

# The National Health Service Corps – A Critical Component of Provider Recruitment in North Carolina’s Rural and Underserved Communities

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Since the mid-1970s, the National Health Service Corps (NHSC) has been an invaluable resource for recruiting primary care providers in North Carolina. NHSC scholars have served in various practice settings across the state including free-standing sites, community health centers, or as private practice option providers. All of these are located in places where there are fewer practitioners and severe barriers to access to primary care, areas designated as Health Professional Shortage Areas (HPSAs) by the federal government. The program offers scholarships to students to attend medical school as well as guaranteed repayment of loans. The scholarship program reached its height in the late 1970s and early 1980s in North Carolina and the nation due in part to a spirit of Peace Corps volunteerism.

In the mid-1980s, the NHSC shifted its primary focus as a scholarship program for medical students to offering fewer scholarships and expanding the programs for loan repayment for medical providers who had completed training. This transition allowed the NHSC to contract for obligated service at a point when providers were more focused on personal and professional needs than when they accepted scholarship funding early in their medical school training. NHSC loan repayment offered another recruitment approach to attract primary care providers to rural and underserved communities where income, lifestyle, and other factors made recruitment more difficult.

Over the years, the NHSC loan repayment program has faced several challenges. Funding has been a major determinant for site eligibility. HPSA designation scores, based on the level of shortage, were used to allocate scarce resources and many providers from areas with low HPSA scores were unable to receive loan repayment due to the funding limitations. In addition, NHSC loan repayment required full-time practice, thus eliminating some candidates who were unable to make a full-time commitment. Finally, the NHSC would not consider

loan repayment until a candidate was already in practice. These factors restricted the potential placements through the program.

The American Recovery and Reinvestment Act of 2009 (ARRA) provided the NHSC with an additional \$300 million in funding over a two-year period. The NHSC has used this funding to increase the number of loan repayment contracts available to providers. The NHSC’s stated goal was to double their field strength through this initiative. The HPSA designation scores, full-time practice status, and the requirement that the candidate already be on-site are no longer required for NHSC loan repayment. These changes have already had a tremendous positive effect on recruitment efforts in North Carolina.

The passage of the Patient Protection and Affordable Care Act (HR 3590), the health care reform legislation of 2010, appropriated \$1.5 billion to the NHSC through 2015 (Section 10503 (b)(2)). Section 5207 authorized over \$4 billion through 2015. Given this significant investment, the NHSC has been charged with bolstering the nation’s recruitment efforts in light of the estimated 32 million individuals who will be insured under the law. Until supply can meet demand, competition among communities will grow. With expanded NHSC loan repayment and the potential for additional scholars, rural and underserved HPSA communities will have a recruitment tool that will allow them to compete in an environment where salary and lifestyle opportunities may be limiting. This is very good news for rural and underserved communities in North Carolina as the nation moves toward the implementation of health care reform.

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In 1972, the AHEC program was created as one mechanism to coordinate the many emerging federal and state programs related to health workforce development. By the 1980s these were bundled under the rubric of Title VII (referring to a subsection of the Public Health Service Act) for physicians, dentists, and other non-nursing health professions. The recent health reform legislation has amended, extended, or enlarged many programs under Titles VII and VIII and has created some new programs that are classified under those sections. Other components of the overall bill touch on or will have important effects on the workforce, but this commentary will focus mainly on the elements under those two parts of the Public Health Service Act.

One of the recognized problems in health workforce policy has been the lack of coordination across programs. In the discussions leading up to the passage of health reform there were several proposals to create some form of coordinating mechanism. In the end, the legislation establishes a National Health Workforce Commission charged with reviewing health workforce supply and demand, evaluating existing programs, and making recommendations on policies and priorities. That commission will consist of 15 members drawn from a range of stakeholder groups, but with health professionals mentioned as only one of the eight groups. The commission is to provide recommendations to Congress and the Administration on national health workforce priorities,