

Virtual Mentor

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POLICY FORUM

Federal and State Initiatives to Recruit Physicians to Rural Areas

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Recruitment and retention of rural health care professionals continues to be a national challenge. A recent study from the Association of American Medical Colleges' Center for Workforce Studies predicts that in the next decade there will be 45,000 too few primary care physicians—as well as a shortage of 46,000 surgeons and medical specialists. Similar primary care findings have been reported for other clinicians, such as physician assistants and nurse practitioners [1]. However, after a decade of dramatic decline in the proportion of U.S. medical school graduates who choose primary care residencies, 2010 and 2011 saw increases in the number who matched into primary care [2-4].

Health professions workforce shortages are exacerbated in rural areas, where communities struggle to attract and keep well-trained clinicians. Rural physician shortages have been documented for at least 85 years [5]. While 19.2 percent of the U.S. population lives in rural America, only 11.4 percent of physicians practice in rural locations [1]. The Bureau of Health Professions' Office of Shortage Designation reports that in February 2011, 65 percent of primary care health professional shortage areas were rural.

Despite medical school initiatives to train rural physicians [6-10], rural areas continue to face greater health professions workforce shortages than do their urban counterparts. Recent HRSA-sponsored research revealed that 77 percent of rural counties in the U.S. are designated as primary care health professional shortage areas or HPSAs. In 2005, 165 rural counties lacked a primary care physician. Many primary care providers are nearing retirement (age 56 or older), and while they constitute 25.5 percent of the clinician workforce in urban areas, they make up 27.5 percent in rural areas and 28.9 percent in remote rural locations.

Well-documented barriers to expanding the rural physician supply include pipeline issues, such as attracting enough interested and academically prepared students from rural areas, and the continuing increase in the cost of medical education. Furthermore, health care delivery can be challenging in rural locations because patients tend to be poorer, sicker, older and less well-insured than their urban counterparts. Other challenges include lower reimbursements for services, clinician lifestyle considerations, spousal career needs, and, for those physicians with children, school quality [1].

Federal Programs

The federal government has taken steps to address the ongoing rural recruitment and retention challenges [11]. Three long-standing programs include Area Health Education Centers (AHECs), Federally Qualified Health Centers (FQHCs), and the National Health Service Corps (NHSC) [12]. AHECs serve as community liaisons with academic institutions and help arrange ambulatory clinical training opportunities for health professions students, emphasizing participation in interprofessional training [13]. Health Centers are community-based and patient-directed organizations that provide comprehensive, culturally competent, quality primary care to populations with limited access to health care, many of which are in rural locations [14]. The NHSC provides scholarship and loan-repayment programs for both allopathic and osteopathic physicians and for other primary care providers practicing in underserved rural and urban areas [15]. These programs all received additional funding support from the 2009 American Recovery and Reinvestment Act and the 2010 Patient Protection and Affordable Care Act legislation. In addition, President Obama has established the Improving Rural Health Care Initiative, included in the 2010, 2011, and 2012 Presidential budget requests to Congress. This initiative charges HHS to improve recruitment and retention of health care providers in rural communities.

Much of this additional funding supports enhancement of the FQHC and NHSC programs. For example, there are currently more than 7,500 primary care NHSC providers—double the number in 2008, although there were still more than 1,600 vacant positions at the end of 2010. There are now more than 7,900 community-based FQHC clinics spread across all states and territories that provide comprehensive primary health care services to approximately 19 million patients, two-thirds of whom are members of minority groups. About 40 percent of FQHC patients have no health insurance and one-third are children. These funding enhancements, along with the annual congressional appropriations, strengthen the rural health care safety net.

