REPORT OF THE

ADVISORY COMMITTEE ON MEDICAL EDUCATION

ON THE

POSTGRADUATE HEALTH PROFESSIONS PROGRAM

January 15, 1992

EXECUTIVE SUMMARY

This report defines the problems Maine faces in recruiting primary care physicians to underserved areas of the State as well as providing Maine residents with a medical education. The report offers recommendations for restructuring the Postgraduate Health Professions Program and the Osteopathic Loan Program to both maximize educational opportunities for health professions students increase the number of primary care physicians returning to Maine and practicing in medically underserved areas.

The problems and issues associated with both access to education and access to health care, within the context of this program include: (1) the low number of Maine residents attending medical school, (2) student debt, (3) the number of Maine's medical school graduates who select primary care specialties, particularly family practice, (4) the number of Maine residents who return to our state after becoming physicians and practice in medically underserved areas, and (5) the social, economic, education and practice issues that work against recruitment and retention of primary care physicians in rural areas.

The Advisory Committee on Medical Education recommends that an integrated approach be developed to meet the legislative intent of these medical education programs and address the problems associated with access to education and health care. Such an integrated approach should include the following components:

* A capitated program of assured access to medical education for Maine residents through contractual relations with one allopathic college of medicine and one osteopathic college of medicine that will offer an integrated medical education designed to increase the likelihood of students selecting primary care specialties and practicing in underserved areas of Maine;

* A need based loan program for medical students and other health professions identified in this legislation;

* Loan forgiveness for those practitioners providing primary care to underserved areas in Maine; and,

* An expanded the State Loan Repayment Program.

The major programmatic changes recommended in this report include:

1. Reducing the number of capitated seats from 23 new seats per year to 20 new seats each year by:

   - Deleting 5 seats currently reserved for dental, veterinary and optometry seats from the Contract Program and,

   - Decreasing allopathic medical seats from 18 to 15 and adding five osteopathic seats for a total of 20 capitated seats;

2. Eliminating the Osteopathic Loan Program;

3. Establishing a loan program for needy students which includes eligible students attending both contract schools and non-contract schools with 90% of the available funds for medical students and the remaining 10% available to dental, veterinary and optometry students;

4. Developing a request for proposals for medical schools to compare medical education programs to determine which schools offer an integrated program that is most likely to prepare students who will select primary care specialties and practice in underserved areas of Maine;

5. Increasing the monies available to recruit physicians and physician assistants to Health Personnel Shortage Areas in the State Loan Repayment Program from $50,000 to at least $100,000 each year. The matching federal funds will also be increased to $100,000.

Maine is finding it increasingly difficult to recruit primary care physicians because fewer students nationally and in Maine are applying to medical school. Those students who graduate are choosing specialties other than primary care (family practice, internal medicine, pediatrics, and OB/GYN). Recruiting primary care physicians, especially family practice physicians from other areas of the country, is very difficult because of lower incomes of Maine physicians. Finally, there exists a serious maldistribution of primary care physicians within the State. The recommendations contained in report are designed increase the numbers of primary care physicians through an integrated approach to medical education and to the recruitment and retention of physicians, particularly in underserved areas of Maine.

TABLE OF CONTENTS

POSTGRADUATE HEALTH PROFESSIONS PROGRAM

INTRODUCTION

This report responds to legislation enacted during the First Regular Session of the 115th Legislature requiring the Finance Authority of Maine (FAME) to critically examine the two Postgraduate Health Professions Programs it administers, the Medical Contract Program and the Osteopathic Loan Program. The law requires that:

> "The report must include suggested changes to the programs designed to maximize the use of available funding to increase the supply of primary care physicians practicing in underserved areas of the State and to provide access to medical education for Maine students. In preparing its report, the Finance Authority of Maine shall consult with the Advisory Committee on Medical Education, the Special Select Commission on Access to Health Care, the Maine Medical Association, the Maine Osteopathic Association, the Maine Ambulatory Care Coalition, the Department of Human Services and other interested entities."

In response to this mandate, this report defines the problems Maine faces in recruiting primary care physicians to underserved areas of the State as well as in providing Maine residents with a medical education and offers recommendations for restructuring both programs to: (1) maximize educational opportunities for health professions students, (2) increase the number of medical education participants, (3) provide medical students with expanded opportunities for exposure to rural practices, (4) enhance the probability of medical students selecting primary care specialties, (5) support linkages with the existing medical education structures in Maine, and (6) increase the number of primary care physicians returning to Maine and practicing in medically underserved areas.

