The National Health Service Corps

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THE MOST FREQUENTLY ASKED QUESTION about the National Health Service Corps (NHSC) is, "What's it like?" This question comes from health professionals considering going to work for the NHSC, scholarship recipients and applicants who are committing themselves to the program, and from deans, advisors, and financial aid officers who are counseling young health professionals in their career choices. The question also comes from the community — community representatives, local professionals, health planners, and politicians. For all of these people and the many others who are interested in the true character of the National Health Service Corps, we have decided to prepare a document to answer their questions.

The problem, of course, is that there is no single answer to the question, "What's it like?" The Corps expresses itself in about as many ways as there are communities where its members work. It is not a single experience. It is not a grant program in the traditional sense. It is certainly not a Sears and Roebuck of health, as many people think. Every placement, every health delivery site is a complex and sensitive social entity, and the style and personality of each one is determined by a mix of the community and its input, the health professionals and their commitment. Every variable of American life affects National Health Service Corps sites — geography, race, culture, economics, and patterns of employment. There are urban Corps sites whose physicians care for families largely supported by welfare checks.

There are rural NHSC sites where the staff minister to the medical needs of well-to-do farm families. Corps professionals working in various parts of the country serve communities that are predominantly Puerto Rican, American Indian, Alaskan Native, Chicano, Black, Oriental, and White. We staff clinics in New York's Chinatown, the Samoan community of Seattle, and the Hasidic Jewish Community in Brooklyn. Currently, we have a request for Portuguese-speaking physicians to work in Boston. Corps professionals staff prison dispensaries, community mental health centers, black lung clinics, and State health programs.

In sum, we decided that no single Corps site or even a

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composite, fictional clinic would do justice to the National Health Service Corps. In truth, the Corps is a mosaic, a multiplicity of efforts by communities and federally supported professionals to provide care where none had existed before. The goals of the sites vary and their success is, predictably, variable. In the main, however, the National Health Service Corps has provided healing where none was available.

So we concluded that the best profile of the NHSC was not a single essay but an anthology of profiles that would give readers a sampling of the spectrum. Six sites were chosen to display the variety of placements in which the Corps is active. The seventh site adds the Indian Health Service (IHS) piece to the mosaic. The IHS is included in this anthology because of its unique place in community medicine and because many NHSC scholarship recipients elect to provide clinical services through the IHS. We selected seven professional journalists to visit these sites, conduct their own interviews, and report their own stories. We urged them to be candid in their essays so that readers might have as balanced a picture as possible.

It is our hope, then, that these seven articles will bring the NHSC and the IHS to life and that, like a true mosaic, the whole will be more than the sum of the parts. Our first purpose is, as I have said, to provide a complete picture of the NHSC for all interested people. Beyond that, we also hope that this anthology will be informative for students of the state of community medicine in the United States — not only future members of the Indian Health Service and the National Health Service Corps but for all health professionals and health professions students who are interested in the basic questions of primary care delivery to all of our citizens. We would hope that these essays will be used in courses on community medicine, social medicine, and public health over the next few years. If they do not answer all of the questions in the critical arena of primary care delivery they, at the least, focus those questions in a manner that invites further discussion and investigation.

Principles of Community Practice

The chief purpose of the National Health Service Corps is to provide primary health care services in communities, areas, and institutions that are currently underserved. This mission has resulted in a range of clinical

experiences; subsequent essays describe some of them. On the whole, the National Health Service Corps could be described as a grassroots community medicine effort. There is more to community medicine, however, than the provision of clinical services. In varied ways, in numerous communities, a number of principles concerning the practice of community medicine have begun to emerge. None of these principles are axioms, and not all of them are present at all NHSC sites. Nonetheless, they represent concepts that promote optimal development of community health, and they should be considered by all practitioners planning to work in underserved areas. Elements of all these principles may be seen in the site profiles in this book. The principles are as follows:

1. Community governance. According to the legislation establishing the Corps, some community group, committee, council, or tribe must request assistance in the provision of medical services. To some extent this group will remain involved in the management of the practice and will, by dint of its personality, influence the clinical setting. There are many possible relationships between the community board and the professional, but in all cases they represent a factor, not present in private practice, that must be taken into account. The better the understanding and the relationship between the community and the practitioner, the better the practice, in general. The NHSC mandates all of its practitioners to develop a written Principles of Practice with the community board which serves as a contract between them. In many settings, an active, supportive community board is essential for the practice to thrive. Board members serve as spokesmen, publicists, and legitimizers. It would be hard to conceive of the Indian Health Service, for instance, functioning on most reservations without tribal support. In most settings, the board is critical to both the success and the longevity of the clinical project.

