likely positive multiplier effect for facilities in larger, less remote rural areas or “micropolitan” areas, but did not find such an effect in more remote or “noncore” areas. See Cristina Miller et al., “Employment Spillover Effects of Rural Inpatient Healthcare Facilities,” USDA, ERS, ERR-241, December 2017, pp. iv, 24-25.

<sup>55</sup> Rural Health Information Hub, “Community Vitality and Rural Healthcare,” <https://www.ruralhealthinfo.org/topics/community-vitality-and-rural-healthcare>.

<sup>56</sup> Anne M. Mandich and Jeffrey H. Dorfman, “The Wage and Job Impacts of Hospitals on Local Labor Markets,” *Economic Development Quarterly*, vol. 31, iss. 2 (February 1, 2017), p. 146, <https://doi.org/10.1177/0891242417691609>; “Exploring Strategies to Improve Health and Equity in Rural Communities,” NORC Walsh Center for Rural Health Analysis, February 2018, p. 33, <https://www.norc.org/content/dam/norc-org/pdfs/Rural%20Assets%20Final%20Report%20Feb%2018.pdf>; and Rural Health Information Hub, “Community Vitality and Rural Healthcare,” <https://www.ruralhealthinfo.org/topics/community-vitality-and-rural-healthcare>.

<sup>57</sup> David E. Bloom et al., “The Effect of Health on Economic Growth: a Production Function Approach,” *World Development*, vol. 32, iss. 1 (2014), pp. 1-13, <https://doi.org/10.1016/j.worlddev.2003.07.002>.

the proximity to health care facilities also factor into worker and retiree location decisions—including remote workers’ location decisions.<sup>58</sup> The effects of community health and health care resources on in-migration (i.e., people relocating to the area) appear to correlate in reverse as well. Regions experiencing high rates of economic distress and diseases of despair, including opioid and substance use disorders (SUD), may have health and health care challenges that limit private investment, economic development, and growth.<sup>59</sup>

In addition to targeted strategies to attract human capital, economic development practitioners increasingly focus on place-making strategies designed to enhance an area’s suite of public and private amenities, which, in turn, contribute to an overall enhanced quality of place.<sup>60</sup> In doing so, economic developers emphasize “attracting and retaining people,” rather than—or in addition to—focusing solely on attracting and retaining businesses and private investment.<sup>61</sup> According to this perspective, factors that contribute to an area’s quality of place may include healthy individuals, health care access, various amenities, and resilient regional economies—which are mutually reinforcing.<sup>62</sup> Creating quality places may attract businesses, which may increase an area’s tax base and population. A community with residents with insurance coverage may be better positioned to support health care businesses. Stakeholder groups have identified a similar relationship between health care industry and economic development in certain communities—noting the reliance of financially sustainable health care systems on the “overarching economic prosperity and revitalization of rural communities.”<sup>63</sup>

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<sup>58</sup> Health care access has been linked with senior and retiree location decisions—see James F. Oehmke et al., “Can Healthcare Services Attract Retirees and Contribute to the Economic Sustainability of Rural Places?” *Northeastern Agricultural and Resource Economics Association Agricultural and Resource Economics Review*, vol. 36, no. 1 (April 2007), pp. 1-12, <https://doi.org/10.22004/ag.econ.10155>; and Jeffrey Dorfman and Anne Mandich, “Senior Migration: Spatial Considerations of Amenity and Health Access Drivers,” *Journal of Regional Science*, vol. 56, no. 1 (August 2016), pp. 96-133, <https://doi.org/10.1111/jors.12209>.

For a description of health care as a consumptive and productive amenity for rural areas, see “Local Amenity Effects” in Cristina Miller, John Pender, and Thomas Hertz, “Employment Spillover Effects of Rural Inpatient Healthcare Facilities,” ERR-241, USDA ERS, December 2017, p. 12, [https://ers.usda.gov/sites/default/files/\\_laserfiche/publications/86254/ERR-241.pdf?v=88835](https://ers.usda.gov/sites/default/files/_laserfiche/publications/86254/ERR-241.pdf?v=88835).

<sup>59</sup> Bokyung Kim et al., “The Opioid Crisis and the Role of Employers,” Stanford Institute for Economic Policy Research Policy Brief, January 2024, [https://drive.google.com/file/d/1gTYv-GiSaQ\\_3ovmUbc1pNPe96EpVsVjD/view](https://drive.google.com/file/d/1gTYv-GiSaQ_3ovmUbc1pNPe96EpVsVjD/view); and Julia Paris et al., “The Economic Impact of the Opioid Epidemic,” The Brookings Institution, April 17, 2023, <https://www.brookings.edu/articles/the-economic-impact-of-the-opioid-epidemic>.

<sup>60</sup> John C. Austin et al., “Improving Quality of Life—Not Just Business—Is the Best Path to Midwestern Rejuvenation,” the Brookings Institution, January 26, 2022, <https://www.brookings.edu/articles/improving-quality-of-life-not-just-business-is-the-best-path-to-midwestern-rejuvenation/>; Manuel Pastor and Rachel Morello-Frosch, “Integrating Public Health and Community Development to Tackle Neighborhood Distress and Promote Well-Being,” *Health Affairs*, vol. 33, no. 11 (November 2014), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0640>; and National Association of Development Organizations (NADO), *Building Healthier Rural Communities: Economic Development Districts Address Social Determinants of Health*, August 2025, p. 13, [https://www.nado.org/wp-content/uploads/2025/08/Social-Determinants-of-Health\\_v6.pdf](https://www.nado.org/wp-content/uploads/2025/08/Social-Determinants-of-Health_v6.pdf).

<sup>61</sup> Steven S. Deller, “Are We at an Inflection Point in Community Economic Development? The 4<sup>th</sup> Wave,” *Economic Development Quarterly*, vol. 39, iss. 4 (May 28, 2025), <https://doi.org/10.1177/08912424251339139>.

<sup>62</sup> Amanda Blanco and Jay Lindsay, “What Stops the Bleeding? Healthcare Gets Harder to Find in Northern New England,” Federal Reserve Bank of Boston, <https://www.bostonfed.org/news-and-events/news/2025/06/health-care-access-health-care-deserts-primary-care-doctor-shortage-northern-new-england.aspx>.

<sup>63</sup> Robert Harrington et al., “Call to Action: Rural Health: A Presidential Advisory,” *American Heart Association and American Stroke Association*, vol. 141, no. 10 (February 10, 2020), <https://doi.org/10.1161/CIR.0000000000000753>.

## Negative Impacts of Certain Health Care Challenges

The preceding sections of this report have discussed the ways that health care and related services may contribute to a region's economy. The inverse may also be true in certain communities and circumstances, where a lack of health care access and the loss of health care providers (particularly hospitals) can have broader impacts on where people and businesses choose to locate.<sup>64</sup>

Health care shortages are particularly acute in rural areas with low population densities that lack primary and specialty providers.<sup>65</sup> The Health Resources and Services Administration (HRSA) classifies areas as Health Professional Shortage Areas (HPSAs) annually, with areas reevaluated every three years. HPSAs are geographic areas, populations, or facilities with a shortage of primary, dental, or mental health care providers.<sup>66</sup> As of March 31, 2026, over 101 million people (approximately 30% of the U.S. population) reside in primary care HPSAs, and approximately 62% of primary care HPSAs are in rural areas.<sup>67</sup> The Delta Regional Authority (DRA) reports that approximately 91% of its counties are HPSAs, and a map of HPSAs by FRCA regions suggests a concentration of these areas in the Delta region (see **Figure 3**).<sup>68</sup> Living in areas with low access to care means greater travel times to access health services and delayed or foregone care, which can worsen existing health conditions.<sup>69</sup>

<sup>64</sup> Multiple factors inform business site selection decisions and may vary by industry. According to a 2024 survey of executive decisionmakers, for instance, quality of life was the second top factor in location decisions. See Jonathan Morgan, "Perspectives on the Business Location and Site Selection Process," November 7, 2025, <https://ced.sog.unc.edu/2025/11/07/perspectives-on-the-business-location-and-site-selection-process/>; and Robert Harrington et al., "Call to Action: Rural Health: A Presidential Advisory," *American Heart Association and American Stroke Association*, vol. 141, no. 10 (February 10, 2020), <https://doi.org/10.1161/CIR.0000000000000753>.

Additionally, analysts observe that certain business may base their location decisions on proximity or availability of an emergency room since workers' compensation rates are related to the distance from an emergency room and that "a closure could generate increased business operating costs and another reason a business moves away or decides not to expand." See Brian Dabson and Victoria Faust, "Rural Development and Rural Health Practices: Trends and Opportunities For Alignment," Aspen Institute, pp. 2, 6, <https://www.aspeninstitute.org/wp-content/uploads/2025/05/TR-FP-1-Rural-ED-Rural-Health-FINAL2-Singles.pdf>.

<sup>65</sup> HHS, Health Resources and Services Administration (HRSA), "Designated Health Professional Shortage Areas Statistics: Second Quarter of Fiscal Year 2026 Designated HPSA Quarterly Summary As of March 31, 2026;" CRS calculations of total U.S. population obtained from U.S. Census Bureau; and Alyssa M. Hundrup, "Why Healthcare Is Harder to Access in Rural America," Government Accountability Office (GAO), 2023, <https://www.gao.gov/blog/why-health-care-harder-access-rural-america>; and Meagan Clawar et al., "Access to Care: Populations in Counties with No FQHC, RHC, or Acute Care Hospital," January 2018, [https://www.shepscenter.unc.edu/wp-content/uploads/dlm\\_uploads/2025/03/r-18\\_Access-to-Care-Pop-in-Counties-w-No-FQHC-RHC-or-Hospital.pdf](https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2025/03/r-18_Access-to-Care-Pop-in-Counties-w-No-FQHC-RHC-or-Hospital.pdf).

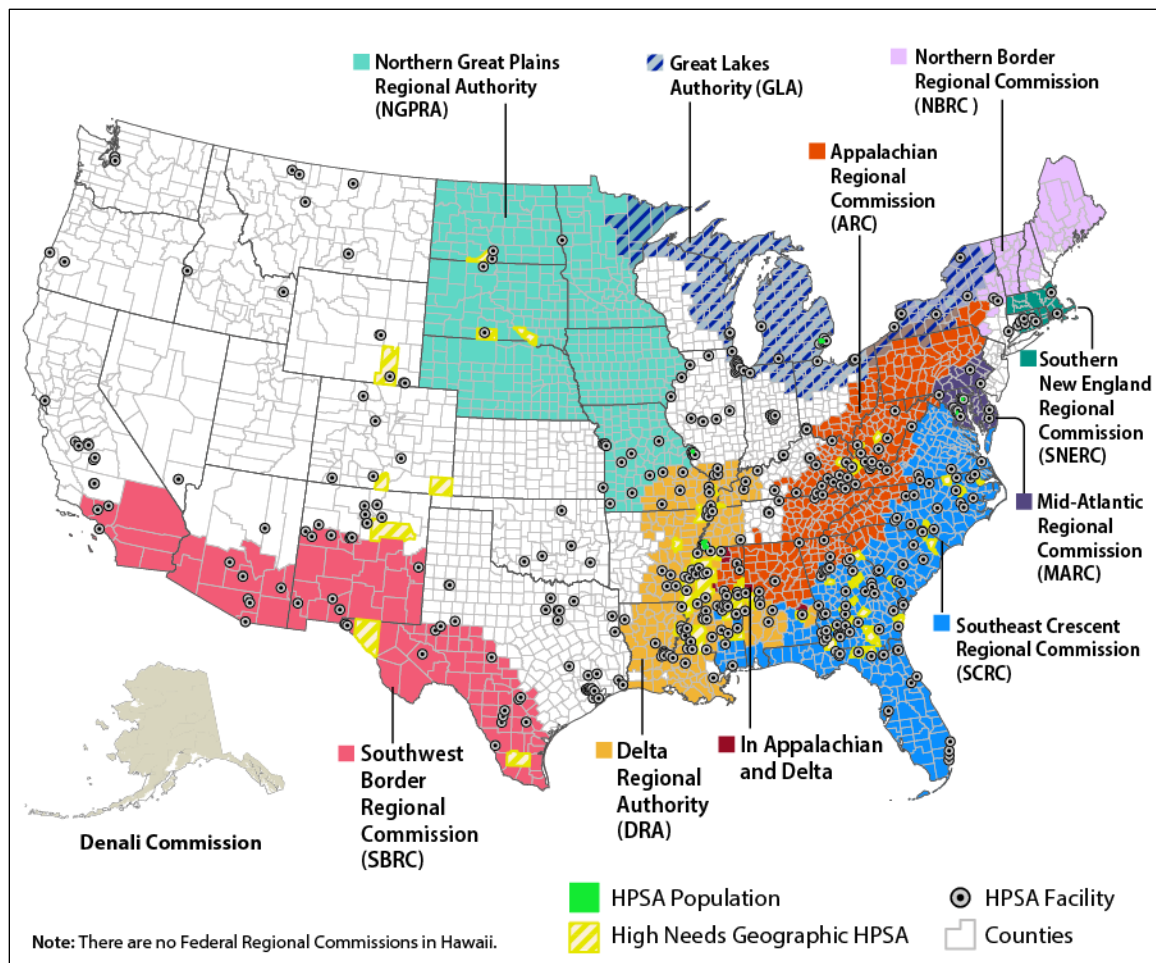
<sup>66</sup> HRSA, "What Is Shortage Designation?" <https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation>.

