

Rural HEALTH NEWS

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A Family (Doctor) Affair

By Thomas D. Rowley

It's difficult to overstate the importance of family physicians to rural areas. You might even say they're the backbone of rural healthcare.

How so?

According to the American Academy of Family Physicians, family doctors provide more than 90 percent of the primary medical care in rural communities. That family docs provide the lion's share of rural care is due largely to their propensity to

locate in rural areas, which is due largely to the fact that family physicians serve much smaller populations than do other specialists. The average family physician serves 2,000 people; the average neurosurgeon needs a patient base of 100,000.

Of all the medical specialties, family physicians are the only doctors distributed in proportion to the general population. Indeed, they are three times more likely than general internists and five times more likely

than general pediatricians (both considered, along with family docs and OB/GYNs, to be primary care physicians) to locate in rural areas.

Consequently, if family doctors were removed from all 3,082 counties in the U.S.—three-fourths of which are nonmetro—the number of counties designated as primary care health professional shortage areas (HPSAs) would increase by 1,332.

Unlikely though it may be that family docs will be removed from all (or even many) counties, demand for family docs already outstrips supply.

Furthermore, the likelihood of new family physicians going to rural areas is in doubt, for several reasons. And that, according to many rural health experts, spells big trouble.

First, despite a growing supply of physicians overall, the number of family physicians has remained relatively stable at approximately 30 per 100,000 population—half of the Council on Graduate Medical Education's recommended minimum for generalists.

Second, beginning in 1997, the percentage of family practice residency positions filled in the National Resident Matching Program—the so-



Dr. Carroll Christiansen, a Family Practice physician in Spencer, West Virginia, is shown with physician assistant student Julia Veresh, who is learning the techniques of physical examination with the cooperation of patient Harry Nicholson.

Photo by Chuck Conner, Winding Roads Health Consortium

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Table 1: Family Practice Fill Rates

Year	Percent Filled	Percent Filled by U.S. Seniors	Positions Filled
1990	70.4	59.3	1,685
1991	65	55.7	1,604
1992	67.5	56.2	1,678
1993	77.3	63.2	2,002
1994	82.7	66.7	2,293
1995	87.1	70.8	2,563
1996	90.5	72.6	2,840
1997	89.1	71.7	2,905
1998	85.5	66.2	2,814
1999	82.6	62	2,697
2000	81.2	57.2	2,603
2001	76.3	49	2,363

Source: American Academy of Family Physicians

called “match” or “fill” rate—has declined each year.

“Rural areas are heavily reliant on family doctors,” said Pat Taylor, a rural health consultant and former director of research at the Federal Office of Rural Health Policy. “As a result, the decline in the fill rate is really bad news in terms of assuring future access to care in rural areas. I’m particularly concerned because it’s happening at a time when we’re seeing so many rural physicians near retirement age.”

Roger Rosenblatt, MD and professor in the University of Washington Medical School’s Department of Family Medicine, agrees.

“The progressive and continuing decline in the fill rate is the most salient and potentially devastating indicator of rural health care,” he said. Rosenblatt notes that a drop in today’s fill rate means a drop in the number of doctors three to four years from now and calls the five-year slide “a dog with a very long tail.”

Third, even when the number of family practice graduates was increasing—prior to the drop-off—the number of family practice graduates going into rural practice remained constant at approximately 600 per year. Indeed, only 2.2 percent of all medical school graduates, according to a 1996 report of the Association of American Medical

Colleges, planned to practice in rural areas or small towns. As a result, while 20 percent of the country’s population lives in rural America, only about 10 percent of the country’s doctors now practice in rural America.

To sum it up, the relative number of family doctors—the physician discipline most likely to locate in rural America—will probably decline, as will the number of doctors—family or otherwise—choosing to practice in rural areas.

The Roots of Decline

Ominous though they are, the declines in family physicians and in physicians locating in rural areas are merely symptoms. The underlying causes—the obstacles to family practice and to rural practice—are many.

While the family doc occupies a special—albeit perhaps nostalgic—place in our hearts, family practice is no longer the specialty of choice, at least not after medical school. According to Wayne Myers, MD, medical educator, and former director of the Federal Office of Rural Health Policy, “A majority of students enter medical school planning to be primary care doctors. Year by year, as they proceed through medical school, this interest is extinguished.”

