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F Mullan

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The Muscular Samaritan: The National Health Service Corps In The New Century

We should expand the NHSC to address medical disparities and imbalances in training the next generation of doctors.

by Fitzhugh Mullan

The passage of the Emergency Health Personnel Act of 1970 established the National Health Service Corps (NHSC) and initiated a creative experiment in the delivery of health services to underserved Americans. Amendments to the law passed in 1972 created the NHSC scholarship program, linking educational support to clinical service payback. Today the NHSC’s record includes more than 42,000 clinician years of service and 15,000 scholarships awarded to students in medicine and other health professions. The NHSC now uses loan repayment and collaborative programs with state governments in addition to scholarships to recruit nurse practitioners, physician assistants, nurse midwives, and dentists as well as physicians. The program has not been without its critics on subjects such as placement policy and retention. Yet it also has received scholarly and political support for its revitalization and continuation. Over its history the NHSC has served as a good Samaritan to underserved U.S. communities.

With reauthorization scheduled for the year 2000, now is an opportune moment to consider how the NHSC might change and develop in the next quarter-century. Affordable health care still remains beyond the reach of many Americans. An expanded NHSC with a variety of delivery programs could provide a great deal more care and diminish medical disparities in this country: It could be the “Muscular Samaritan” of the twenty-first century.

The Past And The Present

Since the 1960s a number of federal programs have addressed medi-
cal underservice: the Community Health Center (CHC) program, Medicaid, and Medicare funding for graduate medical education (GME). Although vital, these programs have never added up to a complete or coordinated solution.

In the large tapestry of American health care, the NHSC is a relatively small undertaking. Over the years 1,500–3,000 clinicians have been placed at any given time by the NHSC; about half have been physicians. Although extremely important to the communities in which they serve, they represent less than 0.5 percent of the half-million U.S. physicians in practice today. The CHC program began in 1965 as the War on Poverty’s Neighborhood Health Centers. Currently 723 centers receive some federal support and provide services to an estimated 8.6 million people annually. Since the late 1970s a significant percentage of CHC clinicians have been recruited through the NHSC. Medicaid has been the single most important source of health insurance for poor persons and families. Significantly, though, the working poor and persons unable to qualify for welfare generally have not been covered by Medicaid, and the number of uninsured workers has risen over the past decade.

An important and little-appreciated form of medical care for the underserved has come with Medicare’s subsidization of GME. Since 1983 hospitals have been paid for the direct and indirect costs of residents, resulting in a $7 billion annual payment to hospitals and substantial growth in the number of residents. Inner-city hospitals with large complements of residents have benefited greatly from Medicare GME payments, and many have relied heavily on residents. This would not have been possible without the addition of many thousands of international medical graduates (IMGs) to the residency workforce, since the number of U.S. graduates has been constant since about 1980. Today 25 percent of residency positions are filled by IMGs, and many less prestigious inner-city hospitals have residency staffs that are almost entirely composed of IMGs.

Without an enunciated or coordinated policy, Medicare GME funding has joined Medicaid, CHCs, and the NHSC in supporting care for the poor. This happenstance system, however, is plagued by a new problem. On leaving training, all U.S. medical school graduates and an estimated 80 percent of IMGs enter practice in the United States; as a result, the U.S. physician-to-population ratio has been climbing steadily since the 1960s. Combined with the growth of managed care, this has led many to believe that the nation is producing too many physicians. The Balanced Budget Act (BBA) of 1997 put caps on the number of residents for which Medicare will reimburse and scaled back Medicare’s indirect GME payments, signaling limits in federal GME support for the first time since the
program’s inception. This legislative action, as well as further proposals to cut residency positions, may cause problems for institutions that are most dependent on IMGs and that often serve the poor.

A related issue is the continued interest of American youth in medical education. There are now 2.5 applicants for every medical school position, and most of these applicants have the educational and personal characteristics to make excellent physicians. Many qualified American graduates are turned away from medical education. Despite this interest in general, minority students are vastly underrepresented in medicine, whose educational and financial demands present huge challenges to many students from minority or immigrant backgrounds. Yet the need for physicians with cultural competency and identity to work with these same populations is acute. The current system does little to address these problems.

Principles For The Future

With this as background, on what principles might the NHSC of the future be built?