The recommendations outlined in this report were developed by the Advisory Committee on Medical Education (listing attached) which is charged with overseeing policy development for both medical education programs administered by FAME. The Advisory Committee formed three subcommittees to study and examine each of the key areas addressed in the report. Those key areas are: separating the purchase of seats (access fee or capitation) from student debt; developing a need based loan program to replace part of the capitation fee that was charged back to students and the Osteopathic Loan Program; and physician recruitment through the State Loan Repayment Program and loan forgiveness. Without dissent, subcommittee recommendations were reviewed, modified and adopted by the whole committee. As required by the Legislature, the committee's recommendations and draft report have been reviewed and commented on by the Maine Medical Association, Special Select Commission on Access to Health Care, Maine Osteopathic Association, Maine Ambulatory Care Coalition, and Department of Human Services.

PROBLEM DEFINITION

The medical education programs administered by the Finance Authority of Maine are designed to fulfill the legislative mandate of assuring opportunities for postgraduate health professions education for Maine students and providing the State with a pool of physicians to help assure access to health care for Maine people, particularly in medically underserved areas. Maine lacks an integrated approach to meet the legislative intent of these programs. However, before initiating any changes to the present financial assistance programs for postgraduate education, it is important to put the problems these medical education programs seek to address in perspective. The problems include: (1) the low number of Maine residents attending medical school, (2) student debt, (3) the number of Maine's medical school graduates who select primary care specialties, particularly family practice, (4) the number of Maine residents who return to our state after becoming physicians and practice in medically underserved areas, and (5) the social, economic, education and practice issues that work against recruitment and retention of primary care physicians in rural areas.

The problems and issues associated with both access to education and access to health care, within the context of this program, are discussed below. The proposed recommendations for addressing these problems and issues are contained in the RECOMMENDATIONS section of this document.

ACCESS TO EDUCATION

The Contract Program is primarily designed to ensure access for Maine students to postgraduate health professions education. The Osteopathic Loan Program provides loans directly to students studying osteopathic medicine and has no access component. The Contract Program was originally developed as an alternative to establishing a State supported medical school under Governor Longley's administration. In the early eighties, Maine's Legislature recognized that this program could serve a dual purpose of assuring medical education opportunities and addressing the issue of the State's need for health professionals in underserved areas. Consequently, the law was amended requiring participants to practice in medically underserved areas if they wished to become eligible for forgiveness for the costs Maine had incurred in securing preferred access. The same conditions were established for the forgiveness of osteopathic loans.

For several decades, Maine has contracted with colleges and universities to provide preferred access through a capitation system for Maine students. Currently, the Medical Contract Program pays an access fee or capitation to schools of dentistry, optometry, veterinary and allopathic medicine to secure seats for Maine residents. A portion of the capitation or access fee is repaid to FAME by Contract students after they have completed their medical

education. Participants who practice in underserved areas have their debt canceled at a rate of 25% per year. Those program participants who practice in other areas or out of State must repay their debt in cash payments, with interest, over a ten year period.

Even though the State has provided its students with a vehicle for access to medical education, Maine still ranks 50th among states in the number of medical students it graduates each year. A majority of Maine residents who graduated from medical school in recent years participated in the Contract Program. Access to medical school continues to be very competitive and extremely expensive. Over the past four years, 60% of Maine students entering allopathic medical schools matriculated at either Tufts or the University of Vermont medical schools (contract schools). Failure to assure preferred access can only result in a decrease in the number of students who are admitted to medical school. (Please see the summary of applicant data over the past 4 years contained on the last page of this report.)

Nationally the number of applicants to medical school increased by 11% this year compared to last. The University of Vermont received 4322 applications for the 91/92 academic year for a class size of 93. Sixty-two (62) were from Maine residents, 66 from residents of Vermont. Since only 600 interviews are granted, 3722 or 86% of these well qualified applicants could not even be interviewed and just 2% of the total applicant pool were accepted. Under the contractual arrangement Maine has with Vermont, 24% of the Maine's applicants were accepted to UVM. Without a capitation agreement for Maine students, few qualified Maine students would have gained admittance.