Doctors Pugno, McPherson, Schmittling, and Kahn write in *Family Medicine* that “...interest in family practice and, in fact, in all primary care specialties, has declined. Market factors, lifestyle choices by medical students, escalating educational debt, and the general turbulence of the health care environment all contribute to this trend.” On average, family physicians make less money than other specialists, they tend to work longer hours, their work is less high-tech and less flashy, and they tend to bear the brunt of pressure and criticism associated with managed care. In addition, as Pugno and his co-authors point out, many students see family practice as more complex, and therefore more demanding, than other specialties. At the same time, others see family medicine as too easy, and therefore less glamorous. Finally, some say Federal funds tend to promote research and specialization at the expense of primary and family practice within medical schools.

Small wonder, then, that there is a decline. “Medical students aren’t dumb,” said Rosenblatt. “They make decisions about their career paths based on their prediction of feasibility,

profitability, and desirability.” Obviously, those predictions are less than rosy.

In addition to the obstacles standing between medical students and family practice are those standing between doctors (family and otherwise) and rural practice. Among the most often cited are isolation from colleagues for back-up as well as social and professional interaction; reduced access to advanced medical

against rural practice), the growing number of female medical graduates (who are less likely than males to locate in rural areas), the growing number of specialists (who are less likely than family docs to locate in rural areas), and admission of the “wrong” students (more about that later).

Rx?

Obviously, a problem with multiple roots requires multiple remedies. As for increasing the number of family physicians, changing a few Federal funding mechanisms seems a good first step.

- Graduate Medical Education (GME) funds

administered by the Health Care Finance Administration (HCFA) go to teaching hospitals, many affiliated with medical schools, to help defray the cost of residency training and therefore increase the supply of doctors. Unfortunately, the payments do little to directly increase the number of family or primary care physicians.

Furthermore, because GME payments were created in a time of overall doctor shortage that no longer exists, Congress, in the Balanced

Table 2: Where Family Practice Graduates Practice

Year	1990	1991	1992	1993	1994	1995	1996
Total FP Grads	2,277	2,137	2,369	2,377	2,399	2,558	2,914
FP Grads in Rural	524	530	616	587	537	568	635
FP Grads in Rural < 2,500 Pop.	123	103	92	100	96	102	111

Source: Dr. Robert Bowman, University of Nebraska Medical Center

technology; lack of continuing education opportunities; lack of urban amenities; lack of professional opportunities for a trailing spouse; and lagging economic conditions that translate into poorer patients and less pay.

Add to that list, the dissuading influence to rural practice that medical schools exert on students (in the form of few and/or inadequate rural training opportunities, the increased focus on high-tech medicine, and—in some cases—a bias

Budget Act of 1997, reduced GME payments and capped the number of residents eligible for funding. Realizing the harm to rural areas, Congress, in the Balanced Budget Refinement Act of 1999, restored some funding and allowed rural hospitals to expand their residency cap by 30 percent. However, according to Ed Fryer, analyst with the American Academy of Family Physicians (AAFP), the BBRA refinements “helped some, but really didn’t do more than put back some of what BBA took.”

- Title VII, Section 747 of the Public Health Service Act could also be enhanced to increase the supply of family physicians. The section provides grants to medical schools—grants that the AAFP says are “the engine that powers the growth of this nation’s supply of family physicians.” Without those grants, according to the AAFP, fewer students would be choosing primary care and family medicine.

Specifically, the grants support training programs in family medicine at both the undergraduate and graduate levels—residency training, academic departments, pre-doctoral programs, and faculty development. Consequently, the AAFP advocates increasing the amount of funds available under the program.

“Family medicine training grants are terribly important,” said Myers. “Medical schools make most of their money on referral subspecialty patient

care and research grants. Primary care grants help a small number of primary care faculty support and encourage students toward careers in primary care in a generally hostile educational environment. This time of adversity for primary care is precisely the time to expand the primary care training grant program.”

- Finally, the National Institutes of Health send money—lots of money—to medical schools to fund research. “Most of that money,” said Pat Taylor, “goes to specialists doing specialist research with specialist residents. Not surprisingly, then, NIH dollars lead schools to focus on research and specialization at the expense of primary care and family medicine.”

As for getting more physicians into rural areas, the Federal government and some medical schools have been trying for years, with some success and—not surprisingly—some criticism.

- The Medicare Incentive Payment Program offers a 10 percent “bonus” on reimbursements for physician services to Medicare beneficiaries in rural HPSAs who are covered under Medicare Part B. And while some doctors are quite positive about the bonus, Rosenblatt says it simply isn’t enough. He argues it should be 25 percent. “With the

stroke of a pen, we could make a program that would work... We have to make it possible for [rural doctors] to survive economically,” he added.

