HOD ACTION: Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-08

Subject: Effectiveness of Strategies to Promote Physician Practice in Underserved Areas

Presented by: Claudette E. Dalton, Chair

Referred to: Reference Committee K
(Lynne M. Kirk, MD, Chair)

Council on Medical Education Report 4-A-07, "Incentive Programs to Improve Access to Care in Underserved Areas," recommended that our American Medical Association (AMA):

> Collaborate with state and medical specialty societies to collect and disseminate information on the efficacy of various types of incentive and other programs designed to promote recruitment and retention of physicians in underserved areas.
>
> Advocate to the federal government, the states, and the private sector for enhanced support for successful models (Policy D-200.984, AMA Policy Database).

Council on Medical Education Report 7-A-08, "Diversity in the Physician Workforce and Access to Care," Recommendation #4, recommended that our AMA continue to study the factors that support and those that act against the choice to practice in an underserved area (Policy H-200.982).

Both reports directed that an update be presented to the House of Delegates at the 2008 Interim Meeting. This report will describe the current status of successful initiatives to increase physician supply in underserved areas and will summarize advocacy and other efforts by the AMA aimed at increasing support for these initiatives.

In considering strategies to enhance the availability of care to the underserved, physician supply is a confounding factor. A 2008 report, *Building a Primary Care Workforce for the 21st Century*,[1] cites a shortage in the primary care workforce as a barrier to staffing clinical sites funded through the federal Community Health Centers Program. Community Health Centers are a valuable resource in providing care to underserved and vulnerable populations in both rural and urban areas. The specific issue of a primary care workforce shortage is addressed in a companion report (Council on Medical Education Report 3-I-08, "Barriers to Primary Care as a Medical Career Choice").

BACKGROUND

Council on Medical Education Report 4-A-07 described strategies that are being used to attract physicians to practice in underserved areas and with underserved populations. There is evidence that the following strategies have resulted in positive outcomes related to practice in underserved areas or have the strong potential to do so. In general, these strategies can be grouped into the following categories.

Tax Credits and Practice Support Programs

A number of states have adopted legislation that provides tax credits for physicians practicing in rural underserved areas. At least six states offer such incentives.[2] Other types of financial assistance programs are available to assist physicians with their practice expenses. For example, New Jersey offers a low-interest loan program to construct or renovate physician office space in areas designated by the state as Health Enterprise Zones.[2]

Admissions and Educational Opportunities in Underserved Areas

These strategies include such things as:

- admissions of students from underserved areas;
- educational tracks and branch campuses in rural and other underserved areas;
- the development of educational programs at the medical school and residency level supported by funding from Title VII of the Health Professions Education Assistance Act; and
- the Area Health Education Centers (AHEC) program, which provides training opportunities in underserved areas.

Scholarship and Loan Repayment Programs

Federal and state scholarship and loan repayment programs, as well as some programs in the private sector, provide funding directly to individuals in return for a commitment to serve in underserved areas or with underserved populations.

J-1 Visa Waiver Programs

In the J-1 visa waiver model, international medical graduates who enter the United States on the J-1 (Exchange Visitor) visa can waive the requirement that they return home for two years if they agree to practice in an underserved area. The largest J-1 visa waiver program is the Conrad State 30, which is run through state Departments of Health. In this program, each state is allotted 30 J-1 visa waiver positions.

CURRENT STATUS OF STRATEGIES TO ENHANCE PRACTICE IN UNDERSERVED AREAS

There has been recent activity related to each of these areas. The following sections summarize the status of each area, present relevant AMA policy, and describe recent actions by the AMA in support of positive change.

Tax Credits

AMA policy supports the use of tax credits as incentives for practice in an underserved area. Policy H-200.998, "Tax Credit to Disadvantaged Area Medical Practices," states that our AMA "actively supports national and state legislation which would grant income tax credits to medical practices established in disadvantaged communities and in areas of critical physician need."

Since late 2007, additional states have adopted legislation providing tax credits to physicians practicing in medically underserved areas. States where such legislation recently has gone into effect include New Mexico, which awards a credit of $5,000.[3]

Admissions and Educational Opportunities in Underserved Areas

Medical students from rural and other underserved areas are more likely to return to such areas to practice than students from other locations.[7,20] Data from the 2001-2002 Annual Medical School Questionnaire, which was sent to the deans of all Liaison Committee on Medical Education (LCME)-accredited medical schools indicated that 27% of schools (34 of 125) gave admission preference to applicants from rural areas. There are no more recent national data on medical school admission policies and preferences that might result in graduates choosing to practice in an underserved area.

Educational opportunities include programs that provide medical students and resident physicians with clinical experiences in rural and underserved areas, as well as faculty development programs to support the planning and implementation of such experiences. These could include such things as longitudinal rural tracks or placements during medical school or residency training or short-term required or elective courses. These types of educational experiences have been facilitated by the federal- and state-funded programs described below.

Title VII

Programs funded under Title VII of the Health Professions Education Assistance Act have, in the past, resulted in increased production of primary care physicians who practice in underserved areas.[4-6] Funding has recently been in jeopardy, with significant cuts being proposed in every federal budget cycle.[4] The 18th report of the Federal Council on Graduate Medical Education (COGME), titled *New Paradigms for Physician Training for Improving Access to Health Care*, recommended that "reinvigoration" of funding of programs through Title VII should be given "serious consideration." It has been recommended that funding for Title VII programs that support this training of primary care physicians, who practice in underserved areas, be restored to at least FY 2005 levels of $88.8 million.[4] Alternatively other forms of financial support to achieve the same ends will be needed.[7]

AMA policy supports funding for Title VII (Policy H-200.956), and a recent directive (D-305.972) states that the AMA will partner with relevant stakeholders to petition Congress to reinstate full Title VII funding to at least FY 2005 levels ($300 million). In June of 2008, the AMA sent letters to the House and Senate Appropriations Committees expressing concern with the proposed cuts to Title VII funding and asking that funding be restored.