<sup>67</sup> HRSA, "State of the Healthcare Workforce, 2025," December 2025, p. 4, <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf>.

<sup>68</sup> DRA, "Navigating the Currents of Opportunity: Regional Development Plan IV," February 2023, p. 13, [https://dra.gov/wp-content/uploads/2023/03/APPROVED\\_DRA-RDP-IV\\_20230215.pdf](https://dra.gov/wp-content/uploads/2023/03/APPROVED_DRA-RDP-IV_20230215.pdf).

<sup>69</sup> Joint Economic Committee Democrats, "Addressing Rural Health Worker Shortages Will Improve Population Health and Create Job Opportunities," Issue Brief, January 2024, [https://www.jec.senate.gov/public/\\_cache/files/80b460a5-62ab-4f5f-a259-86625dab021f/jec-issue-brief-on-rural-health-worker-shortages.pdf](https://www.jec.senate.gov/public/_cache/files/80b460a5-62ab-4f5f-a259-86625dab021f/jec-issue-brief-on-rural-health-worker-shortages.pdf).

Figure 3. Health Care Provider Shortage Areas, by FRCA Region



**Source:** CRS analysis of HPSA data obtained from the Health Resources and Services Administration (HRSA) Data Warehouse, Shortage Area files obtained at <https://data.hrsa.gov/data/download>.

**Notes:** HRSA requires that individuals who receive a scholarship from the National Health Service Corps program to fulfill their requirement to provide health services in a HPSA of greatest need. HRSA annually designates the HPSA scores considered to be greatest need. For 2026, for primary care that score was 21 or above. To examine the overlap between HPSAs and FRCA areas, CRS examined HPSAs that exceeded a score of 21 in 2026. See HRSA, “Review Site HPSA Score and Job Search Requirement for NHSC Scholars,” <https://nhsc.hrsa.gov/scholarships/requirements-compliance/jobs-and-site-search>.

There are no FRCAs in Hawaii. The Northwest Regional Commission is not included in this map. P.L. 119-74 provided appropriations for “expenses necessary to establish a Northwest Regional Commission located in Washington, Oregon, Idaho, and Montana.”

One related challenge that distressed areas may face is the closure of health facilities—particularly hospitals and sole hospitals in rural areas.<sup>70</sup> These closures—and the health policy

<sup>70</sup> The Cecil G. Sheps Center for Health Services Research maintains a database of Rural Hospital Closures since 2005 at <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>. While rural hospital closures have generally received more policy attention, non-rural hospitals have also closed in recent years. See, for example, GAO, *Urban Hospitals: Factors Contributing to Selected Hospital Closures and Related Changes in Available Health Care Services*, 25-106473, August 20, 2025, [https://files.gao.gov/reports/GAO-25-106473/index.html#\\_Toc206076142](https://files.gao.gov/reports/GAO-25-106473/index.html#_Toc206076142).

strategies to avert closure—often tie closely to regional economic development strategies.<sup>71</sup> Such health and economic development interests may overlap for several reasons. Hospital closures may affect access to health care and certain health outcomes,<sup>72</sup> and may also affect worker and business location decisions.<sup>73</sup> As noted, hospitals provide jobs and have other economic impacts (see **Figure 2**), and closures may decrease an area’s number and quality of employment opportunities. Research findings vary as to whether, and to what extent, rural hospital closures impact a given region’s long term economic growth and other measures.<sup>74</sup> However, a 2024 summary of 21 studies on the impacts of rural hospital closures found that most of the studies reviewed reported negative economic outcomes related to income, population, poverty, and community economic growth.<sup>75</sup> Stakeholder groups and analysts note that hospitals often have roles in community development, neighborhood revitalization, workforce training, innovation, telemedicine, and other aspects of regional economic development—particularly in rural areas—which may be impacted by hospital closures as well.<sup>76</sup> Some researchers have suggested that focusing on broader community economic development conditions and opportunities could boost rural economies and thus potentially contribute to sustaining health care systems and facilities.<sup>77</sup>

<sup>71</sup> There are multiple factors/causes that contribute to a rural hospital closure, conversion, or merger. An analysis of such factors is beyond the scope of this report.

<sup>72</sup> The relationship between hospital closures and health is complex and the findings vary. The impact of closures on health is beyond the scope of this report. For more information on this topic, see, for example, Carol A. Mills et al., “The Impact of Rural General Hospital Closures on Communities—A Systematic Review of the Literature,” *The Journal of Rural Health*, vol. 40, iss. 2 (November 20, 2023), pp. 238-248, <https://doi.org/10.1111/jrh.12810>; Paula Chatterjee, “Causes and Consequences of Rural Hospital Closures,” *Journal of Hospital Medicine* (2022), vol. 17, iss. 11, pp. 938-939, doi:10.1002/jhm.12973; GAO, “Rural Hospital Closures: Affected Residents had Reduced Access to Healthcare Services,” GAO-21-93, January 21, 2021, p. 1, <https://www.gao.gov/products/gao-21-93>; Riley Sullivan, “Declining Access to Health Care in Northern New England,” Federal Reserve Bank of Boston, April 10, 2019, <https://www.bostonfed.org/publications/new-england-public-policy-center-regional-briefs/2019/declining-access-to-health-care-in-northern-new-england.aspx>; and Sean McCarthy et al., “Impact of Rural Hospital Closures on Health-Care Access,” *Journal of Surgical Research*, vol. 258 (February 2021), pp. 170-178, DOI: 10.1016/j.jss.2020.08.055.

<sup>73</sup> A 2017 summary of literature on rural hospital closures found that rural hospitals are attributed with providing high-skill, high-wage jobs and serving as an amenity that supports business growth and incoming workers and residents. See Anne M. Mandich and Jeffrey H. Dorfman, “The Wage and Job Impacts of Hospitals on Local Labor Markets,” *Economic Development Quarterly*, vol. 31, iss. 2 (February 1, 2017), p. 146, <https://doi.org/10.1177/0891242417691609>.

<sup>74</sup> See, for examples, George M. Holmes et al., “The Effect of Rural Hospital Closures on Community Economic Health,” *Health Services Research*, vol. 41, iss. 2 (2006), pp. 467-485, <https://doi.org/10.1111/j.1475-6773.2005.00497.x>; and Paula Chatterjee et al., “Changes in Economic Outcomes Before and After Rural Hospital Closures in the United States: A Difference-in-Differences Study,” *HRSA Health Services Research*, vol. 57, iss. 5 (April 27, 2022), pp. 1020-1028, <https://pmc.ncbi.nlm.nih.gov/articles/PMC9441283/>.

<sup>75</sup> See Diane E. Alexander and Michael R. Richards, “Economic Consequences of Hospital Closures,” *Journal of Public Economics*, vol. 221 (January 13, 2023), <https://doi.org/10.3386/w29110>.

<sup>76</sup> Federal Reserve Bank of Philadelphia, *Rural Economic Development Summit: Health Ecosystems and Workforce Pipelines* (presentation), June 3, 2025, <https://www.philadelphiafed.org/calendar-of-events/rural-economic-development-summit-health-ecosystems-and-workforce-pipelines>; Brian Stermer, “‘Economic Development Is Population Health’: A New Vision for Rural Hospital Leadership,” Rural Health Information Hub, April 24, 2024, <https://www.ruralhealthinfo.org/rural-monitor/economic-development>; and Robert Harrington et al., “Call to Action: Rural Health: A Presidential Advisory,” *American Heart Association and American Stroke Association*, vol. 141, no. 10 (February 10, 2020), <https://doi.org/10.1161/CIR.0000000000000753>.

<sup>77</sup> A review of literature noted that

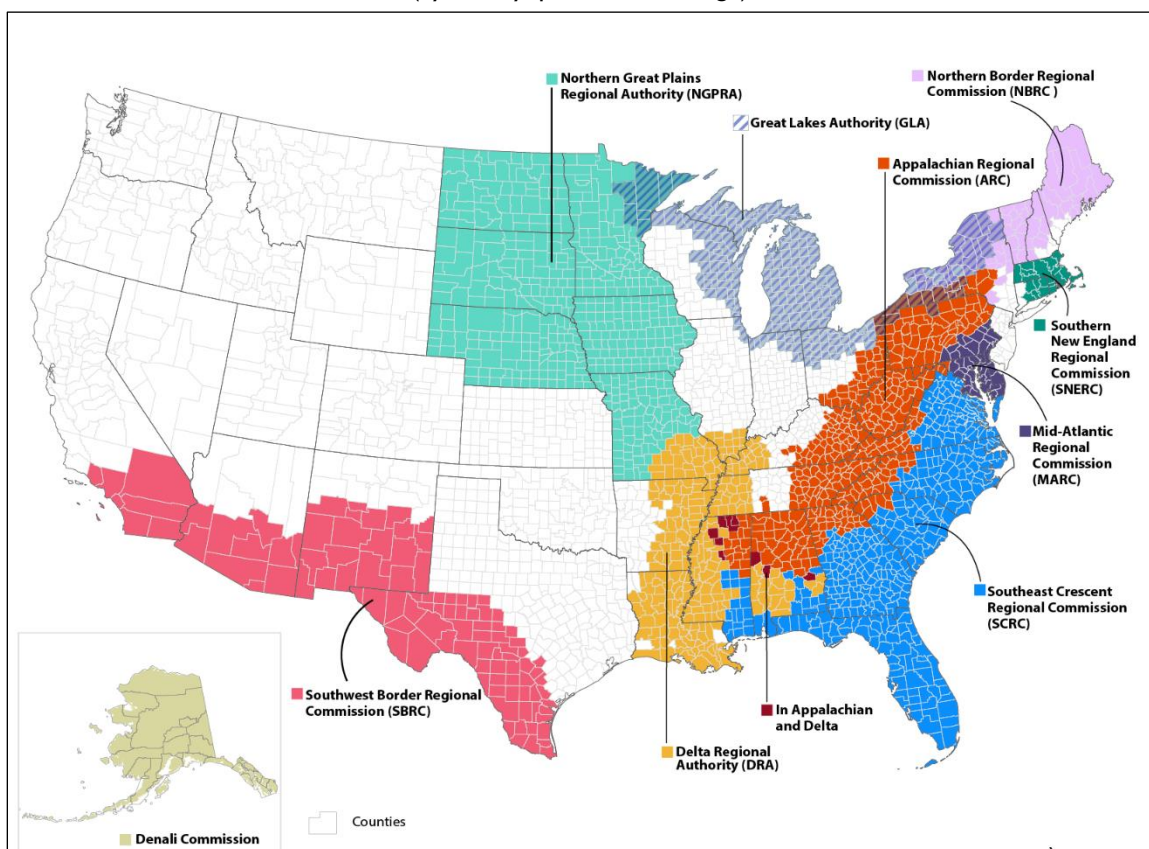
... efforts to reduce the risk of hospital closures may require a broader focus on local communities and economies in order to be successful.<sup>[34]</sup> For example, existing rural economic development efforts, which include state tax credits to encourage industries to enter rural markets or place-based federal investments (e.g., “Empowerment Zones”), may play an important and complementary role

(continued...)

## Overview of FRCAs

Since 1965, Congress has established various FRCAs to address instances of economic distress in geographically defined regions. FRCAs share similar structures and functions, but vary in terms of appropriations, programs, staff sizes, and service regions (see **Figure 4**).

**Figure 4. Regions of the Federal Regional Commissions and Authorities (FRCAs)**  
(by county, parish, or borough)



**Source:** Compiled by CRS using the jurisdictional data in the authorizing legislation of the various commissions and authorities and Esri Data and Maps.

**Note:** There are no FRCAs in Hawaii. The Northwest Regional Commission is not included in the map above. P.L. 119-74 provided funding for a “Northwest Regional Commission located in Washington, Oregon, Idaho, and Montana” and did not identify specific sub-regions or counties within those states.

The authorized FRCAs are listed in **Table 1**. Six of the FRCAs are active as of the date of publication.<sup>78</sup>

in reducing the risk of rural hospital closures.

See Paula Chatterjee et al., “Changes in Economic Outcomes Before and After Rural Hospital Closures in the United States: A Difference-in-Differences Study,” *HRSA Health Services Research*, vol. 57, iss. 5 (April 27, 2022), pp. 1020-1028, <https://pmc.ncbi.nlm.nih.gov/articles/PMC9441283/>.

<sup>78</sup> With the exception of the Denali Commission, a FRCA federal co-chair is a presidentially nominated and Senate-confirmed position. The appointment of a federal co-chair, unless otherwise provided, is essential for most FRCAs’ operations. For example, the Southeast Crescent Regional Commission (SCRC) consistently received appropriations (continued...)