Of the three longstanding federal initiatives mentioned above, the National Health Service Corps opportunities are most relevant for medical students and residents. Since 1972, more than 37,000 health professionals have served in the corps, expanding access to medical, dental, and mental health care in shortage areas. Currently, about half of NHSC professionals work in the HRSA-supported Health Centers discussed above, which deliver preventive and primary care services to patients regardless of their ability to pay. The NHSC is creating a long-term network of support for its clinicians. The corps recently signed a cooperative agreement with the National Center for Primary Care at Morehouse School of Medicine to develop an online training portal with content and format specifically tailored to NHSC clinicians serving in isolated settings. In addition to informational and training resources, the portal will include best-practice examples, tools and templates, chat rooms, forums, and file sharing to create a virtual community for its clinicians.

The corps provides both scholarship and loan repayment programs. The NHSC scholarship pays tuition and fees and provides a living stipend to students enrolled in several health professions programs, including accredited medical (MD and DO) schools. Upon graduation, scholarship recipients serve 2 to 4 years in a community-based clinic in a health-professional shortage area (HPSA) approved by the NHSC. Awards are made to the applicants most committed to helping underserved people and most likely to build successful careers in health shortage areas [16].

The NHSC Loan Repayment Program offers fully trained primary care physicians (MD or DO) \$60,000 to repay student loans in exchange for 2 years of full-time medical practice at a HPSA site [17]. After 2 years, program participants may apply for additional years of support—up to \$170,000 of loan repayment is available for 5 years of full-time service. (For interested full-time physicians, up to 8 hours per week can be spent teaching in a clinical setting. There is also a half-time service option that provides employment flexibility [18, 19].) Additional federal opportunities include those sponsored by the U.S. Armed Forces Health Professions Scholarship and Loan Repayment Programs.

State Programs

The practice requirements of the State Loan Repayment Program (SLRP) are modeled after those of the NHSC loan repayment program. Physicians must commit to practice in a public or nonprofit entity for at least 2 years. Each participating state must match the funds received from the SLRP. Several states and state medical associations also offer scholarship and loan-repayment programs for students and residents interested in rural practice.

Many states also participate in the NHSC Student/Resident Experiences and Rotations in Community Health (SEARCH) program, which enables trainees to do clinical rotations in underserved communities across the United States and its territories [20]. HRSA's Bureau of Health Professions provides grant funding to medical schools and residency programs for primary care curriculum development and clinical training in underserved locations, including opportunities in rural areas. Additional federal educational support comes from the Centers for Medicare and Medicaid Services (CMS), which provide graduate medical education payments to residency programs, including family medicine residency rural training tracks [21].

Supplementary Payment Programs

Historically, primary care services have been reimbursed at lower rates than those provided by other specialties. Procedural services are reimbursed at higher levels than are evaluation and management (that is, cognitive or nonprocedural) services. Data from the Medical Group Management Association indicate that from 1995 to 2004, the median income for primary care physicians increased by 21.4 percent, while that for specialists increased by 37.5 percent [22, 23].

There have also been longstanding payment inequities between lower-reimbursed rural practitioners and their urban counterparts. Supplemental payments for clinical

services are therefore available for primary care physicians and for facilities in rural locations. Through the Affordable Care Act's new Medicare Primary Care Incentive Program that began in January 2011, for example, CMS provides Medicare bonus payments to clinicians practicing in geographic primary care health professional shortage areas. Federal cost-based reimbursement arrangements also exist for certain statutorily defined facilities including FQHCs, critical access hospitals, and rural health clinics [24-26].

These strategies help ensure that rural providers and hospitals receive some of the additional payment they need to offer quality care to their patients and to protect access to care in rural communities. HRSA's Office of Rural Health Policy also provides critical access hospitals with grant support to fund quality, operational, and financial improvement initiatives. These initiatives include integrating emergency medical services into regional and local rural care systems.

Conclusion

Rural practice is not easy and it is not for everyone, but it can be fulfilling for those with a sense of adventure, who can deal with uncertainty, and who enjoy the intellectual challenges associated with evaluating undifferentiated clinical presentations. Doctors who enjoy a more independent working environment and small-town living—and who seek to serve and invest deeply in their community—can thrive in rural medical practice.

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