Community governance, in sum, is not a political slogan but a functional element of a community medical practice. Practitioners working in the community setting must understand the concept and weave it into their clinical activities in order to establish a successful practice.

2. Cultural relevance. Many community medical practices exist in areas where the population is preponderantly a racial, linguistic, or ethnic minority. This situation presents the practitioner with special challenges. For the practice to be maximally effective, the services provided must be perceived as relevant by the community itself. The language, culture, medical habits, trade areas, and the population's traditional expectations of physicians must be taken into account when developing the practice. This is not to say that a community

health practitioner should not challenge certain inappropriate or harmful customs — antibiotics for colds, for example — but he/she must realize that those beliefs exist and approach a campaign of re-education with a clear understanding of local habits. Where appropriate, elements of Indian, Chicano, Puerto Rican, Alaskan Native, Black, and other cultures should be incorporated into the clinical enterprise. These elements may well improve the credibility and utilization of the health service as well as its efficacy.

3. Outreach. An efficient community medicine enterprise that is intended to improve the health of an entire community along some predefined lines will never succeed if it does not reach out to the people. A private physician can open a practice and succeed by simply seeing enough patients to pay the bills, but the challenge of community medicine is tougher. Health education, health awareness, home visits, neighborhood clinics, transportation, and so forth are all important concerns of the staff of a community clinic. Activities that visibly demonstrate that health is not confined to the clinic or office do a great deal to stimulate community health awareness. These might include screening projects run in schools or homes, street corner or neighborhood clinics to promote utilization of the agency's services, campaigns against a given disease or condition, and so forth. If geography and economic circumstance make travel to the clinic too difficult, the clinic should provide some means of transportation. Different from the private

physician, the community clinic must be heavily involved in the propaganda of health.

4. The transfer of knowledge and skills. Whereas the private physician discharges his duty by the diagnosis and treatment of illness, the community clinic should be responsible for changing and upgrading the capabilities of the people of the community. Employment at many community clinics stands out as a tangible benefit to the community. The residents who are trained as outreach workers, nurses aides, and receptionists rank as significant new community resources in themselves. They represent an increased reservoir of knowledge and experience in the community as well as being symbols of local pride and increasing self-reliance. The same may be said for anyone who goes on for further training — community nurses who become nurse practitioners or local youths who can be influenced and supported in choosing careers in the health sciences. The highly trained physician, dentist, or other health worker who chooses to work in the delivery of community medicine should see his or her role as expanded beyond that of the traditional health care provider. Time is well spent if it is used in part for the training and development of the clinic staff as well as for the launching of health educational programs for the community. The physician working in the community setting is not only responsible for the practice of technology but also for the enlightened transfer of that technology to the community to the maximum extent possible.

5. Commitment. Without a considerable commitment by the practitioner of community medicine, none of the previous principles will come to life. The provider working in this setting who has limited or simple self-concept will not suffice. If one sees oneself as a highly trained technician ready to "deliver" medical care, then a community clinic is not a good place to be. All of the principles just stated will detract to some degree from the time spent and the efficiency of the pure practice of medicine. Community governance does not always guarantee streamlined management. Cultural relevance may demand the inclusion of people or principles that detract from efficient office operations. Outreach activities will take time from direct patient care. The transfer of knowledge and skills often invites a rudimentary didactism which is neither selected for nor enforced in health science schools. All in all, none of these principles will have much meaning unless the practitioner is patient, dedicated, and aware of the mission — in a word, committed to the practice of community medicine.

The practice of community medicine in accordance with these five principles is complex. Standing behind all of them, of course, are the standard precepts of the practice of clinical health care. These principles do not necessarily make that practice easier. The five principles added to the practice of medicine, however, create an enterprise that promises to do much more for community development than merely supplying a laying-on of hands. Many of the activities that further the principles can be carried out by persons other than the physician. Most of them, in fact, are for reasons of time, language, and culture best carried out by people other than the physician. But it is unavoidable that trained clinicians (physician or otherwise) will be at the heart of any clinical enterprise. If they are aware of these principles and work actively to promote and coordinate them, the clinic will be far more effective than if the clinicians are unaware of or opposed to the community efforts. The success of a good community clinic rests on much more than the personality or commitment of the professional. Yet without aware, flexible, and committed clinicians, even the most motivated community will have trouble making its clinic function as an effective vehicle for community development.

