

Health Care Workforce Distribution and Shortage Issues in Rural America

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National Rural Health Association

The rural population of the U.S. is about 20 percent, or 61 million people. In 1999, less than 9 percent of physicians practiced in nonmetropolitan counties.¹ In recent years, shortages of non-physician providers including nurses, dentists, pharmacists, radiology and laboratory technicians, and mental health professionals have also become more apparent. Problems with the distribution of physicians and other health professionals, as well as recruitment and retention issues in general are an ongoing problem for rural areas that compete with urban areas to maintain an adequate workforce. The National Rural Health Association (NRHA) believes that it is essential for rural areas to have an adequate and able workforce to deliver needed health care services.

The health care labor shortage in the United States has been widely documented and is expected to last through 2050. Almost half of the health care workforce will be 45 years old or older by 2008.² By 2010, 40% of all registered nurses will be 50 years old or older,³ and the US will need 1.7 million nurses but only 635,000 will be available.

One of the most prevalent obstacles rural Americans face in accessing timely and appropriate primary health care services is the maldistribution and shortage of health professionals to provide needed services.⁴ Workforce shortages are especially serious in remote frontier communities, many of which are located in the Western region of the United States.

Recruitment and retention of healthcare professionals is both challenging and expensive. By 2006, healthcare is projected to increase by 3 million jobs but staff shortages will continue. National employment turnover rates are at 15.1%, but healthcare turnover far exceeds this at 20.4%.⁵ The cost of replacing a critical care RN averages \$64,000 while the cost to replace an RN on a medical surgical unit will average \$42,000, including recruitment, orientation, and non-productive time.

Workforce policy is indivisible from federal Medicare and Medicaid payment policies. For example, the Medicare Prospective Payment System (PPS) has a complex formula to determine the payment amount for providing a particular service to a Medicare beneficiary. In brief, about three-quarters of that payment is increased or decreased by applying a "hospital wage index". For most rural PPS hospitals, their area wage index substantially reduces payments for over half of the services provided. Medicare has a huge impact on the economic condition of rural health care providers, which in turn effects the ability of rural communities to attract and retain staff.

The NRHA previously advocated several changes needed in the use of the wage index to determine hospital payments:

- Change the hospital wage index to reflect only legitimate differences in area wage rates, not average per employee expenditures that are biased toward urban areas.⁶

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- Limit use of the hospital wage index to hospital inpatient services. Modify the currently mandated use for outpatient services, home health care, long-term care and Medicare+Choice payments to reflect only wage rates relevant to those specific services.⁶
- Apply the Medicare wage index to a lower percentage of the DRG payment, based on the actual percentage accounted for by the costs of labor.⁶
- Reimburse facilities located in counties with per capita income in the lowest 20% for all US counties on the basis of a wage index equal to the median wage index for all counties to facilitate recruitment in chronically distressed communities. .

A variety of federal and state programs exist to help maintain and increase the health care workforce in rural areas:

- The National Health Service Corps (NHSC) provides scholarships and loan repayment to physicians and other health professionals who agree to serve in rural and urban underserved areas. As part of the NHSC, the State Loan Repayment program provides funds to the states for their own loan repayment programs. These grant funds are used to match state and community funds to assist in the repayment of educational loans for primary health care clinicians who agree to practice in an underserved area.⁷
- The Health Professions programs in the Health Resources and Services Administration of the U.S. Department of Health and Human Services support training opportunities that encourage students to serve the health care needs of underserved communities. One such program is the Area Health Education Centers (AHECs). AHECs extend the resources of academic health centers into rural areas by recruiting students to health care careers and providing clinical training opportunities to health professions and nursing students.⁸
- In addition, the Quentin Burdick Rural Interdisciplinary Training Program provides grants to improve access to health care services in rural areas by increasing the recruitment and retention of health professionals in these areas. The program funds projects to develop new and innovative methods to train health care practitioners to provide services in rural areas. Over the past 10 years, nearly 13,000 health care providers, teachers, and students in 29 states have been trained through this rural training program. ⁸

The NRHA applauds the work of the federal government in establishing programs to increase the rural health workforce and will continue to support programs such as the National Health Service Corps which address the lack of health care professionals in underserved areas.

- The NRHA calls on Congress to reauthorize the Health Professions programs without delay.⁹
- The NRHA applauds the passage of the Nurse Reinvestment Act of 2002 and calls on Congress to provide funding to programs authorized by this legislation at a sufficient level to ensure benefits to rural areas.
- In addition, the NRHA calls on Congress and the President to provide necessary funding for programs such as the NHSC and the Health Professions programs that help provide health professionals to serve in rural and frontier areas.

