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Recruiting Rural Physicians: Small-Town Socialism

by William E. Pike

As the supreme defender of the status quo, the state often feels a necessity to react whenever a broad market or social change is taking place. Lawmakers and bureaucrats are rarely satisfied to let new trends work themselves out for the public good in a free-market society. Such has certainly been the case with health care in America over the last decade.

Through the 1980s and into the 1990s, as health-care costs grew, society saw a shift in provider demographics. Two conflicting things occurred during this period. First, rising physician salaries in specialties such as radiology and anesthesiology drew more and more medical students away from traditional general practice. Second, managed care became increasingly prominent. Managed care, of course, relies on general practitioners, or primary care physicians, as gatekeepers between patients and more expensive specialized care.

As the ranks of primary care physicians grew smaller, such doctors began to get lucrative offers from large urban managed care organizations. These trends left an obvious void—a shortage of rural primary care physicians. A survey of medical school seniors taken in 1979 showed that only 59 percent preferred a large or moderate city practice. By 1989 that number had grown to 80 percent.[1]

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Government Response

Local, state, and federal government agencies moved to check this shortage by spending tax dollars and manipulating the market. Now most states maintain some sort of program, at a cost of millions of dollars a year, to recruit and retain rural physicians. Politically, such programs are easily defended as absolutely necessary, in the words of Tennessee's rural health office, "to improve and enhance the accessibility, availability, and affordability of quality health care." Few voters, and certainly few legislators, are willing to argue with such a mission. However, are such agencies really efficient in the face of free-market alternatives?

How do government agencies recruit physicians for rural communities? The foremost device is money. Many states lure doctors to rural practice by paying all or part of the cost of their medical education. In some cases the state contracts with new physicians to work in a rural area for a specific amount of time in return for payment of debts at the end of that service. In other, less effective programs, students sign agreements promising to work in a rural area after completion of medical school, which the state pays for in the meantime. Obviously, this arrangement is prone to exploitation by students who, their education paid for and degrees in hand, decide not to practice rural medicine, or at least not to fulfill their entire obligation. In either case, citizens pay heavily.

Other recruitment methods also exist. States have sponsored programs to interest rural high school students in medical careers. They have also set up residency training programs in rural hospitals to give medical students the chance to experience rural life firsthand. Some of these programs have succeeded in bringing doctors to rural areas. In 1971 the University of Minnesota opened the Rural Physician Associate Program, a nine-month elective available to third-year medical students. According to the university, "Students live and train in non-metropolitan communities under the supervision of family practice and other physicians called preceptors." Over 800 medical students have participated, and of those, 65 percent now practice in rural areas. Eighty-two percent of the participants chose primary care.[2]

In addition, state-sponsored recruitment agencies attempt to lure practicing physicians to rural hospitals and communities. For instance, Oregon sponsors the Healthcare Experts for Rural Oregon (HERO) program, which works with rural communities to attract compatible physicians, offering bonuses such as a state income tax credit of $5,000 for up to ten years.

Is State Recruitment Necessary?

Government-sponsored recruitment is certainly a departure from free-market principles. However, it is not the kind of government intervention that is likely to draw much criticism. The state would respond that it is fulfilling its proper role by helping rural communities find the physicians they need for quality care. The subject isn't quite that simple, however, and the outcomes aren't always so rosy.

The emphasis placed on recruiting physicians helps contribute to a dangerous culture of dependence among residents of rural areas. Rural communities come to see themselves as "charity cases," unworthy of having a physician except at the start of his career and not able to support or attract a physician without state help. That culture subverts the free-market principle of voluntary exchange for *mutual* benefit that rules other aspects of our economy, urban and rural. Consider the advice of one publication written as a guide for those working in the field of rural physician recruitment:

> Develop a recruitment fund with donations from the hospital, businesses, and community events, e.g., cake sales and high school car washes. Be prepared to spend several years of hard work developing the fund.
>
> Consider developing a community finance plan to help new doctors purchase equipment or repay their educational debts.[3]

Imagine a community accepting such advice for the recruitment of bankers or lawyers. It wouldn't happen. We do not hear of severe shortages of bankers or lawyers in rural America, not because there are necessarily too many of them, but because the free market offers a place for practitioners of these professions in small towns as well as in large cities. Advocates of state-sponsored rural physician recruitment are bound to argue that physicians cannot be compared to bankers or lawyers. But in fact, none can exist without the others. All three, along with grocers, custodians, restaurateurs, teachers, carpenters, and a host of other workers and entrepreneurs are intertwined into any local economy, and none should be singled out for special treatment. When special treatment is accorded to one occupation, the population is bound to suffer through both the cost and quality of the service offered. Lopsided dependence is no base on which to build any segment of an economy.