**Table I. Statutory Citations for Operating Authorizations**  
(for active and inactive federal regional commissions and authorities [FRCAs])

Commission or Authority	Year Authorized	Operating Authorization of the Commission or Authority	FY2026 Appropriations (P.L. 119-74) (dollars in millions)
<b>Active FRCAs</b>			
Appalachian Regional Commission (ARC)	1965	40 U.S.C. §1430I	\$200.0
Delta Regional Authority (DRA)	2000	7 U.S.C. §§2009aa-1 et seq.	\$32.0
Denali Commission	1998	42 U.S.C. §312I note	\$18.0
Northern Border Regional Commission (NBRC)	2008	40 U.S.C. §§1530I et seq.	\$42.0
Southwest Border Regional Commission (SBRC)	2008	40 U.S.C. §§1530I et seq.	\$5.5
Southeast Crescent Regional Commission (SCRC)	2008	40 U.S.C. §§1530I et seq.	\$20.0
<b>Inactive FRCAs</b>			
Great Lakes Authority (GLA)	2022	40 U.S.C. §§1530I et seq.	\$5.0
Mid-Atlantic Regional Commission (MARC)	2025	40 U.S.C. §§1530I et seq.	—
Northern Great Plains Regional Authority (NGPRA)	2002	7 U.S.C. §§2009bb-1 et seq.	—
Northwest Regional Commission (NRC)	2026	40 U.S.C. §§1530I et seq. note*	\$1.0
Southern New England Regional Commission (SNERC)	2025	40 U.S.C. §§1530I et seq.	—

**Source:** Compiled by CRS.

**Notes:** The table lists citations for authorizing statutes for the FRCAs. For more information, see CRS Report RS20371, *Overview of the Authorization-Appropriations Process*, by Bill Heniff Jr.; and CRS Report R46497, *Authorizations and the Appropriations Process*, by James V. Saturno, which includes a section on “The Relationship of Appropriations to Authorizations.” A dash in the FY2026 appropriations column (“—”) indicates that no appropriation was provided.

\* In FY2026, P.L. 119-74 provided funding “for expenses necessary to establish a Northwest Regional Commission located in Washington, Oregon, Idaho, and Montana,” and noted that the funding “shall be used to carry out activities authorized for other regional Commissions by subtitle V of title 40, United States Code.”

each fiscal year beginning in FY2010, but was unable to begin its operations until a federal co-chair was appointed by the President and confirmed by the Senate in December 2021, over 13 years after it was authorized. Appropriations for this commission were made available until expended (i.e., no-year funds).

The FRCAs are quasi-governmental partnerships between the federal government and the constituent state or states of the given authority or commission. FRCAs are federally chartered, receive congressional appropriations for their administration and activities, and include an appointed federal representative in their respective leadership structures (the federal co-chair and his/her alternate, as applicable). FRCAs' state-federal partnership structure includes substantial input and efforts at the sub-state level, and represents a unique federal approach to economic development.

FRCAs use appropriations to provide economic development,<sup>79</sup> infrastructure, workforce development, and energy reliability and security grants in their respective regions. As noted below, in recent years, in addition to annual appropriations for FRCA activities, Congress has directed several federal agencies to provide funding to support rural health and rural economic development activities in certain FRCA regions.<sup>80</sup> In addition to grant programs, FRCAs also undertake various partnerships and initiatives unique to their regions' opportunities and challenges (e.g., leadership academies, health advisory councils).<sup>81</sup> FRCA programs and strategic directions vary, but are generally designed to build economic resiliency or support economic restructuring in economically distressed regions.<sup>82</sup>

The President's FY2027 budget request proposed to terminate all but one (the ARC) of the FRCAs.<sup>83</sup> FRCAs have been previously proposed for elimination in presidential budgets, but have continued to receive subsequent appropriations from Congress. For instance, in May 2025, the President's FY2026 budget request proposed closeout budgets for most of the FRCAs and the

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<sup>79</sup> The definition of "economic development" often varies depending on the priorities, economy, and values of the communities involved. Generally, economic development includes two definitions: first, a general usage; and second, a more specific description of its application in a public policy context. For the former, economic development can be interpreted as the promotion of certain economic ends through site selection by companies, business expansion and development, and public spending (or tax incentives) that support these activities, particularly as they may relate to job creation. In a more public policy-specific context, the definition of economic development may include policy interventions that may support or shape economic activity. Broadly, policy options for economic development typically fall along a continuum between economic growth and social welfare. Growth-oriented policies tend to focus on maximizing top-line macroeconomic performance, whereas social welfare policies often emphasize ameliorating inequality and poverty.

<sup>80</sup> In recent years, FRCA federal partners have included the United States Department of Agriculture, the Department of Defense (DOD), the Department of Labor (DOL), the National Telecommunications and Information Administration (NTIA), the Federal Highway Administration (FHWA), HHS HRSA, and others. The DOD is "using a secondary Department of War designation," under Executive Order 14347 dated September 5, 2025. See <https://www.federalregister.gov/documents/2025/09/10/2025-17508/restoring-the-united-states-department-of-war>.

<sup>81</sup> Most FRCAs support some form of infrastructure and/or business development and entrepreneurship activity in their various grant programs. FRCAs may also administer programs or initiatives that are unique to their region. For instance, the NBRC is the only FRCA that administers the Forest Economic Program, which is designed to support the forest-based economy and the integration of new technology in the NBRC region. See NBRC, "FY2024 Annual Report," p. 13, [https://www.nbrc.gov/userfiles/files/Annual%20Reports/NBRC-2024-Annual-Report-Web-version%20\(1\).pdf](https://www.nbrc.gov/userfiles/files/Annual%20Reports/NBRC-2024-Annual-Report-Web-version%20(1).pdf).

<sup>82</sup> The FRCAs use annual designations of economic distress levels to prioritize their economic development activities in their service areas. For additional information, see CRS Report R45997, *Federal Regional Commissions and Authorities: Structural Features and Function*, by Julie M. Lawhorn.

<sup>83</sup> U.S. Office of Management and Budget, "Technical Supplement to the 2026 Budget: Appendix," May 30, 2025, [https://www.whitehouse.gov/wp-content/uploads/2025/05/appendix\\_fy2026.pdf](https://www.whitehouse.gov/wp-content/uploads/2025/05/appendix_fy2026.pdf); "Technical Supplement to the 2027 Budget: Appendix," April 3, 2026, [https://www.whitehouse.gov/wp-content/uploads/2026/04/appendix\\_fy2027.pdf](https://www.whitehouse.gov/wp-content/uploads/2026/04/appendix_fy2027.pdf); and Energy and Water Development and Related Agencies Appropriations Act, 2026, appropriations tables, *Congressional Record*, January 8, 2026, pp. H456-H470, <https://www.congress.gov/119/crec/2026/01/08/172/5/CREC-2026-01-08-bk3.pdf>.

enacted FY2026 appropriations measure continued funding for FRCA programs and administrative expenses at 1% over FY2025 enacted levels.<sup>84</sup>

Eight of the authorized FRCAs received \$1 million to \$200 million each in annual appropriations in FY2026 for their various activities.<sup>85</sup> For an overview of the commissions, including legislative and funding histories, see CRS Report R45997, *Federal Regional Commissions and Authorities: Structural Features and Function*, by Julie M. Lawhorn.

## FRCAs' Health-Related Activities

In many FRCA regions, expanding health care access may also support economic development and growth by creating employment opportunities and other economic impacts (see **Figure 2**).<sup>86</sup> Health and FRCA policies have been linked since the ARC's establishment (see text box).

### ARC's Health Demonstration Projects

The Appalachian Regional Development Act of 1965 (ARDA, P.L. 89-4), the Appalachian Regional Commission (ARC)'s authorizing legislation, established a demonstration health system program (i.e., Section 202 of ARDA) that focused on health center construction. A 1967 amendment to ARDA allowed funding to be used for operations as well. In a committee hearing in 1974, the federal co-chair of the ARC observed

*When the Commission was formed and the statute enacted which created the Appalachian Commission in 1965, the Commission was directed to do something in the field of health because it was the feeling of the Congress that a full-scale economic development program could not be achieved in the absence of a healthy population. But there was little understanding about the direct relationship of health and economic development. And so one of the particular mandates of the Appalachian experiment was to investigate the extent to which there is such a relationship.*

Since 1965, ARC's authority to administer demonstration health projects has been amended or expanded by Congress several times. In addition to the 1967 amendment to ARDA, a 1969 amendment extended the health program to include demonstration facilities for nutrition, child care, and occupational diseases (e.g., black lung). According to a history of the ARC, the House Committee on Public Works observed that the expansion of the health program in 1969 was "the greatest contribution of the Appalachian program in building institutions," and a 1986 study showed improvements in access to and number of doctors and medical staff in the ARC region. The projects contributed to improved access to health care as measured by the number of people who had a thirty minute drive to health care facilities in 332 of the ARC's 397 county region at the time. (ARC's region now covers 423 counties.) Critics of the early health programs, however, observed shortcomings in the implementation of the ARC's initial health programs. For instance, the demonstration program guidelines limited the type of health services provided, and "did not demonstrate any new approaches to medical care." Critics further noted that ARC-supported health services were insufficiently coordinated and lacked follow-up care. They also noted the slow implementation and alignment of the ARC black lung program, which may have impeded its effectiveness. Several laws have since amended Section 202 of ARDA (see 40 U.S.C. §14502).

**Sources:** The Appalachian Regional Development Act of 1965 (ARDA), P.L. 89-4; ARC, "Annual Report of the Appalachian Regional Commission for Fiscal Year 1968," 91<sup>st</sup> Cong., 1<sup>st</sup> sess., House Document No. 91-59 (U.S. Government Printing Office: Washington, DC, 1969); U.S. House of Representatives, Committee on Agriculture, "Federal Health Policies in Rural Areas, Part I," October 1-3, 1974, 93rd Congress, 2nd sess.; David E. Whisnant, *Modernizing the Mountaineer* (University of Tennessee Press, 1980), pp. 158-163; and Michael Bradshaw, in *Appalachian Regional Commission: Twenty-Five Years of Government Policy* (Lexington, KY: University Press of Kentucky, 1992), pp. 54, 96.

<sup>84</sup> OMB, "Technical Supplement to the 2026 Budget: Appendix," May 30, 2025, [https://www.whitehouse.gov/wp-content/uploads/2025/05/appendix\\_fy2026.pdf](https://www.whitehouse.gov/wp-content/uploads/2025/05/appendix_fy2026.pdf).

<sup>85</sup> P.L. 119-74. The act also provided funding for a new regional commission, the Northwest Regional Commission, for distressed areas in Idaho, Montana, Oregon, and Washington. As of the date of this report, the commission does not have a federal co-chair and is not active.

<sup>86</sup> For examples of this perspective, see ARC, "Strengthening the Future of Appalachia's Healthcare Workforce," <https://www.arc.gov/investment/strengthening-the-future-of-appalachias-healthcare-workforce/>; and DRA, "DRA Regional Development Plan IV," February 2023, [https://dra.gov/wp-content/uploads/2023/03/APPROVED\\_DRA-RDP-IV\\_20230215.pdf](https://dra.gov/wp-content/uploads/2023/03/APPROVED_DRA-RDP-IV_20230215.pdf).

Several FRCAs have authorities, similar to that of the ARC, under which they can provide financial assistance for the development of health care facilities or related infrastructure; health care workforce training; and similar health-related activities that facilitate regional economic development and growth. Four FRCAs administer J-1 visa waiver programs (i.e., ARC, DRA, NBRC, SCRC), which provides visa waivers for physicians who are willing to provide medical services in distressed communities.

Recent FRCA grant programs and other health-related activities are highlighted in the subsections below.

## Health in FRCA Strategic Plans and Investment Priorities

Most FRCAs' authorizing statutes require the development of region-wide plans and state-specific plans.

FRCAs develop regular strategic plans that outline key goals and grant priorities for the overall region.<sup>87</sup> The plans generally cover five-year periods and include four to seven priorities that are established with input from state members. Some FRCAs' plans include priorities that focus on aspects of health or health care. For instance

- one of the six priorities in ARC's strategic plan is to "expand and strengthen community systems (education, health care, housing, childcare, and others) that help Appalachians obtain a job, stay on the job, and advance along a financially sustaining career pathway",<sup>88</sup>
- one of the Denali Commission's seven priorities is "other programs, such as sanitation, health facilities, housing, and broadband",<sup>89</sup> and
- one of the SCRC's six priorities is to "improve health and support services access and outcomes."<sup>90</sup>

The FRCAs' state-specific plans reflect the member states' goals, objectives, and priorities, and inform implementation activities based on the specific conditions of a particular region.<sup>91</sup> States may emphasize activities or industries, such as health care or infrastructure, in such plans. The state of South Carolina, for instance, included "Improve Health and Support Public Service Access and Outcomes" as one of its six goals for the 2023-2027 period.<sup>92</sup>

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<sup>87</sup> For additional information and links to FRCA strategic plans, see CRS In Focus IF11140, *Federal Regional Commissions and Authorities: Overview of Structure and Activities*, by Julie M. Lawhorn.