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The shift toward physician specialization has resulted in providers who are more likely to settle in urban or suburban areas where more specialty services are utilized. In addition, most medical and health professions education is conducted in an urban setting and few students or residents are likely to have exposure to a rural setting unless they seek it out on their own initiative. It has been demonstrated in previous research that students who train in rural areas are more likely to practice and stay in these communities.¹⁰

- The NRHA supports increased emphasis and resources being directed toward health professions programs that foster interdisciplinary training and support development of training programs in and in collaboration with rural communities.
- The NRHA believes that academic institutions should share with the rural health community the responsibility for addressing maldistribution as well as retention issues within the health professions.

The implementation of telehealth, or distance learning techniques, has potential for extending health professions and medical education to rural areas.¹¹

- The NRHA supports greater investigation of the possibilities for using technology to deliver training to health professionals in rural areas and encourages greater federal funding be devoted to this area.

Rural areas tend to be more isolated and clinicians in rural areas are often without alternate coverage making it difficult to take time off for illness, vacation or continuing medical education. The isolation of rural and frontier areas and the workload and lack of support from professional colleagues create additional stress for rural clinicians that their urban counterparts do not face. The rural environment is also difficult for spouses and families of clinicians undergoing the stress of providing coverage for rural residents, sometimes on a twenty-four hour a day basis. These factors combine to create a situation where recruitment and retention of health care professionals are an ongoing challenge.¹

Certain remote and frontier areas require innovative incentives to recruit health professionals. These sites may always have high turnover, simply because of the isolation and harsh environment inherent to the site. Higher salaries and enhanced benefits may be necessary to entice people to serve in these areas.

- The NRHA supports increasing the current 10 percent Medicare bonus payment in rural Health Professions Shortage Areas (HPSAs) to 20 percent for all primary care providers, including physician assistants, nurse practitioners and certified nurse midwives.⁶
- Geographic disparities in physician payment should be eliminated.⁶

The NRHA supports the development of training programs for healthcare professionals in rural areas. Efforts to train and develop quality healthcare professionals are expensive investments. In this light, the NRHA supports legislation and funding which will support retention of healthcare professionals in rural shortage areas.

Collaboration between the federal government and state governments has been extremely productive in such widely varied programs as Medicaid, The State Children's Health

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Insurance Program and the Cooperative Extension Service. The NRHA notes that while the federal government has the most comprehensive data on health workforce needs and distribution, and supports a variety of professional programs through the Bureau of Health Professions, a large proportion of health professions education institutions are state-supported.

- The NRHA calls on the Health Resources and Services Administration (HRSA) to explore ways to collaborate with state policy makers to provide incentives to state-supported schools to meet health workforce needs.

The nation's oral health workforce is unable to meet the basic public need for care—particularly for children and the poor. There is no reasonable likelihood that this need can be met within the foreseeable future by training more dentists. Over the past 30 years, nurse practitioners and physician assistants have proven their ability to expand access to quality health care to a broad range of patients with conditions traditionally regarded as "medical". It is time to pursue a similar approach to meeting the nation's oral health needs.

- The NRHA proposes that supplemental funding for oral health care be made available through the Medicaid Program to states which substantially expand the scope of practice and range of practice sites permitted dental hygienists.
- The NRHA further proposes that a new grant program be offered through the HRSA Bureau of Health Professions to expand the curriculum of schools of dental hygiene in states expanding the scope and sites of practice of dental hygienists.

Workforce shortages prevent many communities from meeting basic mental health care needs. The NRHA deplores the rivalries among various associations of mental health professionals, all of which are too few in number in rural areas to meet basic needs for care. The NRHA offers to convene representatives of national associations of mental health professionals to draft a multi-professional plan to meet the mental health workforce needs of rural America within 15 years. The NRHA will seek funding for such a planning process and will review the results of this process with the intent of supporting its implementation.

The NRHA recognizes that there is a close interrelationship between rural economic development and the recruitment and retention of the rural health workforce. Secure jobs in other sectors, as well as strong institutions and a robust economy, are integral to the health of a community and impact its ability to support a strong health care sector. These facets help to determine the attractiveness to health professionals considering settling in the community. Leadership development is another critical piece of rural community development. Developing the next generation of rural leaders helps to ensure that the strength of the community will be continued into the future.

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