University of Vermont medical students who participated in the Contract Program over the past two decades were surveyed in the spring of 1990 to determine which of those students were also accepted at other medical schools and whether UVM was their first choice. Surveys were sent to 210 UVM participants; 134 responded. The surveys indicated that:

78 Were not accepted elsewhere
12 Withdrew other applications upon acceptance to UVM
44 Were also accepted at other schools (27 were accepted at Tufts which is also a contract school)
85 Indicated that UVM was their first choice.

STUDENT DEBT

Once access has been gained, students may still face financial barriers. Many Maine students could not pursue their postgraduate education without financial assistance from the State. The average cost of education for U.S students who do not attend their own state supported medical school is approximately $35,000 per year. Under the Maine Contract Program, students are given financial support for only about one-third of the cost of their education. The remaining funds must be sought from other sources.

Although the Contract Program has provided access, it has not decreased the cost of medical education for Maine students unless they select an underserved specialty (usually restricted to family practice) and practice in an underserved area. Students from other states who attend their own state supported university pay tuition which is subsidized by their taxpayers. For example, students at the University of Connecticut pay about $7,500 for tuition. Their state does not encumber them with restrictions related to choice of specialty or practice location. Our students pay the equivalent of non-resident tuition (about $22,500) with the option of loan forgiveness for the portion subsidized by Maine provided the students elect to practice in an underserved area.

The majority of medical students rely on loans to help them meet their medical education expenses. Therefore, the availability of loans with a reasonable interest rate and repayment terms is critical for these students. In 1991, program students were asked to complete a debt survey, as well as a required annual report. Some students report borrowing as much as 65 percent of their loans from high interest loan programs which begin accruing interest with the first disbursement, such as Health Education Assistance Loans (HEAL) and the Alternative Loan Program (ALP). They are also borrowing from lower interest loan programs that begin accruing interest with the first disbursement, such as loans from the Maine Education Loan Authority (MELA). The interest is capitalized during the time they are in school as well as during their residency and internship because medical students have little or no income to begin repaying loans during this period. By the time recipients of these loans are able to practice medicine, it is estimated that their principal amount has doubled. Such excessive debts force many students who may prefer primary medicine to choose sub-specialties or to locate in metropolitan areas in order to repay their loans.

The following information is contained in a table was published in the February 1991 Journal of Academic Medicine. It illustrates the level of income needed to repay education debts. [1]

Examples of Medical Education Debt and the Income Ratios Needed Five Years After Receiving the M.D. Degree in Order to Repay the Debt

	Ratio of Debt to Income Needed		
Level of Debt	Impossible	Difficult	Comfortable
$ 50,000	79%	100%	158%
75,000	97%	130%	194%
100,000	106%	142%	213%
120,000	111%	148%	222%

[1]Robert Petersdorf, "Financing A Medical Education," ACADEMIC MEDICINE, Vol. 66, no. 2 (Feb 1991)

The Federal government is proposing to phase out the HEAL program over the next few years and limit the availability of these loans to minority students. Although HEAL loans are expensive, they have provided many needy health professions students with the additional monies they need to pay for their education. The federal government has also drastically reduced the funding levels for scholarships and loan repayment programs under the Public Health Service such as the National Health Service Corp and Indian Health Services.

Student debt is a significant problem for medical school graduates today. Nationally, the average debt for medical school is reported to be between $35,000 and $50,000, depending upon the source of information. The Association of American Medical Colleges (AAMC) reports the average debt at $46,000. A poll of Maine's contract and osteopathic students show significantly higher debt levels. Those students who graduated after 1985, and who reported debt, show an average debt of $85,000 and a range of debt from $27,500 to $145,000.

It is important to note that the debt of current students is much greater than it is for students who graduated in earlier years. This growth in debt is a reflection of the rapidly rising cost of medical education, the decrease in scholarships and the student's increasing reliance upon loans. This increasing debt level creates a barrier for students who wish to enter primary care and an even greater barrier to those students who want to practice in rural Maine.

Some Maine residents may not want to attend contract medical schools but may need additional financial assistance to attend non-contract schools. Under the present system, there is no provision for financial assistance to students matriculated at non-contract schools. Financial barriers need to be removed for these students as well as for contract students.

Studies show that students from low income families are more likely to become primary care providers. Since primary care physicians are needed in Maine, every effort needs to be made to provide financial aid to lower income Maine residents seeking a medical education and particularly to those who express an interest in primary care.