<sup>88</sup> ARC, "Performance & Accountability Report Fiscal Year 2024," <https://www.arc.gov/wp-content/uploads/2024/11/FY-2024-Performance-and-Accountability-Report.pdf>.

<sup>89</sup> Denali Commission, "Strategic Plan," <https://denali.gov/strategic-plans/>.

<sup>90</sup> SCRC, "SCRC: Strategic Plan (2023–2027)," [https://scrc.gov/sites/default/files/2025-07/strategic\\_plan\\_updated\\_april\\_2025.pdf](https://scrc.gov/sites/default/files/2025-07/strategic_plan_updated_april_2025.pdf).

<sup>91</sup> For ARC, see 40 U.S.C. §14322; for DRA, see 7 U.S.C. §2009aa–6; for NGPRA, see 7 U.S.C. §2009bb–6; and for GLA, MARC, NBRC, SBRC, SCRC, and SNERC, see 40 U.S.C. §15502.

<sup>92</sup> SCRC, "Economic and Infrastructure Development Strategic Plan," pp. 20-21, [https://scrc.gov/sites/default/files/2024-05/sc\\_scrc-5-year-economic-and-infrastructure-development-strategic-plan-2023-2027-approved-document-1.pdf](https://scrc.gov/sites/default/files/2024-05/sc_scrc-5-year-economic-and-infrastructure-development-strategic-plan-2023-2027-approved-document-1.pdf).

## Examples of Health Related FRCA Grant Programs

FRCAs may also use grant programs to support health related activities such as health care facility development and equipment, workforce development, business technical assistance, and substance use disorder (SUD) treatment.

Since the establishment of the first FRCA in 1965 (i.e., ARC), policymakers have directed ARC—and authorized other FRCAs—to award grants to build and equip health care demonstration facilities.<sup>93</sup> In 2022, for example, the ARC awarded a grant in eastern Kentucky to provide equipment for two long-term acute care hospitals.<sup>94</sup> The other active FRCAs also assist with the development of health care demonstration facilities and equipment projects. The GLA, MARC, NBRC, SBRC, SCRC, and SNERC are statutorily authorized to provide economic and infrastructure grants—in addition to health demonstration projects—that fulfill a number of purposes, including “to provide assistance to severely economically distressed and underdeveloped areas of its region that lack financial resources for improving basic health care and other public services.”<sup>95</sup> In January 2026, the Denali Commission reported that it has contributed to over 175 village health clinics and two regional hospitals (see text box).<sup>96</sup>

### Rural Health Facility Construction and Environmental Health Grants: Denali Commission Examples

Since it was established in 1998, the Denali Commission has provided grants to construct and equip rural health care facilities and to address environmental health concerns. The Denali Commission continues to partner with Alaska Native tribal communities, Native corporations, Native nonprofit entities, tribal governments, and other groups on a range of energy, infrastructure, and health projects.

The Denali Commission’s statutory mission includes providing workforce and other economic development assistance to distressed rural regions in Alaska. In 1999, P.L. 106-113 amended the Denali Commission Act and established “demonstration health projects” as an authorized activity and authorized HHS to make grants to the commission to that effect. For approximately a decade thereafter, the Denali Commission co-funded the construction of rural primary care clinics, hospitals, behavioral health facilities, and rural emergency medical services. Examples include hospitals in Nome and Barrow.

In recent years, the Denali Commission has focused on energy and bulk fuel and village infrastructure protection programs—many of which address environmental health concerns pertaining to bulk fuel storage systems. The infrastructure and bulk fuel grants are designed to address threats to “health, safety, and energy security” and often involve partnerships with Alaska Native tribes, nonprofit Tribal health organizations, and federal agencies. In 2025, for example, the U.S. Environmental Protection Agency (EPA) transferred \$100 million to the Denali Commission for bulk fuel facility improvements. The Denali Commission used the funding for a grant to the Alaska Native Tribal Health Consortium to assist ten rural communities with efforts to address environmental health and other concerns.

**Sources:** Denali Commission, “Other Programs,” <https://denali.gov/programs/other-programs/>; “Energy,” <https://denali.gov/programs/energy/>; “Programs,” <https://denali.gov/programs/energy/>; “Energy & Bulk Fuel Program Fact Sheet,” <https://x11.6e7.myftpupload.com/wp-content/uploads/2022/01/Energy-Bulk-Fuel-Program-Fact-Sheet.pdf>; and “Denali Commission Awards \$100 Million to Address Urgent Fuel Infrastructure Needs in Rural Alaska,” [https://denali.gov/wp-content/uploads/2025/07/2025-07-17pressrelease\\_Final\\_v3.pdf](https://denali.gov/wp-content/uploads/2025/07/2025-07-17pressrelease_Final_v3.pdf).

<sup>93</sup> In 1965, the ARC’s authorizing legislation established a comprehensive demonstration health system program that focused on health center construction. See the Appalachian Regional Development Act (ARDA) of 1965, P.L. 89-4.

<sup>94</sup> ARC, “POWER Award Summaries by State As of March 2022,” p. 5, <https://www.arc.gov/wp-content/uploads/2022/03/POWER-Award-Summaries-by-State-as-of-March-2022.pdf>.

<sup>95</sup> 40 U.S.C. §15501(a), 40 U.S.C. §15902.

<sup>96</sup> Denali Commission, “Testimony for the Record,” House Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Smarter Spending, Stronger Results: Reducing Duplication and Ensuring Effectiveness Through Economic Development Reforms*, 119<sup>th</sup> Cong., 2<sup>nd</sup> sess. January 22, 2026, <https://www.congress.gov/119/meeting/house/118896/witnesses/HHRG-119-PW13-Wstate-FentonJ-20260122.pdf>.

**Notes:** The Denali Commission is required by law to create an annual work plan, which solicits project proposals, guides activities, and informs a five-year strategic plan. Although the Denali Commission has recently referred to them as “legacy programs,” one of several allocations in the FY2023 Work Plan was for “Health Facilities.”

FRCAs’ grant programs may also support health care workforce development by funding projects designed to train physicians, nurses, dentists, counselors, or community health workers. These projects are often carried out in partnership with community colleges, workforce investment boards, and other partners. FRCAs may, for example, support state and local “grow your own” efforts designed to train rural residents with the goal of having health care professionals stay in rural areas.<sup>97</sup> For instance, in 2025, DRA provided grants to fund a health care professional job training program in southern Alabama, a medical laboratory science program designed to address workforce challenges in medical laboratory sciences in south central Louisiana, and a medical coding and billing pre-apprenticeship project in southeast Missouri.<sup>98</sup>

Grants for capacity and business technical assistance may also support expanded health care access and employment objectives in FRCA regions. For example, in 2025, ARC provided grant funded technical assistance for under-resourced health care systems and providers across 66 counties in two states. According to ARC, “the project was designed to retain and create health care jobs—and facilitate the development of new payment approaches that both improve health outcomes and reduce costs for providers, patients, and communities.”<sup>99</sup> DRA, in collaboration with HHS, provided technical assistance to rural health providers throughout the region, which the DRA credits with supporting more than 73,000 jobs.<sup>100</sup>

Table 2 provides a summary of FRCA grants for health and health care strategies and project examples, and additional examples of grants for SUD are in the section on “Addressing Specific Health Conditions: The Example of Substance Use Disorder (SUD).”

**Table 2. State, Local, and Regional Health and Health Care Strategies and Selected FRCA Project Examples**

Strategy	FRCA Project Examples
Health facility infrastructure development and equipment	Constructing or renovating clinical facilities, including procuring high-tech equipment for medical and dental screenings and services, and for education and training purposes  Broadband planning or implementation projects to expand access to telehealth services  Infrastructure investments that also promote resiliency, health, reduce pollution and infrastructure investments in other forms, such as mobility or transportation

<sup>97</sup> NGA, “Governors and States Are Advancing Equitable Rural Economic Development and Healthcare,” April 12, 2023, <https://www.nga.org/meetings/governors-and-states-are-advancing-equitable-rural-economic-development-and-healthcare/>; and John Pender et al., “Linkages Between Rural Community Capitals and Health Care Provision: Findings of a Survey of Small Rural Towns in Three U.S. Regions,” USDA ERS, EIB-251, p. 43, [https://ers.usda.gov/sites/default/files/\\_laserfiche/publications/106139/EIB-251.pdf?v=29727](https://ers.usda.gov/sites/default/files/_laserfiche/publications/106139/EIB-251.pdf?v=29727).

<sup>98</sup> DRA, “Delta Regional Authority Invests \$7 Million Toward 25 Workforce Development Projects,” July 10, 2025, <https://dra.gov/delta-regional-authority-invests-7-million-toward-25-workforce-development-projects/>.

<sup>99</sup> ARC, “Appalachian Rural Health Technical Assistance Center—Project Snapshot,” <https://www.arc.gov/wp-content/uploads/2025/03/2025.03-ARISE-Project-Snapshot-Rural-Health-Redesign-Center.pdf>.

<sup>100</sup> See House Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Regional Commissions: A Review of Federal Economic Development Program Effectiveness*, 118<sup>th</sup> Cong., 1<sup>st</sup> sess., October 19, 2023, Serial No. 118–32, p. 21, <https://www.congress.gov/118/chrg/CHRG-118hrg56927/CHRG-118hrg56927.pdf>.

Strategy	FRCA Project Examples
Health care workforce development and training	Establishing rural medical residency training sites Implementing a dual-track training program involving a graduate nurse residency and a virtual nursing training model Conducting training for professionals and paraprofessionals working in the prevention and treatment of opioid (and other substances) use disorders
Capacity and business technical assistance	Business technical assistance for health care enterprises
Substance use disorder workforce recovery	Funding program expenses for comprehensive support services for employers and individuals in recovery across multiple counties (see <b>Figure 5</b> )

**Source:** CRS, using FRCA project examples.

**Notes:** As FRCAs vary in terms of programs, priorities, and governance structures, the examples are illustrative. Not all project examples apply to all FRCAs.

## Addressing Specific Health Conditions: The Example of Substance Use Disorder (SUD)

Some FRCA regions have faced acute challenges with SUD-related conditions. For example, in 2024, Alaska—covered by the Denali Commission and West Virginia—covered by the ARC were the two states with the highest drug overdose mortality rates.<sup>101</sup>

SUD negatively impacts individuals and communities in several ways. In addition to effects on individual lives and families, the economic costs associated with SUD include health care costs for treatment and other medical consequences, criminal justice expenses, and lost productivity.<sup>102</sup> A 2023 review of the economic impacts of the opioid epidemic noted that SUD reduces labor force participation and hinders economic growth due to “disability, incarceration, or death.”<sup>103</sup> SUD affects individuals’ health and their capacity to obtain and maintain employment. Work is often beneficial for people seeking recovery from SUD, but many continue to face hiring challenges.<sup>104</sup> Some employers have drug testing requirements that a significant portion of the workforce may not be able to pass in some areas due to high rates of SUD, and many individuals in SUD recovery face stigma that can affect hiring.<sup>105</sup>

<sup>101</sup> Centers for Disease Control and Prevention, “Drug Overdose Mortality,” March 3, 2026, <https://www.cdc.gov/nchs/state-stats/deaths/drug-overdose.html>.

<sup>102</sup> Bokyung Kim et al., “The Opioid Crisis and the Role of Employers,” Stanford Institute for Economic Policy Research Policy Brief, January 2024, [https://drive.google.com/file/d/1gTYv-GiSaQ\\_3ovmUbc1pNPp96EpVsVjD/view](https://drive.google.com/file/d/1gTYv-GiSaQ_3ovmUbc1pNPp96EpVsVjD/view); and Julia Paris et al., “The Economic Impact of the Opioid Epidemic,” The Brookings Institution, April 17, 2023, <https://www.brookings.edu/articles/the-economic-impact-of-the-opioid-epidemic>.

<sup>103</sup> The report referenced a study that linked “43% of the decline in men’s labor force participation rate between 1999 and 2015, and 25% of the decline for women” to the opioid epidemic. See Julia Paris et al., “The Economic Impact of the Opioid Epidemic,” The Brookings Institution, April 17, 2023, <https://www.brookings.edu/articles/the-economic-impact-of-the-opioid-epidemic/>; and U.S. Department of Justice, National Drug Intelligence Center, “The Economic Impact of Illicit Drug Use on American Society,” 2011, <http://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf>.