However, raising the rate may or may not help, since little of the bonus is being paid out anyway according to research just completed by the RAND Corporation for HCFA. For example, based on study data, a rural Medicare expert estimates that the 1998 bonus payments for care provided to rural, whole county HPSA beneficiaries may have been made on only about one-third of the eligible billings. Translated to dollars, doctors collected only \$22 million of an estimated \$67 million.

The reasons include physicians’ fear of being audited by HCFA if they claim the bonus, a lack of help from the insurance companies who process the bills for Medicare in collecting the bonus, and the fact that some physicians simply are not aware of being eligible.

- The National Health Service Corps was created in 1970 to place primary care physicians and dentists in areas that lacked access to health care—primarily distressed urban and rural areas. Under this indenture program, medical personnel agree to serve in these areas for a limited time (at least two years) in return for scholarships and school loan repayment.

While grateful for the help, some areas receiving Corps doctors are able to keep them only as long the doctors' indenture. In those instances, continuity of care, trust, and long-term relationships suffer. Other areas are able to keep the doctors after their term of service expires.

- Another source of physicians for rural areas are the so-called International Medical Graduates (IMGs)—doctors who attended medical school outside the United States, but come here—typically—on a temporary, J-1 Visa to participate in a residency program. The expense and difficulty of recruiting and obtaining the visa aside, the major criticisms of IMGs are the temporary nature of the arrangement, the cultural and language gaps between the doctors and the people they serve and the deleterious effects those gaps can have on doctor/patient relations and quality of care, and the perception—accurate or not—that IMGs are not as well trained and therefore do not perform as well as U.S. medical school graduates.

Still, IMGs are critical to the supply of rural doctors. Indeed, 3R Net's Moskol, director of the Rural Recruitment and Retention Network, said "Many of our states absolutely rely on IMGs...in the more sparsely settled states...IMGs are the main source of physicians. Though cultural gaps exist, language compe-

tency is the primary barrier. If the doctors can speak English well and are responsive to community needs, they quickly become accepted...Many of these physicians are the "best of the best" in their countries. Though their training in medical school might be less rigorous than U.S. schools, they can get superb residency experiences. Again, it's a case by case basis. Screening is essential and another reason to work with one of the 3R Net state administrators."

- Finally, 29 of the 474 family medicine residency programs in the nation have established separately accredited rural training tracks. These training tracks place residents in rural areas where they can not only learn medicine, but also learn what it's like to practice medicine in a rural area. The idea behind the program is that doctors are more likely to practice where they train. And according to a 1999 AAFP survey of the programs, the idea works. Overall, 76 percent of the graduated residents went on to serve in rural communities.

A Question of Will

Dr. Robert Bowman is a fan of rural training tracks, but thinks the nation and its medical schools could do more, a lot more. Bowman, himself a family physician, is director of Rural Health Education and

Research in the Department of Family Medicine at the University of Nebraska Medical Center—the National Rural Health Association's 2001 Outstanding Rural Health Program. You might say that he is a man with a mission: namely, to increase the number of family doctors practicing in rural America. To do that, he says, will require changing medical education in this country, beginning with admitting the "right" students to medical school.

According to Bowman, the right student—that is, the student most likely to become a rural family practitioner—may not have the highest MCAT scores, but more than makes up for it with a desire to serve and a concern for rural areas—usually stemming from a rural background.

"The problem is poor medical school selections of students who will practice in rural; it's not the match. We waste tremendous resources on primary care by not picking the right students," he said. "These include Title VII, NHSC, and several sources of Federal dollars, state dollars spent on family practice programs, etc. If even a small portion of [these resources] was devoted to better admissions, then we would have far more efficiency in meeting national goals for the underserved."

Once the right students are admitted, the focus shifts to providing an education that increases the likelihood they will choose rural practice. According to Bowman,

such an education emphasizes a continuous approach to rural training—opportunities to experience rural practice, information about rural career decisions, peer support for students’ rural interests, advice from rural physicians, and rural-oriented financial incentives.

“The problem is that medical schools do not educate students and residents as well as they should,” he said. “To be able to tackle the challenges of rural practice, you must first master the clinical aspects and then move on to dealing with the challenges of problem solving beyond medicine, working with other providers and the community.”

To further the mission, Bowman and others have formed a Rural Medical Educators group within the National Rural Health Association. (see *Around the Country*) He also maintains a website (www.unmc.edu/Community/ruralmeded) that has a wealth of material on increasing the number of rural physicians.