Just as government interference creates a culture of dependence among rural residents, it also creates a culture of transience in the rural health-care community. In the free market, physicians take up practice in a community because they want to live there and because they feel that good opportunities exist for them. Some are bound to move on, but many will stay and pursue their dreams. When physicians are lured to a community through state loan repayments, tax breaks, and other perks, a sense of transience is almost expected. One North Carolina study

found that 19 percent of newly recruited rural physicians planned to leave, even when they first arrived. Fewer than half planned to stay.[4] Though some physicians will remain in an area for a long time, others will move on to still greener pastures when their obligations are fulfilled or when they realize that their personalities and dreams do not fit the community in which they were placed. Such transience is detrimental to quality health care in small communities and merely perpetuates the recruitment problem by opening up a vacancy not long after it has been filled.

Market Alternatives

Nevertheless, primary care physicians are few and far between in much of rural America, and access to medical care there is often a real problem. But this situation must not drive us to conclude that free-market solutions don't exist. Indeed, trends that have drawn so much discussion over the past decade may be reversing themselves. The growth of managed care organizations, which drew so many general practitioners to urban areas over the last several years, is slowing. Profits are shrinking. Consumers are clamoring for more choice.[5] The shortage of primary care physicians nationwide may very well be turning into a surplus, as medical students realize where their best opportunities for work might be in the future.[6] Some of these physicians will turn to rural communities on their own, realizing that markets there are open.

In the meantime, rural hospitals and communities should be encouraged to use private recruiting agents or cooperative recruiting efforts, rather than state-supported recruiting mechanisms. Such efforts are more realistic and efficient—and more satisfying in matching a doctor to a community.

In short, we must be careful not to pass off any state-sponsored program as helpful or even as harmless without a full analysis of the free-market alternatives. Though wide-ranging government health-care initiatives, such as the 1993 Clinton plan, are likely to raise the eyebrows of voters, few people will even notice something as seemingly innocuous as government-sponsored rural physician recruitment. On its surface that mission, like so many others, seems to be a proper use of tax dollars, a beneficial action on behalf of those with little political or economic power. Yet it is in exactly such cases that citizens lose freedom and independence to the state, a trend that is hard to reverse. □

1. Victoria D. Weisfeld, ed., *Rural Health Challenges in the 1990s*, (Princeton: Robert Wood Johnson Foundation, November 1993), p. 57.

2. University of Minnesota, *Rural Physician Associate Program*. Http://www.rpap.umn.edu/. May 7, 1997.

3. *Plugging the Leaks in Health Care: Harnessing Economic Opportunity in Rural America*. Center for the New West. December 1992, p. K3.

4. Sari Teplin and Christine Kushner, *Physician Life and Practice in Underserved Communities: Strategies for Recruitment and Retention*, University of North Carolina Rural Health Research Program, March 1994, p. 8.

5. Center for Studying Health System Change, *Issue Brief*, Washington, D.C., May 1998.

6. "Survey shows surplus of primary care physicians." CNN Interactive, U.S. News Story page, http://www.cnn.com/US/9804/13/doctor.shortage.ap/. April 13, 1998.

The Poverty of the United Nations

Twenty years ago, a United Nations report listed the United States as consuming 115,540 kilowatt-hours of energy per person per year. At the same time, each person in the tiny central African nation of Burundi was using up just 120 kilowatt-hours. My guess is that today, the average American is still consuming about a thousand times as much energy as the average Burundian. It's also a safe bet that the "experts" at the United Nations want Americans to feel just as guilty about the disparity today as 20 years ago.

Is this something about which Americans should flog themselves in unremitting guilt? Does Burundi use less energy because America uses too much? Is world energy a fixed pie, with America greedily hogging more than its quota at the expense of the Burundis of the planet? Would Burundi be better off if America impoverished itself? Questions like these were answered definitively by free-market economists decades ago, but like a nagging mother-in-law, the questions just never go away.

You've heard this international class warfare stuff before, from many sources besides the United Nations. A few years ago, the mantra of the international statist community—repeated endlessly in the media—was this: "Americans are only 6 percent of the world's population but they consume 40 percent of the world's energy." Greed was supposed to be the explanation for this disparity, and the solution offered was for America to spread its wealth in foreign-aid gifts to the less fortunate countries of the world.

Energy, of course, wasn't (and still isn't) the only thing of which America consumes more than its share of global population. We also eat more than 6 percent of the world's potato chips and broccoli. We enjoy more than 6 percent of the world's indoor plumbing, hearing aids, and baseballs. We operate more than 6 percent of the world's cars, trucks, hang gliders, tricycles, and skateboards. We listen to more than 6 percent of all lectures and read more than 6 percent of the world's books. And we probably put up with more than our share of nonsense too.

The fact is that Americans *consume* more because Americans *produce* more. That's right—more than 6 percent of the world's potato chips, baseballs, skateboards, and countless other things. If we didn't first produce, we wouldn't have it to consume or to trade for what we really wanted. How can such an elementary point, such a basic principle of life and economics, be lost on anyone who doesn't have to sign his name with an "X"?

Unfortunately, the U.N. is at it again. Last September it issued a document called "The Human Development Report 1998." The richest fifth of the world's nations, declares the report, accounts for 86 percent of private consumption. Never mind the inherently dubious nature of adding up "private consumption" in almost 200 different countries.

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