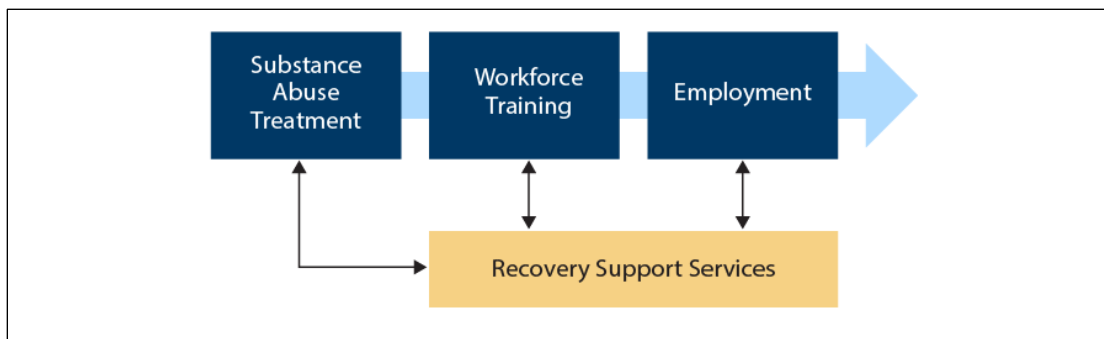
<sup>104</sup> See, for example, Stuart Rumrill and Malachy Bishop, “The Role of Employment Status, Change, and Satisfaction for People Who Have Completed Substance Use Disorder Treatment,” *WORK: A Journal of Prevention, Assessment & Rehabilitation*, vol. 74, no. 2 (January 9, 2023), <https://journals.sagepub.com/doi/10.3233/WOR-236012>.

<sup>105</sup> Nancy M. Petry et al., “Engaging in Job-Related Activities Is Associated with Reductions in Employment Problems and Improvements in Quality of Life in Substance Abusing Patients,” *Psychology of Addictive Behaviors*, vol. 28, iss. 1 (April 15, 2013), pp. 268-275, <https://psycnet.apa.org/doiLanding?doi=10.1037%2Fa0032264>.

(continued...)

Several FRCAs have supported projects that provide employment services and other efforts to address SUD. For example, in FY2024, NBRC partnered with HRSA’s Federal Office of Rural Health Policy (FORHP) on the Northern Border Region Health Care Support Program to address various aspects of SUD in parts of New Hampshire, New York, Maine, and Vermont.<sup>106</sup> In recent years, Congress has directed ARC to allocate a portion of annual appropriations to address SUD in Appalachia. Additionally, ARC’s Substance Abuse Advisory Council developed a recovery ecosystem model, which the council defines as “a complex linkage of multiple sectors, including, but not limited to: recovery communities, peer support, health, human services, faith communities, criminal justice, public safety, housing, transportation, education, and employers, designed to help individuals in recovery access the support services and training they need to maintain recovery and successfully obtain sustainable employment” (see **Figure 5**).

**Figure 5. ARC’s Recovery Ecosystem Model for Substance Abuse Disorder**



**Source:** ARC, “Report of Recommendations: Appalachian Regional Commission’s Substance Abuse Advisory Council,” August 2019, p. 2, <https://www.arc.gov/wp-content/uploads/2020/06/SAAC-ReportofRecommendations-Sept2019.pdf>.

## Other FRCA Health Activities and Partnerships

In addition to their grant-making roles, FRCAs also coordinate activities and partnerships focused on addressing specific health challenges. For instance, several FRCAs administer J-1 visa waiver programs to recruit health care providers; certain FRCAs partner with federal agencies on targeted health care system strategies in their regions; and select FRCAs coordinate research on health issues or host occasional clinics in partnership with the Department of Defense (DOD). Selected examples of FRCA non-grant activity and federal partnership are described below.

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HHS has also awarded grants to address opioid use disorders using a formula that takes into account overdose mortality and awarding funds to states with the highest overdose mortality rates—this included ARC states such as West Virginia and Kentucky. See HHS, Substance Abuse and Mental Health Services Administration FY2022 State Opioid Response Grants, *Notice of Funding Opportunity*, No. TI-22-005, Rockville, MD, p. 74, <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-22-sor-nofo.pdf>.

<sup>106</sup> According to NBRC, the partnerships with HRSA on opioids and rural health care initiatives began in FY2021. See NBRC, *FY2023 Budget Justification*, p. 9, <https://www.nbrc.gov/userfiles/files/Annual%20Reports/FY23%20NBRC%20Budget%20Justification%20Final.pdf>.

## J-1 Visa Waiver Program for Physician Recruitment

FRCAs may support projects designed to recruit and retain physicians.<sup>107</sup> FRCAs may operate as interested government agencies (IGAs) for the Department of State’s J-1 visa waiver program (see textbox).<sup>108</sup>

### J-1 Visa Waivers

Foreign medical graduates (FMGs) may enter the United States on a J-1 visa to undertake medical residency training (called graduate medical education). These FMGs are required to return to their home countries before they can apply for certain other nonimmigrant visas or legal permanent resident status to work as physicians in the United States, unless they are granted a waiver of the two-year home residency requirement. A J-1 physician can receive a waiver of the two-year home residency requirement if

- an interested government agency (IGA) or state department of health requests the waiver;
- the FMG’s return to their home country would cause extreme hardship to a U.S. citizen or legal permanent resident spouse or child; or
- the FMG fears persecution in the home country based on race, religion, or political opinion.

FRCAs are considered to be IGAs and a number of commissions operate J-1 visa waiver programs or are considering doing so as part of their health-related activities.

**Sources:** See “J-1 Visa: Exchange Visitor” section in CRS Report R47528, *Immigration Options and Professional Requirements for Foreign Health Care Workers*, coordinated by William A. Kandel.

J-1 visa waivers allow J-1 visa physicians (who have completed their medical training) to forgo their commitment to return to their home country if they provide care in specific geographic areas. As IGAs, FRCAs can establish programs and request J-1 waivers to meet their region’s health care needs. The DRA’s Delta Doctors program, for example, is designed to address the region’s health disparities and high levels of health professional shortages by granting J-1 visa waivers to physicians who are willing to provide medical services in distressed DRA communities. The DRA reported that between 2019 and 2021 it had sponsored 440 physicians to work across the region, with about half of these placements in Alabama and Louisiana.<sup>109</sup>

For the J-1 visa waiver, a sponsoring entity (e.g., a health care facility) must demonstrate that it has made a good faith effort to recruit an American doctor without success. The J-1 visa waiver program involves collaboration and coordination with member states’ offices of public health

<sup>107</sup> In an oversight hearing, NBRC’s federal co-chair noted that the commission

evaluates what role it should play in addressing obstacles that limit economic opportunity in rural areas. Increasingly both housing and access to health care have emerged as significant priorities for many rural communities. While the Commission is able to fund projects in both of these areas, we are actively considering how to best leverage our resources in order to complement, and not replicate, the work of other agencies. One such strategy is establishing a J-1 Visa Waiver program that will allow for the recruitment of foreign-born physicians trained in the United States to rural areas.

See House Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Regional Commissions: A Review of Federal Economic Development Program Effectiveness*, 118<sup>th</sup> Cong., 1<sup>st</sup> sess., October 19, 2023, Serial No. 118–32, p. 29, <https://www.congress.gov/118/chr/CHRG-118hrg56927/CHRG-118hrg56927.pdf>.

<sup>108</sup> See CRS Report R47528, *Immigration Options and Professional Requirements for Foreign Health Care Workers*, coordinated by William A. Kandel.

<sup>109</sup> See House Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Regional Commissions: A Review of Federal Economic Development Program Effectiveness*, 118<sup>th</sup> Cong., 1<sup>st</sup> sess., October 19, 2023, Serial No. 118–32, p. 21, <https://www.congress.gov/118/chr/CHRG-118hrg56927/CHRG-118hrg56927.pdf>.

and/or rural health. Requests are submitted to the FRCA from the state’s governor.<sup>110</sup> As an IGA, a FRCA is not limited in the number of physician waivers. This differs from the Conrad 30 Waiver Program (also known as the Conrad State Program) for J-1 visa waivers, which limits the number of waivers each year to 30 per state.

A 2023 ARC evaluation of its J-1 program indicated that it improved patients’ access to high quality care and shortened wait times.<sup>111</sup> The medical practices surveyed indicated that the program allowed them to serve more patients, provide more comprehensive care, and diversified skills, among other impacts. The evaluation also reported several instances of physicians opting for the ARC program because the Conrad 30 program in a particular state was full.<sup>112</sup>

**Table 3** summarizes the J-1 visa waiver activity of FRCA with active programs.

**Table 3. Summary of FRCAs’ J-1 Visa Programs**

FRCA	Initial Year	Priority Areas	Type of Physician	Fee?
ARC	1991	Health Professional Shortage Area (HPSA) or Mental Health Professional Shortage Area (MHPSA)	Primary or Specialty Care	No
DRA	2002	HPSA, MHPSA, or Medically Underserved Areas/Populations (MUA/P)	Primary or Specialty Care	No
NBRC	2023	HPSA or MUA/P	Primary or Specialty Care	No
SCRC	2022	HPSA or MUA/P	Primary or Specialty Care	Yes

**Sources:** ARC, “J-1 Visa Waivers,” <https://www.arc.gov/j-1-visa-waivers/> and <https://www.arc.gov/wp-content/uploads/2024/04/J-1-Visa-Waiver-Program-FAQs.pdf>; DRA, “Delta Doctors,” <https://dra.gov/programs/human-infrastructure/health/delta-doctors>; NBRC, “NBRC J-1 Visa Waiver Program,” <https://www.nbrc.gov/content/J1Visa>, and “NBRC J-1 Visa Waiver Expansion Program FAQ’s,” <https://www.nbrc.gov/userfiles/files/J%201-Visa/NBRC%20J-1%20Waiver%20FAQs.pdf>; SCRC, “J-1 Visa Waiver Program Guidelines,” [https://scrc.gov/sites/default/files/2025-06/j1\\_vis\\_a\\_waiver\\_program\\_guidelines.pdf](https://scrc.gov/sites/default/files/2025-06/j1_vis_a_waiver_program_guidelines.pdf), and “FY2024 Congressional Budget Justification,” <https://scrc.gov/sites/default/files/Reports-2024/scrc-fy-2024-budget-justification-final.pdf>.

**Notes:** ARC formally established its J-1 Visa Waiver Program in 1991 and accepted J-1 visa waiver requests on an ad hoc basis prior to 1991. DRA started a pilot J-1 program in 2002 and formalized their program in 2004. As of the date of publication, the SBRC has planned for a J-1 program, but it is not active.

Most FRCAs have the authority to collect fees. As of the date of publication, SCRC is the only FRCA that charges a fee. The fee is paid by the employer (e.g., a health facility).

<sup>110</sup> Examples of other interested government agencies include HHS and the Department of Veterans Affairs. For additional information, see “J-1 Visa: Exchange Visitor” in CRS Report R47528, *Immigration Options and Professional Requirements for Foreign Health Care Workers*, coordinated by William A. Kandel.

<sup>111</sup> This paragraph draws from ARC’s “Report on the Appalachian Regional Commission’s J-1 Visa Waiver Program Participants and Impact on Communities 2012–2021.”

<sup>112</sup> Specifically, more than half of the ARC’s J-1 physician placements between 2012 and 2021 were in New York and Pennsylvania. These states have higher numbers of medical residency and fellowship programs, which help with recruitment and may be the reason for the higher number of physicians placed there during this time. See “Report on the Appalachian Regional Commission’s J-1 Visa Waiver Program Participants and Impact on Communities 2012 – 2021,” pp. 18, 20.

## Selected FRCA-Federal Partnerships

FRCAs have partnered with federal agencies such as HHS, Department of Labor (DOL), and DOD on issues such as health care access, health care technical assistance for health care businesses, health care workforce development, and one-time health clinic events. For example,

- HHS funding supported village primary care clinics, residential psychiatric treatment centers, behavioral health facilities, long-term care facilities, emergency medical service and telehealth equipment, and the design of Indian Health Service replacement hospitals with the Denali Commission.<sup>113</sup> The Denali Commission has also partnered with the Centers for Disease Control and Prevention to conduct rural Alaska health and drinking water related studies.<sup>114</sup>
- HHS HRSA funding has supported several technical assistance initiatives in the DRA and NBRC regions to help improve the administration of rural health care organizations and hospitals and to enhance health care access and health care workforce training.<sup>115</sup>
- Through the Workforce Opportunity for Rural Communities (WORC) Initiative, DOL partners with ARC, DRA, and NBRC for workforce and economic development projects. Although the WORC Initiative is not exclusively for health care-related activities, some WORC grants have supported health care workforce development and training.<sup>116</sup>
- ARC and DRA have hosted Innovative Readiness Training (IRT) medical mission events in partnership with the DOD and military reserve forces. IRTs generally provide one or more days of free medical, dental, and vision care while providing a training opportunity for medical personnel in military reserve units. IRT events provide services at scale and often prioritize economically distressed areas within FRCA regions.<sup>117</sup> The Denali Commission partners with the DOD on IRT activities primarily for infrastructure, homeland security, and emergency response objectives.<sup>118</sup>

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<sup>113</sup> Denali Commission, “Denali Commission Strategic Plan 2023-2027,” p. 18, <https://denali.gov/strategic-plans/>.

