PHYSICIAN RECRUITMENT AND RETENTION

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As there is a vast amount of research on the subject of rural physician recruitment and retention, this paper is not intended to be a comprehensive scholarly review or policy analysis. Rather, the purpose is to briefly overview the current status of rural physicians, underscoring concerns that need to be addressed, and to present the need for advocacy and those policies that should be supported.

CURRENT HEALTH STATUS OF RURAL POPULATIONS

More than 51 million Americans live in areas classified by the U.S. Office of Management and Budget (OMB) as nonmetropolitan. They comprise one-fifth of the U.S. population. Rural populations are found to be older, poorer, sicker, less educated and to have a perception of worse health status than their urban counterparts (Cordes, 1989; Braden, 1994). They also have higher infant mortality and injury-related mortality rates, fewer hospital beds and physicians per capita, and are much less likely than urban residents to have private or public health insurance (Braden, 1994). Moreover, while the number of individuals living below the poverty line is disproportionately high in rural areas, the number receiving Medicaid benefits is disproportionately low (Rowland, 1989). In a study of the utilization rates of 28 categories of medical services, Miller (1994) found that, with the exception of major surgical procedures, urban residents received between 20 percent and 30 percent more of each type of service than did rural residents.

CURRENT STATUS OF RURAL PHYSICIAN PROVIDERS

With at least 20 percent of the population living in rural areas, less than 11 percent of the nation's physicians are practicing in nonmetropolitan areas (Fact Sheet, 1997). In 1997, more than 2,200 physicians were needed in nonmetropolitan areas to remove all nonmetropolitan health professional shortage area (HPSA) designations for primary care. More than twice that number are needed to achieve a 2,000-1 ratio in those HPSAs (Fact Sheet, 1997). This is the current situation and does not factor in the aging physician population serving rural areas (Lawthorne, 1993), nor does it factor in the statistical designation dealing with counties as the main reference point. Data from larger metropolitan areas may overwhelm data from smaller, more remote communities in the same county giving a mean value, which conceals a broad variance in underlying data. By using county status alone, there is an inability to profile the different communities in a single county (Patton, 1989).

CURRENT STATUS OF PHYSICIAN RECRUITMENT EFFORTS

Allopathic and Osteopathic Medical Schools

Selective medical school admission policies to enhance primary care career choice and rural preference have been shown to increase the number of physicians serving in rural areas (Rabinowitz, 1988; Rabinowitz, 1993; Adkins, 1987; Brazeau, 1990; Verby, 1991; Boulger, 1991). Also, physicians from underrepresented minorities are more likely to care for medically underserved populations (Xu, 1997). Recruitment to rural practice is aided by exposure to positive rural physician role models (Roberts, 1993) and early and long-term clinical training in rural sites and hospitals (Connor, 1994; Norris, 1988).

In spite of such data, the current medical school environment is highly discouraging of a career in generalism (Linzer, 1994; Kassebaum, 1996), and medical schools vary greatly in the percentage of their graduates who enter rural practice, ranging from 41.2 percent to 2.3 percent of the graduating classes studied (Rosenblatt, 1992). Medical students are discouraged in both subtle and overt ways from entering primary care specialties and from practicing in underserved areas (Young, 1990). There is thus a need to modify significantly the value sets, attitudes and behaviors of medical school faculty to prevent the dissuasion of rural-oriented students from entering rural practice.

In terms of osteopathic vs. allopathic training, in 1989, differences between the graduates of osteopathic and allopathic medical schools were seen in that osteopathic physicians made up only 5.5 percent of the physician work force in the United States, yet they represented 15 percent of all physicians practicing in rural areas with a population of less than 2,500 and 18 percent of all physicians practicing in frontier areas with a population of less than 2,000 (Area, 1989). Whether this differential has been sustained is unknown due to a difference in reporting since 1989.

Graduate Training

Graduate training can positively enhance recruitment to rural communities and impact retention by training the physicians for the realities of practice through rural selectives, rural training tracks and rural emphasis (Brazeau, 1990; Foley, 1994; Mangus, 1993; Connor, 1994; Rosenthal, 1998; Fryer, 1997; Bowman, 1998; WONCA, 1995). Rural selective sites mostly have not been reimbursed for graduate medical training and the funding for primary care programs with a rural initiative has been inadequate and unsecured.