History of the NHSC

During the 1960s, national attention became focused on the unavailability of health care in a significant number of rural and urban areas in the United States. As a result, the Emergency Health Personnel Act (Public Law 91-623) was enacted in 1970, establishing the NHSC to alleviate the problem by providing health care in critical health manpower shortage areas. The NHSC was designed as a partnership between the community and the Government, with the community supplying the support personnel and the facility while the NHSC supplied the medical and dental personnel. Fees collected for the provider's services were used to pay the operating expenses of the practice and to provide some degree of reimbursement to the U.S. Treasury for the cost of the NHSC providers.

The NHSC became operational in 1972 when 16 communities received 20 providers from the Corps in January. This initial group was joined by 162 additional providers during the summer of 1972. Table 1 shows that the NHSC grew slowly in subsequent years, a consequence of modest Public Health Service salaries and difficult practices in shortage areas. Most NHSC placements were rural and small in size, emphasizing private practice models and the possibility of converting the NHSC practice to a private practice.

Understanding the difficulties of recruiting physicians, dentists, and other health care personnel, Congress established the National Health Service Corps and Public Health Service Scholarship Program (Public Law

Table 1. Growth of the National Health Service Corps

Date	Providers	Sites
January 1972	20	16
July 1972	182	94
July 1973	330	183
July 1974	405	193
July 1975	495	248
July 1976	600	331
July 1977	690	398
July 1978	1,283	668
July 1979	1,725	800

92-585, passed in 1972) which authorized the payment of tuition and a monthly stipend to health professions students. Students choosing the scholarship agreed to a commitment of 1 year of clinical service with the Public Health Service for each year of scholarship support with a required minimum commitment of 2 years. The first scholarship awards were made during the 1973-74 school year, and the first graduates of the Scholarship Program joined the NHSC in 1976.

On October 12, 1976, Congress passed the Health Professions Educational Assistance Act of 1976 (Public Law 94-484), an act which reestablished and augmented the Scholarship Program and enlarged the potential scope of NHSC placement by broadening the methodology for designating health manpower shortage areas. Hence the NHSC has increasingly emphasized development of integrated systems for the provision of services, placing health care professionals in small to moderate-sized group practices, many of which are recipients of Federal health grant support. This strategy maximizes cross coverage by colleagues, quality of care, and retention of providers. During 1979, 68 percent of the new health professionals placed by the NHSC went to communities that were the recipients of Federal grant monies. The Corps is also taking a more active role in urban health care delivery. At the present time, 22 percent of the NHSC placements are in urban sites — a significant change from the 5 percent urban placements 2 years ago. Corps projections call for 40 percent of the placements to be in urban areas by the mid 1980s.

The Scholarship Program is reaching maturity. In 1978, the National Health Service Corps placed 458 graduates of the program. In 1979, that number will rise to 640 and in 1980 to 1,040. A carefully coordinated recruitment program placed an additional 283 physicians, who have no scholarship obligation, in NHSC sites during 1978 for a total field strength as of March 1979, of 1,504. The result of the growth of the Scholarship Program, as well as the success of the volunteer recruitment program, has resulted in a rapid growth phase for the National Health Service Corps. The current field strength is double that of the fall of 1977, and projections call for 2,820 NHSC professionals by the fall of 1980, a threefold growth in a period of 3 years.

NHSC professionals come from a variety of health science disciplines, depending on the community needs in approved sites. Table 2 shows the present distribution of NHSC field staff. A total of 53.1 percent of the NHSC physicians are board certified or board eligible. Their distribution according to postgraduate training is shown in table 3.

In Sum

To complete this picture of the National Health Service Corps, we have included both a chronology of its development (inside front cover) and an annotated bibliography of materials written about the Corps and by members of the Corps. We hope that, along with the profiles, the maps, and the foregoing discussion of the background of the NHSC, this publication will be helpful and stimulating to everyone interested in seeing that all Americans have ready access to primary health care.

I would like to add a special word of thanks to Paul Dickson for his counsel in designing the project and to Carron Maxwell of the Physicians National House Staff Association for her assistance in all phases of this project.

Table 2. Professional composition of the National Health Service Corps, March 1979

Profession	Number	Percent of total
Doctor of medicine	701	46.6
Doctor of osteopathy	54	3.6
Doctor of dental surgery	242	16.1
Nurse practitioner	205	13.6
Physician assistant	106	7.0
Social worker	47	3.1
Other	149	10.0
Total	1,504	100.0

Table 3. Specialties of National Health Service Corps physicians

Specialty	Number	Percent of total
Family practice	183	24.3
Internal medicine	118	15.6
Pediatrics	116	15.4
Psychiatry	13	1.7
Obstetrics and gynecology	12	1.6
Other	41	5.4
General medical officer (internship trained)	272	36.0
Total	755	100.0