RECRUITMENT AND RETENTION

Maine is finding it increasingly difficult to recruit primary care physicians (family practice, internal medicine, pediatrics, and OB/GYN) because fewer students nationally and in Maine are applying to medical school. Those students who graduate are choosing specialties other than primary care . The exception to this trend exists at the University of New England where 70% to 80% of their osteopathic graduates are entering primary care specialties. Unfortunately, the high debt load of most of UNE's graduates make primary care practice in rural Maine difficult if not impossible.

Current literature indicates that choice of specialty is influenced by a number of factors including the students' educational experience. The existing program attempts to encourage students to select primary care specialties, particularly family practice, by offering loan forgiveness for those participants who practice primary care in underserved geographic area or provide service to underserved population groups. However, the program in its present form does not require specific medical school experiences designed to influence students toward the selection of any given specialty. Neither does the program provide a mechanism for an integrated approach to accomplish its goal of creating a pool of primary care physicians who will practice in underserved areas of Maine.

Poverty and rurality restrict our ability to compete with more affluent and more populated areas in attracting physicians to our State. Recruiting primary care physicians, especially family practice physicians from other areas of the country, is very difficult because of lower incomes of Maine physicians. In 1988, the American Medical Association and the Maine Academy of Family Practice reported that the level of compensation for Maine Family Practice physicians averaged 58% of the national average compensation for Family Practice physicians.

Finally, there exists a serious maldistribution of primary care physicians within the State. While Maine has increased the overall number of physicians over the past twenty years, we have generally been unsuccessful at recruiting and retaining primary care physicians to underserved areas of the State. It is primary care physicians who are responsible for looking at the broad base of patient issues which include prevention, as well as the social and psychological aspects of health and illness. Many believe it is through primary care physicians that we might gain control of our health care system and its costs.

The Department of Human Services' Office of Planning, Research and Development divides Maine into 61 Primary Care Analysis Areas. Twenty- one of those areas are federally designated Health Personnel Shortage Areas (HPSA's). HPSA's are areas with the most severe shortage problems. In other words, 34% of the state is experiencing severe shortages of physicians who provide basic health care.

The Medical Advisory Committee feels that policy makers should be aware that while rural areas have the greatest difficulty recruiting primary care physicians, some other areas are also experiencing difficulty maintaining adequate ratios of physicians to patients. Part of the difficulty arises from Maine's inability to compete financially with other areas of the country for the declining pool of primary care physicians. As previously stated, the salaries or earnings of most primary care physicians throughout the country are considerably less than those of other specialists. Maine is no exception; the rural and underserved practices are even less competitive.

Rural areas may not experience physician shortages for the same reasons as more populated areas. While a single physician in a rural area may appear to solve the problem of patient to physician ratio, that very ratio tends to exacerbate the recruitment and/or retention problem. A solo practice in a rural area results in long work hours, little interaction with other professionals, and little opportunity for any kind of respite. Sparse populations seldom provide adequate income to support more than one practitioner and usually result in physician burn-out.

The following examples demonstrate the need for primary care physicians throughout Maine.

* The Augusta area lost a family practice physician to a hospital based practice and has been unable to recruit a replacement.

* Lewiston and Biddeford do not have an adequate supply of family practitioners.

* Portland and Bangor need additional primary care physicians who will accept new medicaid patients.

* Aroostook County recently lost its only pediatrician and is attempting to restructure the practice environment for a pediatrician to facilitate recruitment.

* Maine's Community Health Center system is presently recruiting for 13 family practice physicians.

* Skowhegan and Farmington have both lost primary care providers.

* Women living in rural areas, women eligible for medicaid benefits and uninsured women remain underserved by physicians who provide prenatal and obstetrical services.

The State has responded to the need for prenatal and obstetrical services with a program to subsidize malpractice insurance for physicians who supply obstetrical and prenatal services to women in underserved areas. While this technique has proved useful, the problem is far from resolved.

There are other educational issues which are significant barriers to recruitment of physicians just completing their training and to retention of current practitioners. First, rural physicians, particularly those in solo practices, lack opportunities to interact with larger hospitals, lack coverage to enable them to participate in extended medical education opportunities, lack opportunities for peer interaction, and have little opportunity to act as mentors to students.