<sup>114</sup> Denali Commission, “Special Projects & Initiatives,” <https://denali.gov/programs/special-projects-initiatives/>.

<sup>115</sup> See HRSA, “Delta Region Community Health Systems Development Program,” <https://www.hrsa.gov/grants/find-funding/HRSA-25-033>; “Delta Health Systems Implementation Program,” <https://www.hrsa.gov/grants/find-funding/HRSA-24-079>; “Rural Northern Border Region Healthcare Support Program,” <https://www.hrsa.gov/grants/find-funding/HRSA-22-166>; and “FY24 Rural Health Network Development Planning Program Awards,” <https://www.hrsa.gov/rural-health/grants/rural-community/nbrc-fy-24-awards>.

<sup>116</sup> The Department of Labor (DOL) Employment and Training Administration (ETA) awarded the first round of WORC funding in FY2019 for grants in the ARC and DRA regions. The ETA’s WORC partnership with NBRC began in FY2023. In recent years, reports accompanying appropriations measures have directed DOL to set aside funding for enhanced worker training in the ARC, DRA, and NBRC regions. See DOL, “Workforce Opportunity for Rural Communities (WORC) Initiative,” <https://www.dol.gov/agencies/eta/dislocated-workers/grants/workforce-opportunity>. See also the explanatory statement accompanying the Consolidated Appropriations Act, 2023 (P.L. 117-328), <https://www.congress.gov/117/crec/2022/12/20/168/198/CREC-2022-12-20-bk2.pdf#page=322>, p. S8874.

<sup>117</sup> DOD, “Innovative Readiness Training,” <https://irt.defense.gov/>. DRA began hosting IRT events in 2009. See <https://dra.gov/programs/human-infrastructure/health/innovative-readiness-training/>; and DRA, “2024 DRA Annual Report,” p. 20, <https://dra.gov/wp-content/uploads/2025/08/2024-ANNUAL-REPORT-0714.pdf>.

<sup>118</sup> Denali Commission, “Testimony for the Record,” House Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Smarter Spending, Stronger Results: Reducing Duplication and Ensuring Effectiveness Through Economic Development Reforms*, 119<sup>th</sup> Cong., 2<sup>nd</sup> sess., January 22, 2026, <https://www.congress.gov/119/meeting/house/118896/witnesses/HHRG-119-PW13-Wstate-FentonJ-20260122.pdf>.

## Health Research and Evaluation Activities

Most FRCAs face region-specific health and health care challenges, which may influence economic development, health outcomes, and business location decisions. Some FRCAs have coordinated research and evaluation projects to study health opportunities and challenges in their regions and to better understand economic and workforce development impacts. For example,

- In 2026, ARC completed an evaluation of its health grants that closed between FY2017 and FY2021. According to the report, the grants used a range of strategies such as the “procurement or purchasing of clinical equipment, technology, and/or supplies; establishing, improving, or expanding clinical services; and constructing or renovating health-related facilities.”<sup>119</sup>
- In 2024, SCRC commissioned an assessment of health care needs and health care access in its region. The assessment highlighted the high concentration in the SCRC region of rural hospitals that closed nationwide during the 2011-2021 period (nearly 20% of the 76 closures were in the SCRC region).<sup>120</sup>
- In 2024, DRA reported that each “Delta Doctor” is estimated to “create five full-time jobs within their clinics and offices and an additional 3.4 full and part-time jobs within the communities where they work.”<sup>121</sup> In this context, the term “Delta Doctor” refers to a foreign physician trained in the United States who received a J-1 visa waiver to work in medically underserved areas because of the DRA’s Delta Doctors program.<sup>122</sup>
- In 2017, ARC commissioned a report on the impact of diseases of despair on mortality in the ARC region. ARC made several updates to the original report since 2017. The 2025 update noted that the ARC region “has experienced a decline in the diseases of despair mortality rate since the peak in 2021,” and that “[t]he 2023 data continue to demonstrate that the Appalachian Region is rebounding more quickly than the non-Appalachian U.S., despite the continued disparity and higher mortality rates in the region.”<sup>123</sup>

## Advisory Councils

FRCAs may convene and lead health-focused advisory councils. Such councils involve public and private sector stakeholders and provide a framework for gathering community input, analyzing options, and receiving guidance and expertise on regional health concerns. For instance, ARC’s Substance Abuse Advisory Council is tasked with analyzing opportunities and

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<sup>119</sup> According to ARC’s report, “Survey findings indicated that these grants aimed to improve health-related services or infrastructure; strengthen the health-related workforce; and advance health through planning, education, or other promotion strategies. Commonly reported project strategies included procurement or purchasing of clinical equipment, technology, and/or supplies; establishing, improving, or expanding clinical services; and constructing or renovating health-related facilities.” See ARC, “Evaluation of ARC’s Health Grants,” January 22, 2026, <https://www.arc.gov/report/evaluation-of-arcs-health-grants/>.

<sup>120</sup> SCRC, “2024 Annual Report,” p. 1, [https://scrc.gov/sites/default/files/Reports-2025/scrc\\_annual\\_report\\_2024.pdf](https://scrc.gov/sites/default/files/Reports-2025/scrc_annual_report_2024.pdf).

<sup>121</sup> DRA, “FY2025 Congressional Budget Justification,” pp. 25-26, [https://dra.gov/wp-content/uploads/2024/03/DRA-FY-2025-Budget-Justification-FINAL\\_Updated03072025.pdf](https://dra.gov/wp-content/uploads/2024/03/DRA-FY-2025-Budget-Justification-FINAL_Updated03072025.pdf).

<sup>122</sup> DRA, “Delta Doctors,” <https://dra.gov/programs/human-infrastructure/health/delta-doctors/>.

<sup>123</sup> The 2017 study focused on “mortality from three main causes: alcohol, prescription drug, and illegal drug overdose; suicide; and alcoholic liver disease/cirrhosis of the liver.” See ARC, “Appalachian Diseases of Despair, 2025,” July 30, 2025, <https://www.arc.gov/report/appalachian-diseases-of-despair-2025/>.

challenges to developing a recovery ecosystem.<sup>124</sup> ARC’s Substance Abuse Advisory Council provided guidance on the development of ARC’s INSPIRE grant program.

## Selected FRCA Features, Roles, and Activities

The FRCA’s structural, governance, and operational features may facilitate collaboration and contribute to economic development—particularly in distressed, rural FRCA areas—in ways that may contribute to, or otherwise facilitate, the implementation of health-related programs.<sup>125</sup> These features are separate from, but related to FRCA’s specifically health-focused activities discussed above, such as the economic development grant-making activities (see “Examples of Health Related FRCA Grant Programs”). Select features and examples are described below.

### Links to Regional, State, and Local Organizations and Convenor Roles

FRCA’s connections to state, regional, and local development entities, health agencies, and philanthropic organizations may be used for health-related initiatives in several ways. Many FRCA convene stakeholders from within and outside of their respective regions. FRCA occasionally facilitate or incentivize multi-jurisdictional or regional projects involving multiple levels of government and private sector partners.<sup>126</sup> For instance, although not focused exclusively on health policies, DRA facilitates a leadership academy for public and private sector participants. The activities involve regional economic development, government relations, and collaboration.<sup>127</sup>

Additionally, FRCA partner with state and regional development organizations, and these partnerships could be used for expanded or new health-related initiatives.<sup>128</sup> For instance, administratively, most FRCA coordinate their grant-making and other activities with member states’ program offices, which are generally staffed by state employees. The FRCA’s member

<sup>124</sup> ARC, “Substance Use Disorder Advisory Council,” <https://www.arc.gov/substance-abuse-advisory-council/>.

<sup>125</sup> U.S. House of Representatives, Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Regional Commissions: A Review of Federal Economic Development Program Effectiveness*, 118<sup>th</sup> Cong., 1<sup>st</sup> sess., October 19, 2023, Serial No. 118–32, <https://www.congress.gov/118/chr/CHRG-118hrg56927/CHRG-118hrg56927.pdf>; Anthony Pipa et al., “Unlocking Investment in Distressed Rural Places,” The Brookings Institution, January 13, 2025, <https://www.brookings.edu/articles/unlocking-investment-in-distressed-rural-places/>; Tyler Morin and Mark Partridge, “The Impact of Small Regional Economic Development Commissions: Is There Any Bang After Just a Few Bucks?” *Economic Development Quarterly*, vol. 35, iss. 1 (February 2021), pp. 22-39, <https://doi.org/10.1177/0891242420972475>; and John Pender and Richard Reeder, “Impacts of Regional Approaches to Rural Development: Initial Evidence on the Delta Regional Authority,” USDA ERS, Report No. 119, June 2011, <https://www.ers.usda.gov/publications/pub-details/?pubid=44857>.

<sup>126</sup> Tyler Morin and Mark Partridge, “The Impact of Small Regional Economic Development Commissions: Is There Any Bang After Just a Few Bucks?” *Economic Development Quarterly*, vol. 35, iss. 1 (February 2021), pp. 22-39, <https://doi.org/10.1177/0891242420972475>; U.S. House of Representatives, Committee on Agriculture, “Federal Health Policies in Rural Areas, Part 1,” October 1-3, 1974, 93<sup>rd</sup> Congress, 2<sup>nd</sup> sess.; and House Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Regional Commissions: A Review of Federal Economic Development Program Effectiveness*, 118<sup>th</sup> Cong., 1<sup>st</sup> sess., October 19, 2023, Serial No. 118–32, pp. 14, 18, <https://www.congress.gov/118/chr/CHRG-118hrg56927/CHRG-118hrg56927.pdf>.

<sup>127</sup> DRA, “Delta Leadership Institute,” <https://dra.gov/programs/human-infrastructure/leadership/delta-leadership-institute/>.

<sup>128</sup> For additional information about regional development organizations, see CRS In Focus IF11511, *The Role of Regional Development Organizations (RDOs) in Economic Development*, by Julie M. Lawhorn.

state program offices generally coordinate activities with their states' governors' offices and other state agencies and are often based in the state-level departments of commerce, community, and/or economic development.

Most FRCAs' authorizing statutes also require planning and other collaboration with local development districts (LDDs), a type of regional development organization.<sup>129</sup> LDDs are generally available to advise on local priorities, and to assist local and regional stakeholders with applications for federal grants, including FRCA and other federal programs.<sup>130</sup> For instance, NBRC partners with LDDs to provide project planning, coordination, and implementation services to certain communities. NBRC notes that many of the small, rural communities in its region “rely on part-time staff and volunteer leadership” and may face other leadership and capacity constraints.<sup>131</sup> FRCAs' LDD connections may also provide a bridge to local elected officials, philanthropic organizations, and business leaders. For example, an LDD in western North Carolina partnered with a philanthropic organization to provide non-medical supportive services to eligible Medicaid members in a multi-county health project.<sup>132</sup>

## FRCAs' Capacity for Regional and Multistate Projects

FRCAs may provide grants for projects that serve multiple counties or states (see “Health in FRCA Strategic Plans and Investment Priorities”).<sup>133</sup> Similarly, health care services and workforce training may be provided in a regional or multistate manner.<sup>134</sup> Though states license health providers and facilities, many health care issues—including access to care and workforce recruitment challenges—span multiple counties and states. FRCAs and FRCA members may identify additional collaborative options for multistate or regional initiatives as they update strategic and state plans or as new priorities or opportunities emerge.

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<sup>129</sup> See, for example, 40 U.S.C. §15505.

The U.S. Economic Development Administration (EDA), within the Department of Commerce, also partners with regional development organizations (RDOs) that lead long-term economic development planning activities and provide technical assistance or administrative support to member jurisdictions. Some local development districts (LDDs) are also EDA-designated Economic Development Districts (EDDs). For information about EDDs, see EDA, “Economic Development Districts,” <https://www.eda.gov/about/economic-development-glossary/edd>. For information about RDOs, see CRS In Focus IF11511, *The Role of Regional Development Organizations (RDOs) in Economic Development*, by Julie M. Lawhorn.

<sup>130</sup> Certain FRCAs may provide financial assistance to LDDs for their planning and technical and administrative assistance roles.

<sup>131</sup> NBRC, “How LDDs Work with NBRC,” <https://www.nbrc.gov/content/nbrc-ldd-partnership-program>.

<sup>132</sup> See NADO, *Building Healthier Rural Communities: Economic Development Districts Address Social Determinants of Health*, August 2025, p.11, [https://www.nado.org/wp-content/uploads/2025/08/Social-Determinants-of-Health\\_v6.pdf](https://www.nado.org/wp-content/uploads/2025/08/Social-Determinants-of-Health_v6.pdf). See also, Tim Sablik, “Connecting a Region Apart,” *Economic Focus*, Federal Reserve Bank of Richmond, vol. 27, iss. 2 (2022), p. 18, [https://www.richmondfed.org/-/media/RichmondFedOrg/publications/research/econ\\_focus/2022/q2/economic\\_history.pdf](https://www.richmondfed.org/-/media/RichmondFedOrg/publications/research/econ_focus/2022/q2/economic_history.pdf).