The battle is decidedly uphill. Most medical schools, Bowman says, “don’t get it.” The few “that do it right, do so because a senator or someone else got fed up and made them change. It’s a question of political will.”

Pat Taylor concurs. “State governments could make a lot happen and they don’t.” To give a much-needed push to state governments, which run most of the nation’s medical schools, Taylor suggests Congress create a Federal-state match program to encourage rural physician training. Such a program could, for example, increase stipends for rural residents. Noting the presence and position of several rural-friendly Senators, Taylor likes the chances of finally getting something done. “There’s never going to be a better time than now to ask Congress to help rural health care.”

Capital Area Rural Health Roundtable Looks at EMS

On May 8th several experts gathered to focus on key policy issues affecting rural EMS and rural access to trauma care. Speakers included Jeff Michael, Chief, EMS Division of the National Highway Traffic Safety Administration; Mark King, Director of the West Virginia Office of EMS; Dan Manz, Vermont Director of EMS; Dia Gainor, Idaho EMS Bureau Chief; and Neleen Eisinger, Legislative Assistant to Senator Kent Conrad.

Speakers outlined several of the barriers to rural EMS: low volume, low tax base, and little money; recruitment and retention worries; difficulties with medical oversight; the need for management training; and problems with skill retention. They also discussed several potential solutions: improving rural reimbursement schemes; improving state capacity for technical assistance; and paying for preparedness and care, not just “the ride”.

Information available at <http://rhr.gmu.edu/forums.html>.

Rural Medical Educators

More than 70 people interested in rural medical education attended a 2-day conference in conjunction with the 2001 National Rural Health Association conference in Dallas in May. The group—a recently formed special interest group of the NRHA—elected leaders, determined its priorities, and put together work groups on the following issues: web-based tools, federal advocacy, state advocacy, research, and membership expansion.

Information available at www.unmc.edu/Community/ruralmeded/calendar.htm.

National Rural Development Partnership Health Care Taskforce

The taskforce is a national network of rural health care leaders and advocates who work through State Rural Development Councils, State Offices of Rural Health, and with other rural constituents to create opportunities for partnerships to improve the health and well-being of

America’s rural citizens. The taskforce does this by identifying issues and trends in healthcare that affect rural America; collecting, analyzing, and disseminating information on legislation and programs; communicating rural healthcare concerns to national, state, and local leaders; and providing a forum for the exchange of ideas.

In addition to sponsoring events at the annual National Rural Development Partnership conference, the taskforce organizes and holds a monthly conference call. Recent topics include disability in rural areas, emergency medical services, and access to dental care.

For more information or to participate, contact at Suzanne Powell at (202) 205-3505 or suzanne.powell@hhs.gov.

Call for Input

Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at t-mrowley@juno.com.

Rural Task Force

The Secretary of the U.S. Department of Health and Human Services wants to know more about how his department serves the country's 54 million rural residents and he's turned to the Federal Office of Rural Health Policy (ORHP) to get the answers.

Tommy G. Thompson, the HHS Secretary, has asked Dr. Marcia Brand, Director of ORHP, to lead an internal review of all the department's programs. That review will encompass a wide variety of programs run by Federal agencies such as the Centers for Medicare and Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administration on Children and Families (ACF) just to name a few.

"As former governors of states with large rural populations, President Bush and I know how important it is for people outside urban centers to have access to quality health care and social services. We have carried that understanding to the White House and HHS," Secretary Thompson said in a speech to the Joint International Summit on Rural and Community Development.

The Task Force will report back to the Secretary within three months and will be the first comprehensive assessment of how HHS serves rural

America. The idea for the task force emerged from Secretary Thompson's visit to ORHP in May as part of a larger tour of HRSA.

"The Secretary made it clear in that meeting that he wanted to do something to improve health services for rural communities," said Dr. Brand. "The challenge is figuring out what to do. The Task Force is the first key step in that direction."

There are 54 million Americans who live in rural areas. Health care can represent up to 20 percent of a community's employment and income. In some lower income communities, Federal support may account for as much as 50 percent of the income in the community. Medical care and a strong social services network are also important factors for employers who might consider moving to or expanding into rural communities.

The Federal Office of Rural Health Policy serves as a natural coordinating body for this activity. The Congress created ORHP in 1987 to act as a voice for rural within HHS. Since its inception, ORHP has worked to provide a rural perspective across HHS.