The increased availability of and enrichment of outreach education programs for Maine's rural physicians could be an important recruitment tool. Outreach education is presently provided through the

major medical centers, the Area Health Education Center (AHEC) system, Cooperative Health Education Program (CHEP), Medical Care Development, Maine Ambulatory Care Coalition and others.

A bill (Draft LD245) has been introduced that is intended to provide additional financial support to the Primary Care Residency Programs in Maine. The residency programs have proposed to increase the number of residents in each program. Increased numbers of residents and perceived program quality by students tends to assure more applicants. The residencies are a major source of primary care practitioners to Maine and provide access to primary medical services for underserved population groups residing in and around the medical centers with Primary Care Residency Programs. They also serve as educational centers for rural family practitioners.

A notable and innovative grant project is being initiated by the Maine Ambulatory Care Coalition. The project is designed to enhance the practices of rural physicians. It will involve the Coalition, 26 rural health centers, the Eastern Maine Medical Center, Family Practice Residency Program in Bangor and the Maine-Dartmouth Family Practice Residency Program in Augusta. On alternate years, the two residency programs will provide a resident fellow, funded by the National Health Service Corp, who will be available for coverage to health center physicians. The grant also provides FAX machines to each health center which will enable physicians to consult with other professionals; a medical computer program and modem to enable access to medical library services; and provide continuing medical education (CME) conference calls on subjects selected by the participating physicians. The components of this grant are expected to serve as a collaborative model for retention of physicians in rural areas.

RECOMMENDATIONS

CAPITATION

If Maine hopes to maintain the number of Maine residents seeking medical education, it is necessary to continue to include a system of capitation or preferred access to a medical school which offers an integrated educational approach that will increase the likelihood of medical students selecting primary care specialties and practicing in underserved areas of Maine.

A significant number of program participants are needed if Maine expects any medical school to provide preferential treatment to Maine residents and if the State is to use the capitation program to ensure a curriculum which is appropriate to encourage students to pursue primary care. Therefore, it is probably advisable that Maine develop a contractual arrangement with just one allopathic medical school and one osteopathic medical school. A single educational provider for each medical discipline insures some measure of negotiating leverage with respect to the educational pathway of Maine students. Since the objectives of this program include providing the State with a pool of physicians, many of whom will become primary care providers and rural practitioners, Maine needs to work with medical schools to establish criteria for focusing specific educational components toward achieving our objectives.

1. Separate capitation or access fees paid directly to medical schools from loans to students.

Responsibility for funding the access to education component of the program should be the responsibility of the Finance Authority of Maine through an appropriation from the Legislature. The cost of a medical education for any Maine student who benefits from capitation shall not exceed out-of-state tuition at the school the student is attending.

In the past, the program has melded the access cost and a loan component together. A capitation fee was paid directly to the institution. UVM and all other state supported schools also charged Maine students a reduced tuition rate which the student had to pay from a source unrelated to this program. Maine then required students to pay the State back the difference between the tuition they were charged and the amount of tuition charged all other out-of-state students. In the end, Maine students paid the equivalent of out-of-state tuition. The portion of the tuition owed back to Maine could be forgiven if the student practiced in an underserved area.

Needless to say, this system of tuition payment resulted in confusion. Students did not know how much money they owed back to Maine until after the beginning of their last year of medical school. The separation of the capitation or access fee from money loaned to the student is cleaner. It is expected that any school with which FAME contracts for seats will charge students non-resident tuition. If students were also expected to assume financial responsibility for that access fee, they would be paying far more for tuition (tuition + access fee or capitation) than any other student matriculated at a given school.

2. Restrict preferential access to medical students.

The Advisory Committee on Medical Education has found that there is not a critical need for access to dental, veterinary or optometry schools for Maine students. For example, Tufts Dental School admitted six Maine residents in 1991. Only two of those students were awarded contracts under the Contract Program. Therefore, since the State is pressed to conserve its scarce resources for critical needs, it is recommended that students in these disciplines should not be included in the capitation component of this program. However, financially needy dental, optometry, veterinary and medical students attending non-contract schools may participate in the need based loan program.

3. Provide access to 20 seats for medical students each year, 5 seats for osteopathic students and 15 seats for allopathic students, with flexibility for increasing or decreasing the number of students in either discipline contingent upon the applicant pool.