- **Critical mass.** The nation needs a publicly funded, flexible clinical workforce large enough to assist in meeting the clinical needs of the underserved. Both the scholarship and loan-repayment mechanisms of the current NHSC are proven, valuable recruitment instruments that should remain part of any future program. The future NHSC should be large enough to serve in communities in need. Current federal estimates of need in the nation’s 2,778 health professional shortage areas (HPSAs) indicate that 5,587 primary care physicians would be needed to achieve basic levels of service. To begin to address these chronic staffing deficits, the size of the NHSC should be increased to 1 percent of America’s physicians (5,000–6,000).

- **Self-sufficiency.** The United States is a wealthy nation with a surfeit of qualified young people who want to study medicine and nursing. There is no reason that we should not be “self-sufficient” in clinical care. If it is estimated, for instance, that the country needs 20,000 new physicians each year to meet practice, teaching, and research needs, medical schools should be encouraged to produce that number of medical students. Continued reliance on foreign educational systems to train physicians for the United States limits opportunities for young Americans, draws important talent away from other nations’ medical systems, and creates a U.S. medical workforce whose cultural and linguistic skills are significantly mismatched with the U.S. population.

- **Cultural competency and parity of opportunity.** Medicine is
a cultural and linguistic vocation as well as a biological science. Public policies and public funding in support of medical education should promote opportunities for Americans to study medicine in such a way that the next generation of physicians reflects as much as possible the composition of the U.S. population as a whole. The application of this principle would create patterns of practice in which diverse populations could reasonably expect to find physicians with whom they could identify. Such strategies also would promote opportunities for American students in a way that would enable young people of all cultural and ethnic backgrounds to aspire to careers in medicine. The NHSC Scholarship Program has had an outstanding record of support for minority students. In 1997, for example, 36.6 percent of new scholarship recipients were from disadvantaged minority groups. An expanded program in the future should build from this record with increasing attention to new, diverse population groups.

Debt as opportunity. Medical student debt has risen rapidly in recent years to a current average of $80,000 at the time of graduation. This unhappy circumstance is a predictable by-product of the cost of medical education and limited public commitment to subsidize those costs. Indebtedness, however, creates an opportunity to link professional service commitment to educational subsidy—the basic operating premise of the current NHSC scholarship and loan-repayment programs. The opportunity to build programs around this strategy will only increase as the cost of education and the level of indebtedness among students continue to rise. Interest in service-payback opportunities will provide a strong recruitment tool for the future NHSC.

The Multiple-Option National Health Service Corps

Since the NHSC’s inception, communities’ demand for clinicians has greatly exceeded supply. Based on the original NHSC concept of delivering community-based primary care, the program has limited placements to primary care providers doing clinical work in community-based facilities. This policy has met certain needs for urban and rural primary care services but has fallen short of addressing the needs of many other underserved populations. A future, enlarged NHSC might be a “multiple-option” endeavor comprising a number of different programs designed to meet specific elements of the overall problem of underservice.

The community-based primary care option. An extension of the basic model of the current NHSC, this option would place clinicians trained in primary care in urban and rural community-sponsored sites throughout the country. The option would continue
to be a central program of support for primary care services in poor communities nationwide.

- **The urban hospital option.** This option would expand the basic NHSC model to include specialty physician placements along with primary care assignments in inner-city hospitals. Placements would be targeted particularly to safety-net institutions that, by choice or circumstance, were experiencing decreasing residency positions. Creating incentives, as this option would do, to encourage board-eligible or board-certified U.S. medical graduates to work in these hospitals would have the multiple benefits of improving the quality and efficiency of the services rendered; decreasing the need to import IMGs and, thus, the growth in the overall physician workforce; and developing self-sufficiency in U.S. medical education and practice. Additional funding might be made available to participating hospitals to assist them with the cost of making the transition from a resident-based program to an NHSC-supported staff physician model.

- **The public health option.** Public health agencies often find it difficult to recruit skilled physicians trained in primary care and preventive medicine. In the eyes of many, public health departments have not been seen as appealing career options, and public agencies can rarely match the salaries of clinicians in private practice. As the roles of primary care and public health move closer together and as managed care blurs the distinction between them, the need for excellent clinicians with an interest in administration and policy in health departments will grow. The NHSC could provide high-quality clinicians for state, local, and city public health departments, who would play important roles in prevention and primary care.

- **The prison health option.** For better or worse, the number of inmates in federal, state, and local prisons continues to grow, as does the need for health care in prisons. Over the years NHSC clinicians have occasionally been assigned to the Federal Bureau of Prisons to care for federal prisoners. The NHSC could provide a stable source of clinicians for prisons at all levels and, in the process, improve the quality of prison health services.