"The Task Force will reach across all 12 divisions in HHS and will work to assess how we can do a better job of expanding and improving the provision of health care and social services in rural America," Secretary Thompson said. "It's a high priority for this administration."



HHS Secretary, Tommy Thompson

"The Task Force will consider any and all ideas," Secretary Thompson said. "However, it is imperative as we begin this effort that we remember that rural Wisconsin is different than rural Maine, rural California, or rural Georgia. In health care, rural hospitals and their needs will differ, too, even as the underlying challenges remain the same. In social services, individuals and families need supportive services, adult and child-care services, and help securing child support without regard to where they live or the size of their community."

The initial work of the Task Force will be internal as the various operating divisions within HHS join together to begin a rural self-assessment. The idea is to identify current barriers to serving rural individuals and families. Each agency will be asked to find ways to strengthen existing programs and services.

Medicare in Rural America.

Medicare Payment Advisory Commission, June 2001, Draft

The long-awaited MedPAC rural report required by the Balanced Budget Refinement Act of 1999 assesses Medicare's payment systems and policies in rural health care markets. Its major findings include:

- Rural Medicare beneficiaries are not facing widespread serious problems.
- With few exceptions, beneficiaries' access to care, use of care, and satisfaction with care are similar in rural and urban areas.

• Still, a substantial gap has opened over the past decade in the financial performance under Medicare between rural and urban hospitals.

• The Medicare + Choice program is unlikely to bring coordinated care plans to rural areas.

Among its recommendations are:

- Implement a low-volume adjustment.
- Remove salaries and hours of professionals paid under Medicare Part B from the wage index.
- Raise the cap on disproportionate share payments.

These recommendations, MedPAC says, are targeted to take into account factors affecting rural hospitals' costs and allow Congress to get dollars where they are needed most.

Available at www.medpac.gov.

2001 Report to Congress on Telemedicine.

Office for the Advancement of Telehealth, Health Resources and Services Administration, Department of Health and Human Services. May 2001.

Mandated by the Healthcare Research and Quality Act of 1999, the report describes barriers to telemedicine, determines the extent of patient and physician satisfaction with telemedicine delivery, and assesses patient benefits from telemedicine services.

Key issues examined in the report include

- Lack of reimbursement for telehealth services;
- Legal issues surrounding service;
- Safety and standards in telehealth;

• Privacy, security and confidentiality in telehealth; and

• Telecommunications infrastructure.

Available at <http://telehealth.hrsa.gov/pubs.htm> or by calling (301) 443-0447.

Is the Rural Safety Net at Risk? Analysis of Charity Care Provided by Rural Hospitals in Five States.

Walsh Center for Rural Health Analysis, Project Hope. March 2001.

The report examines trends in charity care expenditures between 1996 and 1998 for 310 rural hospitals in five states with large rural populations—Iowa, Texas, Vermont, Washington, and West Virginia. Its objective: to improve the understanding of the relationship between charity care expenditures and hospital financial health by

- characterizing recent trends in the provision of charity care;
- identifying rural hospitals that are financially vulnerable and quantifying the amount of charity care they contribute; and

• exploring the potential impact on rural communities' access to charity care services if the worst case scenario was to occur and financially vulnerable hospitals were forced to close.

Available at www.projhope.org or by calling (301) 656-7401.

Congressional Briefing on Current Issues in Rural Health Policy.

RUPRI Center for Rural Health Policy Analysis April 19, 2001.

The briefing, cosponsored with the Senate Rural Health Caucus and the House Rural Health Care Coalition, presented the results of recent research on Medicare reform, Medicare + Choice, and prescription drugs. Additional issues discussed following the formal presentations included HIPPA, rural uninsured, and the Medicare wage index.

Available at <http://www.rupri.org/programs/health/present.html>.

Redesigning Medicare: Considerations for Rural Beneficiaries and Health Systems.

RUPRI Center for Rural Health Policy Analysis, May 2001

The report provides a framework to help shape proposals to redesign Medicare to the benefit of rural beneficiaries and providers. The chapters focus on considerations of equity, quality, choice, access, and cost. Each chapter outlines the current situation for rural beneficiaries, analyzes the implications of various approaches to changing the program, and makes recommendations for developing a Medicare program of greatest benefit to rural residents.

Available at www.rupri.org/.

Legislative Update

For the latest in legislation pertaining to rural health, see the Rural Information Center Health Service publication at <http://ruralhealth.hrsa.gov/legislate.htm>.

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