The current effort to roll back support of graduate medical education (GME) will hinder the newly developing rural medical schools and rural residencies. GME funding linking reimbursement to inpatient hospital volume specifically hinders the expansion of primarily outpatient setting residencies, such as family medicine residencies (Saver, 1998). The relatively small number of family physicians educated has contributed to the shortage of rural physicians (Council on Graduate Medical Education [COGME], 1998). As the nation works within the constraints of the Balanced Budget Act of 1997, any freeze on GME spending must ensure reallocation to address these issues.

Medical schools and residency programs are integrating the importance of the community into their curricula. This enhances the rural physicians' community-oriented care and integrated team approach. As the physicians integrate this approach, infrastructure building of the allied health teams in rural areas will need to be continued.

GOVERNMENT INITIATIVES

National Health Service Corps

The National Health Service Corps (NHSC) program was designed to place physicians in medically underserved rural and inner city areas. The underlying philosophy involved placing a physician in a rural community with temporary financial and technical support in the hope that the physician would stay on to establish a private practice after completion of whatever contractual obligations existed. The designation of a community as a HPSA gives eligibility to receive NHSC personnel through the agency acting as a placement program, a scholarship program tied to service in underserved areas, and a loan forgiveness program with similar contingencies.

Though much effort has been expended in placement of physicians in these rural areas, relatively little has been done to enhance the retention of these physicians because this is not the charge given nor funded to the NHSC (Pathman, 1992). Once the physicians complete their service obligations, if they continue to practice at the rural sites they will be faced with the same factors of low reimbursement, overwork and professional isolation that most rural physicians face.

Even with these noted barriers to retention, a 1997 study shows 20 percent of the physicians assigned to rural areas were still located in the county of their initial assignment and an additional 20 percent were in some other rural location in 1991. Completing family medicine residencies before assignment enhanced retention (Cullen, 1997).

A caveat should be noted. Were the NHSC given the charge to enhance retention, this might serve as an incentive to the NHSC to staff the more desirable sites first, thereby increasing the retention rate, but this would not serve the undesirable locations well.

The NHSC also offers the potential of providing locum tenens coverage for isolated rural physicians to have time off for activities such as continuing medical education and family vacations. In both Australia and Canada, government-sponsored coverage such as this has been one of the most popular retention tools in the Rural Incentive Programs currently in force. This would have the added benefit of exposing NHSC physicians to a variety of rural localities and practice settings and offer these localities increased opportunities for recruitment efforts.

International Medical Graduates and J-1 Visas

International medical graduates, through state initiated J-1 visa programs, have initially met some unmet needs of rural areas (Kirk, 1991; Merritt, 1993). The February 1998 COGME paper states that although international medical graduates have made an important contribution to the provision of medical care in some rural areas, training these graduates is an inefficient way to expand physician supply in rural areas. Although many inner city hospitals are dependent on international medical graduates for providing care to underserved urban populations, more direct avenues exist for meeting the needs of these hospitals. The funds would be better targeted to programs that increase the flow of U.S. medical graduates to underserved rural areas (COGME, February 1998; Mullan, 1997).

This COGME position underestimates the value international medical graduates have provided to rural areas. International medical graduates constitute a greater percentage of the U.S. primary care physician work force in underserved, rural areas than in rural areas that do not have a physician shortage. Distribution varies according to state policies, state-federal interaction, social and cultural networks, and public perceptions. Local and state conditions should be given consideration in any policy that seeks to change the supply of international medical graduates to rural or other underserved areas (Baer, 1997). If the J-1 visa status were to be eliminated, the primary care work force in underserved, rural areas would be adversely impacted. Only when the remedies suggested by COGME have been in place long enough to validate their projections and ensure graduates through the entire pipeline process, should any intervention with the J-1 visa status be entertained.