- **The international health service corps option.** U.S. clinicians’ involvement in international health has been modest over the years, and, with few exceptions, government programs have not directly sponsored clinical activities abroad. The idea has been discussed intermittently over the years, however, starting with a draft International Health Service Corps bill sponsored by Sen. Edward Kennedy and Sen. Jacob Javits in the mid-1970s. International health activities, of course, are different from domestic clinical assignments and quite variable from country to country. An international compo-
otent of the NHSC could function as follows: Clinicians would be chosen to participate following their NHSC domestic assignment, during which time they would have established their competencies and interests. International assignments for a limited number of NHSC “graduates” could be made through other agencies such as the Centers for Disease Control and Prevention (CDC), the U.S. Agency for International Development (U.S. AID), the Peace Corps, and private voluntary organizations. An international health service corps of this sort would be a prestige initiative for the NHSC, providing a professional ladder for clinicians interested in working in all aspects of underservice. It also would build valuable links between clinicians and programs working here and abroad.

The Money

Expansions as envisioned under the multiple-option NHSC would necessitate an increased budget for both educational costs (scholarship and loan repayment) and support expenses (clinicians in practice). The most straightforward, traditional form of financing for an expanded NHSC would be direct federal appropriation—the way the NHSC has been supported to date.

A less orthodox approach to funding would be the use of Medicare GME funds. Reductions in Medicare GME funding could be invested in the NHSC’s education and service costs. This mechanism, in fact, could fund the urban hospital option in an expanded NHSC. Under this scenario clinicians would be assigned to some of the same institutions in which GME dollars were being reduced.

The great appeal of this funding strategy is that it is budget-neutral. Its costs would be supported by redirected Medicare GME dollars and not require increased direct appropriations. The problems with this strategy are both political and legislative—political in that teaching hospitals generally oppose any cuts in GME funds, and legislative in that it would represent a new way of spending Medicare money. Although Medicare has long paid teaching hospitals for education and services, there is no precedent for Medicare to pay another federal program to carry out similar functions. These are major obstacles, but the workforce rationale behind this option is strong, and it could provide an important source of future support for an expanded NHSC.

A third mechanism might be to create a “Samaritan tax” on health insurance premiums. Taxes are unpopular in legislative circles, but a Samaritan tax that supported doctors for the poor might appeal to Congress and the public in ways that other taxes do not. Roughly $688 billion of the $1 trillion that Americans spend yearly on health goes toward private or public health insurance payments. A 0.1
percent tax placed on those premiums (one-tenth of a cent per
dollar) would generate $688 million per year, or approximately six
times the current NHSC budget.

A mix of these funding strategies could be employed, and other
funding mechanisms involving state and local governments also are
possible. The monetary resources necessary to finance an aug-
mented NHSC are available if the political will and legislative lead-
ership can be mustered.

How To Proceed?
The muscular Samaritan—an expanded, multiple-option NHSC
that increases opportunities for financing the education of young
people in the health sciences and facilitates the practice of clinicians
in medically underserved communities—is within our reach. The
enactment, funding, and success of an expanded NHSC, however,
would require an alliance of supportive organizations. A partnership
among representatives of community-based organizations, aca-
demic organizations, health sciences students, and organized medi-
cine would be new and potentially powerful.

The original NHSC concept appealed to Congress at a time when
federal budgets were in a growth mode. The NHSC has endured
through many years of difficult budgets and now faces reauthoriza-
tion at a time when the federal deficit is being reduced and increased
funding for federal discretionary programs is once again available.
Although the politics of expansion are always difficult, the moment
is promising to start a campaign to enact the Muscular Samaritan

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NOTES
2. Data supplied by the National Health Service Corps program office.
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Accounting Office, Foreign Physicians Exchange Visitor Program Becoming Major
Route to Practicing in U.S. Underserved Areas, Pub. no. GAO/HEHS-97-26 (Wash-


6. Data supplied by the NHSC program office.


11. *Balanced Budget Act of 1997* (P.L. 105-33), Sec. 1421b and Sec. 1423.


13. AAMC Data Book, Table B1.


15. U.S. medical schools now produce approximately 17,000 students each year. Some 8,000 IMGs then join this group in residency training, an estimated 80 percent of whom will remain in the United States for their careers.

16. Data supplied by the NHSC program office.

17. AAMC Data Book, Table E4.


19. Ibid.