<sup>133</sup> See, for example, the Delta Revitalization through Innovation, Vision, and Empowerment (DRIVE) initiative, led by the University of Memphis with support from DRA and DOL (<https://www.drivempower.org/>) and ARC's Appalachian Regional Initiative for Stronger Economies (ARISE) initiative that focused on large-scale, multistate economic development projects (<https://www.arc.gov/grants-and-opportunities/arise/>).

<sup>134</sup> For instance, the Pacific Northwest University (PNWU) of Health Sciences coordinates a regional graduate medical education (GME) training for the rural and medically underserved areas of Washington, Alaska, Idaho, Oregon, and Montana. See Pacific Northwest University of Health Sciences, “About,” <https://www.pnwu.edu/about/>.

## FRCAs' Program and Funding Flexibilities

Outside groups and policymakers have noted that FRCAs are unique because of their program and funding flexibilities. FRCAs' broad-based assistance programs can be used by and for a variety of different communities, conditions, and circumstances.<sup>135</sup> FRCAs' flexibility in providing early-stage investment and/or support for small or pilot projects may also distinguish them from other federal agencies.<sup>136</sup> For example, FRCAs sometimes note that they are available to meet emerging needs and provide “patient capital” for rural communities that often have limited public financing options or philanthropic funding sources.<sup>137</sup>

Rural and economically distressed communities often face challenges in securing the nonfederal cost share match for federal grants due to smaller populations and tax base and/or resource constraints.<sup>138</sup> Denali Commission, GLA, MARC, NBRC, SBRC, SCRC, and SNERC funding is considered flexible because it may be used to meet the nonfederal cost share match in other federal programs (unless otherwise prohibited), which provides an option for projects that require matching funds.<sup>139</sup> This flexibility can be used by rural and economically distressed communities to meet match requirements for federal health facility construction in certain programs. Additionally, United States Department of Agriculture (USDA) Rural Development (RD) funding may be available for certain health facility construction projects in rural areas.<sup>140</sup> If matching funds are required for USDA grant programs, FRCA funding can potentially provide a portion of matching funds for such projects.<sup>141</sup>

Generally, other federal funding for health facility construction is limited; a number of HHS grant programs explicitly prohibit construction activities and there are no dedicated HHS programs that support general health facility construction.<sup>142</sup> An exception is funding that has been made available in recent appropriations laws to support community projects (e.g., Community Project Funding).<sup>143</sup> Such funding is limited, generally available on a one-time basis, and requires

<sup>135</sup> House Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Regional Commissions: A Review of Federal Economic Development Program Effectiveness*, Serial No. 118–32, pp. 14–15, 28.

<sup>136</sup> Alison F. Davis et al., *Program Evaluation of the ARC's Health Projects, 2004-2010*, prepared for ARC, pp. iv, 89, 92, <https://www.arc.gov/report/program-evaluation-of-the-appalachian-regional-commissions-health-projects-2004-2010/>.

<sup>137</sup> House Committee on Transportation and Infrastructure, Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Regional Commissions: A Review of Federal Economic Development Program Effectiveness*, 118<sup>th</sup> Cong., 1<sup>st</sup> sess., October 19, 2023, Serial No. 118–32, p. 21, <https://www.congress.gov/118/chr/CHRG-118hrg56927/CHRG-118hrg56927.pdf>.

<sup>138</sup> Tony Pipa and Natalie Geismar, “Reimagining Rural Policy: Organizing Federal Assistance to Maximize Rural Prosperity,” The Brookings Institution, November 2020; and Emily Corcoran and Jen Giovannitti, “The Flow of Capital into Rural Areas,” Federal Reserve Bank of Richmond, *Regional Matters*, February 12, 2025, [https://www.richmondfed.org/podcasts/speaking\\_of\\_the\\_economy/2025/speaking\\_2025\\_02\\_12\\_rural\\_investment](https://www.richmondfed.org/podcasts/speaking_of_the_economy/2025/speaking_2025_02_12_rural_investment).

<sup>139</sup> For the Denali Commission, see 42 U.S.C. §3121 note, Section 305(e). For GLA, MARC, NBRC, SBRC, SCRC, and SNERC, see 40 U.S.C. §15507. As noted, FRCA funding may be used for the nonfederal match in EDA projects (see 42 U.S.C. §3144(b)).

<sup>140</sup> USDA Community Facilities Programs can fund construction of certain health facilities in rural areas. For more information, see CRS Report R48462, *Rural Community Facilities: A Guide to Programs*, by Lisa S. Benson.

<sup>141</sup> Federal grant programs may limit the share of total project expenses that may be provided by federal sources.

<sup>142</sup> Facilities that serve members of American Indian and Alaska Native tribes are eligible to receive funding from the Indian Health Service for facility construction and renovation. A number of HHS grants explicitly exclude construction funding. For information about existing programs that support health facility construction, see CRS Report R48081, *Sources of Federal Funding for Health Care Facilities: Frequently Asked Questions*, by Elayne J. Heisler et al.

<sup>143</sup> CRS Report R46722, *Community Project Funding: House Rules and Committee Protocols*, by Megan S. Lynch, and CRS Report RS22867, *Earmark Disclosure Rules in the Senate: Member and Committee Requirements*, by Megan S. Lynch.

sponsorship by a congressional office. As noted, FRCAs have the flexibility to fund different types of projects that address different aspects of individual and community health and some FRCAs have provided grants for health care facility construction activities. Health construction funding from FRCAs can support facilities unable to secure Community Project Funding, or it can expand the reach of existing Community Project Funding.

## Recent Legislation and Policy Proposals Involving FRCAs and Health

In recent years, Congress has enacted legislation to continue or expand FRCAs' health and health care roles and partnerships. Congress also directed FRCAs to address specific health and development objectives in report language accompanying certain appropriations measures. Certain FRCAs have requested explicit authority to carry out health-related grant activities. Combined, the laws and proposals reflect a certain amount of interest in expanding the FRCAs' role in health care and economic development.

Recent notable laws include

- In January 2025, reauthorization legislation (P.L. 118-272, Division B, Title II) was enacted that expanded certain FRCAs' authority to develop health care demonstration projects (e.g., to support the planning, construction, equipment, and operation of demonstration health, nutrition, and child care projects to serve distressed areas, including hospitals, regional health diagnostic and treatment centers, and other facilities and services). The legislation also provided authority for most FRCAs to collect fees, which may be used to support a physician waiver program (i.e., the J-1 visa waiver program) to sponsor international physicians residing in the United States.<sup>144</sup>
- In reports accompanying annual appropriations laws for each of FY2020–FY2023 and FY2026, Congress directed ARC to allocate appropriations to address issues related to substance use disorder (SUD).<sup>145</sup>
- In October 2018, the SUPPORT for Patients and Communities Act (the SUPPORT Act, P.L. 115-271) was enacted, which authorized the ARC to support projects and activities that address substance use, including opioid abuse, in the region.<sup>146</sup>

An example of an authority proposal is one made by DRA requesting grantmaking authority to align their statutory language with that of other FRCAs in terms of health care, conservation, renewable energy, and related areas. One of the requests pertained to expanded grantmaking

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<sup>144</sup> The Economic Development Reauthorization Act (EDRA) of 2024—enacted as a part of the Thomas R. Carper Water Resources Development Act of 2024 (P.L. 118-272 Division B, Title II) on January 4, 2025, reauthorized seven FRCAs and authorized two new FRCAs. EDRA authorized GLA, MARC, NBRC, SBRC, SCRC, and SNERC to administer a demonstration health project program that is similar to the ARC's demonstration program and designed to serve distressed areas. Prior to EDRA's enactment, in addition to ARC, HHS was authorized to transfer funding to the Denali Commission for demonstration health project programs as well. For the authorization of the ARC's demonstration health projects, see 40 U.S.C. §14502. For the authorization of the Denali Commission's demonstration health projects, see Section 307 of the Denali Commission Act of 1998 (42 U.S.C. §3121 note).

<sup>145</sup> See explanatory statements accompanying P.L. 116-260, P.L. 117-58, P.L. 117-103, P.L. 117-328, and P.L. 119-74.

<sup>146</sup> P.L. 115-271, Title VIII, Subtitle E—Treating Barriers to Prosperity, §8062. For additional information, see CRS Report R45423, *Public Health and Other Related Provisions in P.L. 115-271, the SUPPORT for Patients and Communities Act*, coordinated by Elayne J. Heisler and Johnathan H. Duff.

authority in severely economically distressed areas for grants that seek to improve basic health care and other public services.<sup>147</sup> As of the date of this report, the requested changes have not been enacted.

## Considerations for Congress

Interest in rural health care, determinants of health, and the health care workforce raise a number of issues for Congress. The following sections describe some economic development policy options involving FRCAs, including options to integrate health access, health care workforce development, and health care business development with place-making and other regional economic development goals. This discussion is not comprehensive.

Broadly speaking, Congress may consider options to further integrate health and health care activities into existing FRCA investment and partnership initiatives. Congress may consider directing FRCAs to focus on particular strategies or to address specific health challenges in certain regions or communities. Congress could do so by authorizing new programs or by directing FRCAs to allocate a portion of their appropriations to address a particular strategy or initiative, for instance. Alternatively, Congress could maintain its general practice of providing FRCAs with discretion to use state and other stakeholder input to determine priorities and strategies—without providing new program authority or congressional directive to prioritize a particular health condition or strategy to address it.

Congress may also consider limiting federal-FRCA partnership activities or addressing rural health care and economic development through other policy channels. Some observers and policymakers are critical of FRCAs generally or of their current framework, arguing that they are duplicative, inefficient, and an unnecessary involvement of the federal government in local economic development. Some policymakers and outside groups that view FRCAs as duplicative have proposed phasing out, streamlining, or integrating their programs with others.<sup>148</sup>

Others have proposed enhanced coordination among federal agencies and among federal agencies and FRCAs.<sup>149</sup> Congress may also consider legislative or oversight activities on the coordination of EDA's and FRCAs' economic development programs.<sup>150</sup>

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<sup>147</sup> The DRA request was to add the language to the DRA's authorizing statute that would be similar to the following subsections (i.e., (a)(5), (a)(6), and (a)(7)) of Section 15501 of title 40, which pertain to the GLA, MARC, NBRC, SBRC, SCRC, and SNERC:

(5) to provide assistance to severely economically distressed and underdeveloped areas of its region that lack financial resources for improving basic health care and other public services; (6) to promote resource conservation, tourism, recreation, and preservation of open space in a manner consistent with economic development goals; (7) to promote the development of renewable and alternative energy sources.

See House Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Regional Commissions: A Review of Federal Economic Development Program Effectiveness*, Serial No. 118–32, p. 23.

<sup>148</sup> For examples of this perspective, see testimony by the Cato Institute in U.S. Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Spending Oversight and Emergency Management, *Wasteful Spending in the Federal Government: An Outside Perspective*, S.Hrg. 114-59, 114<sup>th</sup> Cong., 1<sup>st</sup> Sess., June 10, 2015, pp. 9-10, <https://www.congress.gov/114/chr/CHRG-114shrg95798/CHRG-114shrg95798.pdf>; and House Subcommittee on Economic Development, Public Buildings, and Emergency Management, *Regional Commissions: A Review of Federal Economic Development Program Effectiveness*, 118<sup>th</sup> Cong., 1<sup>st</sup> sess., October 19, 2023, Serial No. 118–32, pp. 2-3, 9, 35.

<sup>149</sup> For instance, legislation enacted in FY2025 called for enhanced coordination among FRCAs and EDA. See P.L. 118-272, Section 2212.

<sup>150</sup> P.L. 118-272, Section 2233 required GAO to complete the report by September 30, 2026.

## FRCA-Federal and Other Partnership Activities

In recent years, FRCAs have partnered with federal agencies such as DOL, USDA, and HRSA, on a range of issues such as health care workforce development, health care facility development, health care access, and technical assistance for health care businesses (see “Selected FRCA-Federal Partnerships”). The FRCAs’ administrative and governance structures could further be used for new or expanded FRCA-federal partnerships across one or more policy areas with the intent to improve health (e.g., agriculture, transportation, disaster recovery). Congress could direct additional agencies to partner with FRCAs in order to provide targeted funding for specific initiatives, such as broadband-enabled telemedicine or other initiatives.<sup>151</sup> Congress could direct federal agencies to extend their partnerships to cover FRCAs not currently engaged in FRCA-federal agency partnerships or to change aspects of existing partnerships. Congress may consider evaluating aspects of current FRCA-federal agency partnerships.

As convenors, FRCAs could continue to use their existing network (e.g., federal, state, regional, and local government and private sector and philanthropic partners) to further health and economic development projects to advance health related goals.<sup>152</sup> In addition, Congress could consider options to involve FRCAs in convening stakeholders or otherwise developing partnerships to address additional socioeconomic factors related to health (such as employment, economic mobility, and income security).

