UNIVERSITY OF CHICAGO FALL 2007 BIOLOGICAL SCIENCES DIVISION

Medicine
ON THE MIDWAY

What makes us human?

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by John Schumann, MD

PLUCK THE LOW-HANGING FRUIT

The time for national health service has come.

Not the U.K. model, in which the government employs physicians and finances are controlled by law.

No, I mean *national service* in health care—provided by our young physicians and trainees. The time is ripe for such a program, and it would go a long way toward alleviating some of the inequities we face in health care access and delivery in the United States.

The current National Health Service Corps (NHSC), founded in 1972 and administered by the Health Resources and Services Administration, is a mere shadow of the service program our nation needs. It has a minuscule impact on the distribution of health care. It could achieve so much more.

At present, students who apply to the NHSC scholarship program must demonstrate commitment to a career practicing primary care in a medically underserved area. For each year of schooling paid for by the program, these students commit an equal amount of time in service payback. NHSC also offers a loan repayment program, incentivizing clinicians with educational loans to work in underserved areas.

Upon completion of residency, an NHSC scholarship recipient must find a job from a limited list of employers based on a "hardship score." The score is determined by the ratio of health care providers to population and income. Not unexpectedly, most of the jobs posted are in medically underserved places: rural areas, poor urban neighborhoods and American Indian reservations.

The NHSC is restrictive in its policies. During their payback, scholars must work full time; there is no part-time option allowing them to repay the scholarship over a longer period. Bureaucracy makes changing jobs from one hardship site to another unnecessarily difficult. And the job requirements can be onerous: NHSC clinicians see patients a minimum of 32 hours per week (though individual health centers often require more). This leaves little time for follow up on nearly a hundred patient encounters per week. With so much pure clinical work, NHSC clinicians feel less invested in administrative aspects or quality improvement initiatives in the clinics they work in. Not surprisingly, many NHSC scholarship recipients leave their jobs once their debt is repaid, often feeling exploited or burned out—or both.

In addition to its archaic rules, the NHSC suffers from organizational dysfunction. It is both understaffed and critically underfunded. Because of these limitations, the NHSC turns away qualified applicants each year, putting more of strain on the nation's skeletal primary care system for the underserved. This comes during a decade-long decline in the number of medical school graduates choosing to enter primary care fields (pediatrics, internal medicine and family medicine). Facing heavy medical school educational debt, most of our graduates now seek careers in the more highly remunerated subspecialties.

With our population aging and national health care spending consistently rising at more than twice the overall inflation rate, we need a revamped and revitalized NHSC. Funding the NHSC to an appropriate level, or even expanding it, is a political no-brainer. Who could say no to a stronger national primary care infrastructure? Add a few family-friendly policy changes, and voila—motivation to enter and stay in a primary care field is renewed amongst our best and brightest. Are you listening Sens. Obama and Clinton? Sen. McCain and Mr. Giuliani?

> A broad-ranging national service requirement would be slightly more difficult fruit to cultivate, but the harvest would be well worth it.

The winds of change in politics, business and economics are converging to create a perfect storm of opportunity for such revitalization. (Perhaps the winds of culture, too, as Michael Moore's recent film "Sicko" illustrates.) The 2008 presidential race is taking shape at an unprecedented pace—earlier than ever, with seemingly more at stake. Although our nation is at war and we face dire predictions about global warming, health care reform has returned to the center of debate, at a level not seen since President Clinton's ambitious Health Security Plan went down to defeat at the hands of vested interests, most notably the Health Insurance Association of America. (Remember the famed Harry and Louise ads?)

For the first time, the business community is a genuine part of the debate on health care costs and access. The Starbucks franchise spends more on health care for its employees than it does on coffee. Retail giant Wal-Mart has been castigated in the press for its inability (or unwillingness) to provide affordable coverage for its one million hourly employees. And automakers, facing a huge burden of health care for their retirees, literally cannot compete with foreign companies when more than $1,500 of the sticker price of every vehicle made in America goes toward the health care costs of carmakers' employees.

Schumann donates part of his time at an on-site clinic for the tenants of Maria's Shelter—a temporary housing program for homeless women with or without children.
Photo by Dan Dry

Year after year medical costs rise at double or triple the rate of overall inflation. National health care expenditures in 2005, the latest year for which figures are available, were more than $2 *trillion*. This amounts to $6,200 per year for every person in the United States—more than double what the next-most-affluent nation spends. Health care in 2006 was 16 percent of the GDP, the highest ever, and the government projects it will exceed 20 percent by 2010.

In spite of this extraordinary expenditure, one sixth of our citizens have no means of regular access to care.

As a faculty physician, I interact with many of our students as they enter medical school. Our students are among the brightest and most idealistic found at any great school. Yet the pressure of mounting debt drives many of them away from choosing careers in primary care, where their services will be most needed in the decades to come.

In four years of medical school, students continually are challenged to find outlets for their creativity, idealism and desire to contribute meaningfully to society. Sadly, the educational process often dampens their enthusiasm by devaluing their desire to volunteer their time for social-action projects. With so much biomedical knowledge to master, students are given the message that while idealism is important on their application, it's not what matters in the workaday world of academic medicine.

I propose an expansion of the NHSC concept to include all medical trainees. For a period of two years after residency or fellowship, all graduates, in all specialties, would work in a medically underserved area. This would have two dramatic effects: First, it would bring recently minted physicians to areas truly in need of their services. Bringing all graduates, not just those in primary care, would help solve the shortage of specialists that underserved areas face even when they obtain primary care through the NHSC. Secondly, it would foster a commitment to health care for the underserved amongst all of our graduates and trainees—and renew the ideals with which they entered medical school.

This isn't true merely of medicine. The concept of national service could be extended to include other professions as well. If all young Americans were required to fulfill two years of national service, whether in the armed forces or in civilian jobs, we could institutionalize the idea of diversity and meritocracy. A broad-ranging national service requirement would be slightly more difficult fruit to cultivate, but the harvest would be well worth it.

In health care, the framework is already in place. All we need is to reform and expand the NHSC. A national service commitment would remedy much of what ails our country and our medical education system. It would refocus priority on the importance of preventive care and health care delivery in the areas of greatest need in our country. It would help in the effort to reduce health care disparities. Most of all, it would develop in our talented trainees a commitment to service that would last a lifetime.

John Schumann is an assistant professor of medicine at the University of Chicago. He is interested in the use and interpretation of clinical guidelines in physician practice, and is involved in issues related to health and human rights. Schumann is a volunteer for the Physicians for Human Rights Asylum Network and Maria's Shelter, and teaches health and human rights in the medical school.