Area Health Education Center (AHEC) Programs

AHECs are academic and community partnerships for training in sites and programs responsive to state and local needs. The goal of AHEC is to enhance the supply, distribution, diversity, and quality of the health care workforce.[8] The Basic AHEC Program was initiated in FY 1972.[9] The Model State Supported AHEC Program was initiated in FY 1993. Funding comes from federal cooperative agreements/grants and matching state and local funds.[8] AHECs have been involved in both decentralized residency training[9-10] and in clerkship training for medical students.[10] As of October 2007, there were 53 AHEC programs and 221 affiliated AHEC Centers in 45 states and the District of Columbia.[8]

AMA Policy supports continued federal and state legislative support for AHEC funding (Policy H-465.988). Federal support for AHEC is funded through Title VII, which leaves the program vulnerable to the regularly proposed federal budget cuts. The AMA is a member of the National AHEC Organization.

Scholarship and Loan Repayment Programs

Scholarship and loan repayment programs are funded from the federal government, state and municipal governments, and from the private sector. Evidence for the success of these programs comes mainly from data about federal and state programs.

National Health Service Corps

The National Health Service Corps (NHSC) programs include scholarship and loan repayment options. The scholarship program is directed at current students who agree to serve one year in an approved practice site for every year of scholarship support. The loan repayment program is directed at clinicians who practice in needy communities. Need is determined based on the communities' health professions shortage area (HPSA) designation score.[11]

Currently, NHSC positions are generally filled. In FY 2005, there were 340 scholarship recipients. Also in that year, about 1200 physicians in the loan repayment program entered HPSAs.[7] Data on the impact of the NHSC indicates that the NHSC physicians are more likely to continue to practice in community health centers and to locate in physician shortage areas.[12] There also is evidence that the presence of NHSC physicians contributes positively to attracting non-NHSC primary care physicians to a region.[13]

AMA policy supports legislative funding for the NHSC (Policies H-200.983, H-200.984). In June 2008, the AMA sent letters to the House and Senate Appropriations Committees expressing concern that cuts in funding to the Health Professions programs (Title VII) and to the NHSC would harm investments in the nation's health care workforce. On July 21, 2008, the Senate approved S. 901 (the Health Care Safety Net), which included funding for the Community Health Center program, rural health programs, and the NHSC. The legislation reauthorized the NHSC through 2012, with funding increases each year. Parallel legislation in the House does not address funding for the NHSC.

State and Other Loan Repayment Programs

A database from the Association of American Medical Colleges lists 43 states with loan repayment and/or scholarship programs for physicians.[14] There also are programs available from private payers. For example, the University of Chicago provides up to four years of loan repayment support for its graduates who agree to practice in a Federally Qualified Health Center or a community hospital on the south side of Chicago.[15] A novel proposal was presented in the 18th report of COGME,[7] which called for the creation of a United States Public Health Medical College. The school would be a federally funded institution created to produce physicians to work in underserved areas. Tuition would be waived in exchange for a commitment to such service.

State loan repayment programs have been successful in initial recruitment of physicians to practice in underserved areas, as well as in physician retention.[16-18] There is AMA policy in support of scholarship and loan repayment programs at the state and private sector levels, as well as at the national level (Policies H-200.973, H-200.978, H-465.988).

J-1 Visa Waiver Program

The Conrad State 30 program is due for reauthorization in 2008. Legislation introduced in the Senate (S. 2672) would permanently reauthorize the program, and includes provisions that would allow expansion of the current cap of 30 positions per state per year and would exempt physicians who have completed their service from immigration caps. The AMA has sent a strong letter of support to Senators Conrad and Brownback, the sponsors of the legislation. Legislation introduced in the House of Representatives would reauthorize the program for five years, without expansion of positions.

SUMMARY AND RECOMMENDATIONS

Many medical students have an intention to practice in an underserved area or with underserved populations. Over the past five years, 20-25% of respondents to an Association of American Medical Colleges survey of graduating medical students indicated that they planned to locate their practices in an underserved area.[19] This enthusiasm needs to be maintained as the students continue through training and enter practice.

There are a number of strategies that have been shown to be effective in encouraging physicians to practice in underserved areas. Support for these strategies is reflected in AMA policy and in recent AMA advocacy activity. However, some successful programs are in jeopardy due to uncertainties related to funding. Therefore, the Council on Medical Education recommends that the following be adopted and that the remainder of this report be filed.

1. That our American Medical Association, in collaboration with relevant medical specialty societies, continue to advocate for the following:
   (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations.
   (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program.
   (c) Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas. (Directive to Take Action)

2. That our AMA, through its Initiative to Transform Medical Education, study and report back to the House of Delegates at the 2010 Annual Meeting on:
   (a) medical school admissions policies designed to attract medical students who will practice in underserved areas or with underserved populations; and
   (b) the availability of educational opportunities for medical students and residents in rural and urban underserved areas. (Directive to Take Action)
   (c) the efficacy of community-based initiatives such as the Area Health Education Center Programs and their impact on supply of physicians to the area.

3. That our AMA encourage medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations. (Directive to Take Action)

4. That our AMA advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas. (Directive to Take Action)
5. That AMA Policies H-200.973, H-200.978, H-465.988 be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: $2000 for staff time to conduct research and for advocacy activities.

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