Federal agencies that address aspects of rural, health care, and health research policy could be incorporated into FRCA partnerships in various ways, and existing partnerships could be expanded. Such agencies may include the National Institutes of Health, the Department of Veterans Affairs, the DOD, the Patient-Centered Outcomes Research Institute, HRSA, the Agency for Healthcare Research and Quality, and USDA, among others. In some cases, for example, federal agencies could be *required* to consult with FRCAs to coordinate projects and funding. Of relevance, in recent years Congress has made community project funding available through the HRSA account to support health facility construction and renovation, among other projects. HRSA also provides funding to support rural hospitals and provides technical assistance to struggling rural hospitals. These efforts could be coordinated to expand the reach of federal funding (e.g., community project funding could be used to complete facilities supported by FRCAs or vice versa). Should mandatory coordination be pursued, it may also be useful in minimizing duplication: federal funding could be withheld from facilities that have received funds from other sources, thereby stretching the reach of federal funds.

FRCA and federal agency collaboration could be especially useful in the case where federal health agencies may provide time-limited funds to support a particular initiative; flexible FRCA funding can support the project on an ongoing basis if the project is useful. One potential opportunity for such coordination is the Rural Health Transformation fund included in the

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<sup>151</sup> For examples of FRCAs’ grants for broadband projects, see ARC, “Computer and Broadband Access in Appalachia,” <https://www.arc.gov/about-the-appalachian-region/the-chartbook/computer-and-broadband-access-in-appalachia/>; and NBRC, “NBRC 2023 Catalyst Grant Awards Press Release,” August 23, 2023, <https://www.nbrc.gov/userfiles/files/Announcements/NBRC%202023%20Catalyst%20Grant%20Awards%20Press%20Release%20-%20August%202023%20FINAL.pdf>. In the Broadband Equity, Access, and Deployment (BEAD) program (see the Speed for BEAD Act, H.R. 1870) and potentially for broadband projects funded by the ARC (see the Expanding Appalachia’s Broadband Access Act, H.R. 2474). For more information on broadband projects and ARC, see ARC, “Broadband Projects,” <https://www.arc.gov/broadband-projects/>.

<sup>152</sup> For example, in response to concerns about disparities in capital access, ARC conducted research on challenges and opportunities in its region. Several years later, as government and private sector leaders convened, they assembled a team to work on drawing more capital into the region. One of the strategies was the formation of the Appalachian Community Capital, which received ARC startup funding.

FY2025 Reconciliation law (P.L. 119-21), which provides five years of funding to states to test innovative approaches to improve rural health care.<sup>153</sup> FRCAs could be considered in conjunction with this funding in several ways. First, the Rural Health Transformation funding is time limited and FRCA funding may be a way to sustain successful projects. Second, this funding is made available to states that were required to develop a state plan, and FRCAs—having established state partnerships—could bring together neighboring states to examine how these funds were used and lessons learned. The regional nature of FRCAs could also be useful in providing funding to expand successful projects into neighboring states.

## Pilot Programs to Address Nonmedical Determinants of Health

FRCAs may provide a vehicle for implementing policies to address some of the socioeconomic factors that contribute to health. Outside groups note that addressing SDOH requires “a holistic, cross-sector approach involving health care, education, housing, and economic development agencies.”<sup>154</sup> FRCAs currently address multiple objectives related to sub-national economic development and growth and health, and many FRCAs have existing partnerships with health care, education, housing, and economic development agencies at the state and federal levels. FRCAs also have flexible grant-making authorities and existing partnerships with regional development organizations (i.e., LDDs)—many of which provide technical and administrative assistance to community stakeholders and implement regionally oriented projects. Certain LDDs may work to expand broadband to improve access to telehealth, online education, and job opportunities.

Congress could direct FRCAs to continue or expand investments designed to address non-medical determinants of health. Existing FRCA grant programs could be used to support built environment concerns and other activities that are generally considered supportive of positive health outcomes—in addition to economic health. Such efforts could be undertaken through grants for community and economic development initiatives entities that are currently partnered with FRCAs or with additional types of partners.<sup>155</sup>

Congress could also encourage FRCAs to conduct additional, targeted outreach and engagement activities. For instance, FRCAs may be positioned to convene public and private sector stakeholders to identify specific health challenges in their respective regions. FRCAs could work with LDDs to solicit input from local stakeholders on ways to reduce longevity gaps and create interventions that are suited to communities or regions. Some researchers have noted the potential impact of such programs that focus on changing health behaviors in particular.<sup>156</sup>

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<sup>153</sup> CRS Report R48633, *Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law*, coordinated by Alison Mitchell.

<sup>154</sup> NADO, *Building Healthier Rural Communities: Economic Development Districts Address Social Determinants of Health*, August 2025, [https://www.nado.org/wp-content/uploads/2025/08/Social-Determinants-of-Health\\_v6.pdf](https://www.nado.org/wp-content/uploads/2025/08/Social-Determinants-of-Health_v6.pdf).

<sup>155</sup> In 2018, the U.S. Environmental Protection Agency (EPA) provided planning and technical assistance to facilitate strategies for healthy, walkable downtown districts and neighborhoods with economic impacts. HRSA and certain FRCAs also participated in the initiative. See EPA, “Healthy Places for Healthy People,” <https://www.epa.gov/smartgrowth/healthy-places-healthy-people>.

<sup>156</sup> Raj Chetty et al., “The Association Between Income and Life Expectancy in the United States, 2001-2014,” *JAMA*, vol. 315, no. 16 (April 26, 2016), pp. 1763-1764, <https://jamanetwork.com/journals/jama/fullarticle/2513561>.

## Research and Evaluation

Several opportunities exist for additional research and evaluation of FRCA activities. Congress may consider encouraging FRCAs to complete regular evaluations of health resources and conditions in their region, as well as funding to support such evaluations. Additional research on the economic impact of health or health care strategies could provide insight on aspects of rural health care in the FRCA context. Research could be completed by GAO or through funding provided to FRCAs for third-party evaluators of specific programs or initiatives. Outside groups, for instance, suggest that additional research regarding the effectiveness of rural health care workforce recruitment and retention and the effectiveness of telehealth as well as a better understanding of technologies and interfaces, could be helpful to inform regional economic development policies.<sup>157</sup> Additionally, researchers who study the relationship between education and health call for additional examination of the effects of early education as well as postsecondary enrollment and attrition.<sup>158</sup> Outside groups also call for additional evaluations of evidence-based strategies that focus on what works in rural areas.<sup>159</sup>

## Concluding Remarks

Researchers, policymakers, and federal agencies continue to study the relationships between places, social policies, economic opportunity, and health.<sup>160</sup> In documenting the relationships between population health and socioeconomic conditions, some researchers have observed that

Improving the economic conditions of Americans at many income levels—from those who are poor to those in the middle class—could improve health and help control the rising costs of health care. Jobs, education, and other drivers of economic prosperity matter to public health.<sup>161</sup>

Health is associated with a range of medical and non-medical determinants, including place-specific economic conditions.<sup>162</sup> Community health and economic development practitioners

<sup>157</sup> Robert Harrington et al., “Call to Action: Rural Health: A Presidential Advisory,” *American Heart Association and American Stroke Association*, vol. 141, no. 10 (February 10, 2020), <https://doi.org/10.1161/CIR.0000000000000753>.

<sup>158</sup> Jill S. Cannon et al., “Decades of Evidence Demonstrate That Early Childhood Programs Can Benefit Children and Provide Economic Returns,” The Rand Corporation, Research Summary, November 16, 2017, [https://www.rand.org/pubs/research\\_briefs/RB9993.html](https://www.rand.org/pubs/research_briefs/RB9993.html); and Anna Zajacova and Elizabeth M. Lawrence, “The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach,” *Annual Review of Public Health*, vol. 39 (April 1, 2018), pp. 273-289, <https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-031816-044628>.

<sup>159</sup> Georgia Health Policy Center, “Reimagining Rural Health: Landscape Analysis,” April 2025, pp. 39-40, <https://www.gih.org/wp-content/uploads/2026/01/Reimagining-Rural-Health-Landscape-Analysis.pdf>; and Robert Harrington et al., “Call to Action: Rural Health: A Presidential Advisory,” *American Heart Association and American Stroke Association*, vol. 141, no. 10 (February 10, 2020), <https://doi.org/10.1161/CIR.0000000000000753>.

<sup>160</sup> See, for example, William B Weeks et al. “Rural-Urban Disparities in Health Outcomes, Clinical Care, Health Behaviors, and Social Determinants of Health and an Action-Oriented, Dynamic Tool for Visualizing Them,” *PLOS Global Public Health*, vol. 3, iss. 10 (October 3, 2023), <https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0002420> and Alex M. Azar, “The Root of the Problem: America’s Social Determinants of Health,” 2018, Speech delivered at the Hatch Foundation for Civility and Solutions, Washington, DC, <https://library.vbcexhibithall.com/the-root-of-the-problem-americas-social-determinants-of-health/>.

<sup>161</sup> Steven H. Wolf et al., “How Are Income and Wealth Linked to Health and Longevity?” April 2015, <https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf>.

<sup>162</sup> Amelia Whitman et al., “Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts,” 2022, <https://aspe.hhs.gov/sites/default/> (continued...)

increasingly design strategies (e.g., assistance for health care facilities, health care workforce training, health care business assistance) to address a range of such factors—many of which intend to enhance an area’s overall quality of place and seek to improve community health. These strategies may also contribute to an area’s quality of place as well as business, resident, and worker location decisions. Additionally, health care facilities are considered regional amenities and public health assets and economic development practitioners view health care as a leading industry sector for employment opportunities.

Macroeconomic constraints, state and federal policies, and changes to insurance coverage contribute to some of the health care system challenges that are beyond the scope of FRCAs resources and jurisdiction. The health care system’s challenges include rural hospital closures, provider shortages, and quality of care concerns. Some observers anticipate that a decline in federal funding for medical education and research may dampen the availability of new health care workers (due to fewer training resources).<sup>163</sup> Others point to low payment rates for health services and a broader set of market-based and economic factors, including inflation, that may contribute to higher housing prices and costs for other goods and services.<sup>164</sup> Federal and state law set economic policies that impact individuals’ income and benefits (e.g., federal nutrition, education, social safety net programs that provide assistance to low-income households). Collectively, these trends and policies may add to financial pressures on health care systems and patients as well as the economic trajectory of certain regions.

As Congress considers the scope and scale of FRCAs’ authorities and appropriations measures, policymakers may direct FRCAs to further integrate health-focused activities into their existing regionally-oriented and community-driven approach to economic development. FRCAs currently have a role in several aspects of community-based health and health care improvement initiatives that address place-specific opportunities and challenges for regional economies. As there are no universal remedies or one-size-fits-all road maps for improving health, some experts suggest that social and economic policies as well as community-driven implementation strategies could be helpful in addressing multiple determinants of health.<sup>165</sup> FRCAs do not provide a panacea for health challenges; they may, however, offer a pathway for implementing economic development policies that could overlap with place-based health policies.

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## Appendix A. FRCAs and Rurality

Most FRCA regions face health and health care challenges, which may impact economic development, health outcomes, and business location decisions in their regions. Researchers have also documented disparities in certain health outcomes for residents of rural areas.<sup>166</sup> Four of the FRCA regions tend to be more rural compared to the general U.S. population—see **Table A-1**. Most FRCA regions include rural areas.

**Table A-1. Percent of FRCA Regions' Population in Rural Areas, 2020**

(for active FRCAs and the United States)

	Total Population	Rural Population	Percent Rural
<b>U.S.</b>	331,449,281	66,300,254	20%
Appalachian Regional Commission	26,212,015	11,530,222	44%
Delta Regional Authority	9,957,978	4,176,522	42%
Denali Commission	733,391	257,424	35%
Northern Border Regional Commission	4,443,467	2,576,003	58%
Southwest Border Regional Commission*	36,297,312	2,177,278	6%
Southeast Crescent Regional Commission	51,352,030	9,960,742	19%

**Source:** CRS calculations on March 4, 2026, using U.S. Census Bureau (Census), 2020 Decennial Census of Housing and Population, Demographic and Housing Characteristics (DHC) File.

**Notes:** Population figures as of 2020. CRS assigned counties to regional commission areas and aggregated county-level population data, except for United States (national-level data) and Denali Commission (state-level data for Alaska). Some counties are part of more than one commission's region.

For definitions of “urban” and “rural,” see U.S. Census Bureau, 2020 DHC Technical Documentation, April 2023, p. A-33, <https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/complete-tech-docs/demographic-and-housing-characteristics-file-and-demographic-profile/2020census-demographic-and-housing-characteristics-file-and-demographic-profile-techdoc.pdf#page=77>. See definition of “rural” in Census, DHC Technical Documentation, April 2023.

\* The SBRC region includes Los Angeles, CA; Phoenix, AZ; San Antonio, TX; and San Diego, CA, which are ranked as #2, #5, #7 and #8 highest in population for all incorporated areas in the United States, 2020-2025. See Census, “City and Town Population Totals: 2020-2025,” May 2026, <https://www.census.gov/data/tables/time-series/demo/popest/2020s-total-cities-and-towns.html#v2025>.

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