There is also an ethical consideration. When the international literature on rural physician recruitment and retention is evaluated, the problem is found to be no less severe in other countries and, in some cases, even more intractable. The United States, although having what many regard as an increasing oversupply of maldistributed physicians, is seen as drawing off the supply of physicians trained in other countries who are greatly needed back where they were trained. Indeed, one of the basic requirements for the issuing of a J-1 visa for foreign physicians training in the United States is that the home country certify that the skills learned here are necessary (or in the case of a visa extension for a post residency fellowship, "exceptionally necessary") in the home country (Chang and Boos, 1997; U.S. Information Agency, 1994). To escape the mandatory two-year return to the home country after completion of training, the holder of a J-1 visa may apply for a waiver of the return stipulation, which requires a letter of "no objection" to the waiver from the home country, but does not indicate the sudden cessation of the previously certified "necessary or exceptionally necessary" need for the physician's skills.

In a report from Canada, which is subject to the same J-1 and HB-1 visa requirements for physicians as other countries (with one small exception involving the North American Free Trade Agreement [NAFTA]), one of the largest impediments to Canada's rural recruitment and retention was found to be the presence of recruiters from the United States, who are successfully recruiting Canadian physicians with packages rural Canadian communities can't match (College of Family Physicians of Canada, 1995). This is true to such an extent that some Canadian provincial health authorities are now refusing to

certify the need for training in the United States that is required to obtain the J-1 visa (Siskind, et. al., 1998).

Other Government Initiatives

With the decentralization of health care projects during the 1980s and the institution of federal block grants to states for health purposes, the states have been forced to give more thought and legislative focus to rural health activities. Along with the establishment of the federal Office of Rural Health Policy (ORHP) in 1987, the states were given the opportunity to set up state offices of rural health. By 1992, 38 states had done so, and as of 1994, all 50 states had a state office of rural health in place, although not all offices command the same amount of a state's resources (ORHP, 1994). The state offices of rural health engage in health care provider recruitment and placement, technical and financial assistance, expansion of local health departments (Gordon, 1992) and research and demonstration projects.

States are also pursuing courses independent of the federal government to enhance rural health care delivery, most notably in the areas of medical education and legislation. In state-supported public medical schools, for example, policies may be mandated to meet expectations established through the legislative process. States also have taken the initiative in loan forgiveness, scholarship programs and tax credits.

The Bureau of Health Professions has long provided development grants to primary care residencies, but this funding continues to be in jeopardy with each budget cycle.

PRIVATE ORGANIZATION, COMMUNITY AND INDIVIDUAL INITIATIVES

Private, religious and corporate leaders have been instrumental in addressing the needs of rural citizens and are an integral reason for the advancement of issues, interventions and service.

Additionally, it is critical that communities take a positive and productive role in recruiting and successfully retaining health professionals, especially in rural areas. Many national initiatives, funded by private foundations and federal programs, have demonstrated positive outcomes when health professions training programs and local rural communities develop partnerships to address this issue.

Community members, as stakeholders in this process, have combined local resources with state and federal resources to develop and operate community-based training programs and to provide financial incentives to new recruits. Many of the successful models of collaboration between community and higher education operate under the general principles of partnerships, high-quality education, community service and interdisciplinary education. Some of these models also created new organizational structures that have initiated health professions education and reform and have changed how public funds are spent (Richards, 1996). A number of studies show that community

support is integral to recruitment and retention and needs to be encouraged (Amundson, 1991; Conte, 1992; Crandall, 1990; Doeksen, 1988; Hicks, 1991).

CURRENT PROBLEMS WITH RETENTION OF RURAL PHYSICIANS

Economic issues

Nonmetropolitan physicians derive a larger share of their gross practice revenue from Medicare and Medicaid patients than metropolitan physicians. These public programs pay physicians at lower rates than private insurers (Fact Sheet, 1997; Phillips, 1995; Coombs, 1995). There is a decreased ability in nonmetropolitan areas to perform economically enhancing procedures (hospitals with decreasing obstetrical and surgical units, etc.), which further decreases relative reimbursement rates. Nonmetropolitan physicians, on average, work more and earn less than their metropolitan counterparts (Fact Sheet, 1997; Rosenthal, 1992).

Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) in designated HPSAs and medically underserved areas (MUAs), and differential Medicare payments to qualifying rural areas have helped to enhance reimbursement. The number of HPSAs is increasing as more communities become aware of the importance the designation can bring in enhancing the revenue of a provider such that it begins to approach that of urban providers. Rural areas with high numbers of Medicare and public aid patients and patients with no insurance, cannot support a provider without such programs (Phillips, 1994; Phillips, 1995). Currently, the mandate that states pay RHCs and FQHCs their reasonable costs under Medicaid is being phased out. Medicare managed care program reimbursement to RHCs has threatened to be lower than the current reimbursement. Both of these payment changes will put providers in jeopardy.

The HPSA and MUA designations are presently being overhauled. Areas that have been successful in establishing RHCs or FQHCs and now have reached an adequate number of providers face the danger that they will lose their RHC and FQHC designation. There must be built-in protection for areas that still have the same problems-higher number of Medicare, Medicaid and uninsured citizens-but have been fortunate to attract providers. If the enhanced reimbursement is withdrawn, the providers will be forced to leave, and a potential cycle of revolving providers depending on the designation status will occur. Continuity of care and access to care would be markedly diminished.

Diminished reimbursement continues to be a major factor among heavy Medicare and Medicaid populations that do not or cannot qualify for RHC status or Medicare bonus payments because reliance on this reimbursement is not feasible to a viable practice (Phillips, 1995).

The impact on rural physicians' economic status by managed care, and managed Medicare and Medicaid programs has yet to be determined but bears careful monitoring and analysis.

Social Adjustment

Retention must take into consideration the social adjustment of the physician and family, which is directly influenced by good recruitment that defines mutual needs and expectations, shared values and beliefs and relationship strengthening (Wilhide, 1995). These efforts can be strengthened by preselection criteria, through medical school and residency curriculum enhancements, and at the community level through specific retention efforts (Cutchin, 1997).

The problem of the spouse and children of the rural physician is one that is too often neglected. A spouse, especially one with a career, may be relegated to a trivialized position in a move to a rural area, and the desired level of educational facilities may be unavailable for children. This problem (known as the "Trailing Spouse Syndrome" in human resources and management literature), has been addressed in other countries and deserves more attention and support here (WONCA, 1995).

The needs of the spouse must be addressed in the recruitment process. The evolving needs of children as the family grows is a major factor in retention and must be given adequate attention (Crouse, 1995).

Professional isolation is often cited as a reason to leave a rural area. Outreach organizations that provide continuing medical education have been helpful, but in reality, these rarely deal with specific rural topics. The Internet and teleinformatics can become resources for diminishing isolation. Some states, through their state offices of rural health and area health education centers (AHECs), have helped to bridge this isolation issue by advancing continuing medical education, encouraging health professions education in rural areas, and helping communities to address specific issues (Forti, 1995).

Cultural Diversity

Every effort should be taken to match the cultural aspects of the physician and the community to enhance retention. If this is not possible, efforts should be made to orient and integrate the physician and family to the specific cultural aspects of the community. This needs to be an ongoing process.

Work Issues

The workload and demands placed upon rural physicians are greater than those experienced by their metropolitan counterparts (Fact Sheet, 1997). Knowledgeable utilization of nonphysician providers' abilities to reduce the physician's workload and decrease professional isolation should be encouraged.

Lack of coverage is another significant issue causing dissatisfaction among providers. Positively furthering rural physician networking can begin to address this problem, as can an organized system of locum tenens coverage to provide periodic relief for isolated physicians.

POLICY RECOMMENDATIONS

Although there is much overlap in the policy suggestions that influence recruitment and those impacting retention, there are enough differences to warrant their separate consideration. Recruitment focuses mainly on those processes occurring prior to arrival in the community; retention focuses onthose occurring after. The importance of this distinction arises when much attention is given to the former and little to the latter, as has been the norm until recently. All policy statements dealing with the recruitment and retention of physicians to rural areas must recognize the equal importance of both these issues.

Recruitment

This category may be subdivided into categories of research, education and graduate training.

Research

The ORHP funding for research related to physician recruitment, retention and networking should be supported and enhanced.
The designation of HPSAs and MUAs must be fully researched so the designated areas accurately reflect underserved status.
Since international medical graduates constitute a greater percentage of the primary care physician work force in rural underserved areas, withdrawal of GME funding that will reduce the number available to the rural areas should be researched and the ramifications fully realized. Before the international medical graduate supply to the rural area is reduced, there needs to be an adequate supply of physicians ready to serve the needs of the rural population.
State recruitment initiatives need support for modeling, database development and profiling. Funding to states to maintain these resources to assist in appropriately designating funds to the areas of higher need should be provided.
Education

The Title VII funding for AHECs and health education training centers should be supported and enhanced.
Legislators and other policy-makers should encourage medical schools to confront their obligation to target admissions and training to underserved populations, both rural and urban, in the primary care professions.
The medical school environment should encourage primary care and encourage early and long-term rural exposure to positive rural physician role models, and such educational programs should be adequately funded.
Scholarship programs to place medical students with mentoring physicians in rural or remote practices during an elective or vacation period should be encouraged.
Support medical schools' and residencies' efforts to integrate community orientation and a team approach to health care. To achieve the full benefit of this effort, there needs to be

further infrastructure building of rural allied health teams and rural communities' commitment to meeting the challenges of a changing health care system.

Graduate Training

Family practice residencies should be encouraged to offer rural selectives, rural emphasis and rural training tracks.

Any proposed reallocation of GME funding should be targeted to enhance the more outpatient-based primary care residencies and newly expanding programs designed to meet rural needs. Furthermore, specific allowances should be made to raise resident caps on urban-based programs to support the training needs of rural-based residencies.

Bureau of Health Professions (BHP) funding for residencies that are building rural-based programs and funding for those programs that have a history of producing rural physicians should become a staple rather than be at the mercy of national budget politics. An aggressive plan to increase funding should be sought.

Support by the BHP to primary care residencies should be continued and enhanced. Funding should be focused on those programs that have achievable, realistic plans to enhance production of physicians who eventually will practice in rural or urban underserved areas or on programs that have demonstrated a higher production of such physicians.

Retention

The retention of a physician in a community is dependent on the perception of that physician that his or her life needs have been satisfied. These perceived needs may be divided into professional fulfillment, financial remuneration and lifestyle.

Professional Fulfillment

Decrease professional isolation by supporting teleinformatics and outreach education programs of states and by the use of nonphysician providers.

Increase retention through more appropriately rural-trained candidates.

Identify care needs at the community level. Use state and federal funds to assist rural hospitals where access to care would be threatened by hospital closure and physicians would be further deprived of opportunities to utilize their professional skills.

Develop and use innovative delivery systems that emphasize coordination and cooperation among providers, institutions and communities.

Develop programs allowing rural clinicians to undertake periodic rotations through academic hospital services (with locum tenens backup) in order to learn or update procedures.

Financial Remuneration

For those areas that do not qualify for RHC or FQHC status but still are faced with the disproportionate numbers of Medicare and Medicaid patients, there should be enhanced Medicare and Medicaid payments to rural providers. More research to determine the best way to construct incentives so as to optimize their influence should be pursued.

The enhanced reimbursement available through RHC and Community Health Center designations needs to be adequately maintained to retain providers and avoid decertification as the area's needs are met. If the same level of Medicare and Medicaid and uninsured patients persists and the area is decertified because of an adequate supply of physicians, a cycle will develop leading to economic unfeasibility, provider dissatisfaction and lower retention rates.
Mandates to the states to pay RHCs and FQHCs reasonable costs under the state's Medicaid program should be continued.
Medicare managed care reimbursement must equal or exceed the RHC and FQHC Medicare reimbursement.
Increase the supply of primary care providers in rural areas by lessening specialty and geographic differentials in physician income.
Retention should be reinforced with tax credits for those who serve in acute shortage areas.
Consideration should be given to the establishment of relocation grants, especially for remote areas, to defray the costs of moving and setting up a practice.
Lifestyle

Support NHSC, state and professional initiatives to offer locum tenens to rural practitioners that would be available on a periodic basis for purposes of continuing medical education or family vacations.
Programs should be developed (and communities urged to adopt them) for support of the physician, spouse and children of the physician. This should include work and social opportunities for the spouse.
Work to create innovative plans to share the workload through aggressive network building, partnering over distances, and sharing of resources.

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