The number of contract seats each year would be reduced from 23 in all disciplines to 20 entering medical students each year. The distribution of allopathic to osteopathic seats should approximately parallel their respective representation in Maine's medical community.

4. Develop and circulate a Request For Proposal to medical schools in New England and New York as well as medical schools receiving planning grants from the Robert Wood Johnson Foundation or the Kellogg Foundation to identify at least one allopathic school and one osteopathic school Maine can contract with.

The universe of medical schools that will receive an RFP will be primarily limited to those in New England and New York because educational ties back to the State are an integral component of any new medical education program. Medical schools receiving the Robert Wood Johnson or Kellogg Foundation planning grants will also be included since they are likely to offer integrated medical education programs and be interested in innovative programs.

5. Design the RFP to select a medical school with an integrated medical education program that will increase the likelihood of medical students selecting primary care specialties and practicing in rural areas of Maine.

A Request For Proposals from selected medical schools is recommended so that FAME will have an opportunity to compare medical education programs and determine which schools are most likely to prepare students who will select primary care specialties and practice in underserved areas of Maine.

Maine students are not unlike medical students in other areas of the country with respect to the decline in selecting primary care specialties. Many students enter medical school expecting to become family practice physicians. However, there are numerous factors which influence the specialty choices of students. Some of these factors include individual interests and expectations, lifestyle, workload, student debt, income potential, educational exposure, and positive primary care role models. Educational exposure is a critical factor as is debt load. Many physicians who want to practice in an underserved area can not afford it due to student loan debts and low salary levels.

Current literature indicates that there are several factors that can influence a doctor's choice of practice location. These include where the physician grew up, the nature of the medical school experience, residency training and the practice environment. It is recommended that Maine contract for medical seats with a program that provides an integrated approach to medical education. The goals of such an approach must include supporting Maine residents seeking medical education,and particularly from underserved areas, encouraging them to return to the State, encouraging Maine medical students to select primary care specialties, and developing ways to support rural practices. As such, the Request For Proposal shall be designed to select medical schools with a program that can fulfill and/or address the following criteria:

MEDICAL SCHOOLS

* A formal department of family medicine
* Primary teaching hospitals with a family practice residency or general internal medicine residency
* A history of graduating students who practice in rural and/or underserved areas
* Program cost
* Special tuition arrangements for Maine students

PROGRAM

* Primary care rotations in rural Maine
* Meaningful rural clerkships and preceptorships that include goals, objectives, and specific outcomes
* Educational activities in rural Maine utilizing existing educational systems within the State
* Linkages to Maine residency programs

STUDENT ADMISSIONS

* An admissions committee member from Maine
* A preferential selection process for admitting students from rural areas
* A process for selecting students who demonstrate a serious interest in primary care

STUDENT LOANS

This report recommends that the funds currently used for the loan component of the capitation payments to schools, as well as the Osteopathic Loan Program funds, be reprogrammed as follows.

1. Create a need based loan program for which allopathic, osteopathic, dental, optometry and veterinary students may apply.

A need based loan program should be created that would replace high interest loans and/or loans with interest that begins accruing as soon as the loan is disbursed. The loan program should be targeted to financially needy students and based on their expected student contribution. Ninety percent (90%) of the loan funds would be available to allopathic and osteopathic medical students. Maine residents studying optometry, veterinary and dental medicine could apply for the remaining ten percent (10%). Students enrolled in the Contract Program, as well as students attending other medical, dental, veterinary and optometry would be eligible for program loans on the basis of need.

This loan program is not intended to replace other low interest loans. The Stafford Loan, Perkins Loan and Supplemental Loan for Students (SLS) programs are examples of low-interest loans with repayment provisions that defer the payment of interest and/or principal until the student has graduated. These loans should not be replaced by a new need based loan program.

2. Include forgiveness provisions for primary care specialists.

The loan program should include loan forgiveness provisions for primary care specialists practicing in underserved areas. Such forgiveness provisions should be an integral part of recruiting physicians back to underserved areas of Maine.

Since physician debt is a significant recruitment barrier for rural practice sites, it is imperative to provide this kind of financial incentive if Maine hopes to recruit primary care, particularly family practice physicians, to underserved areas within the State.

RECRUITMENT AND RETENTION

Any possible solutions to addressing the need for physicians must utilize an integrated approach. There are many complex issues related to the recruitment of physicians to Maine. Solutions will not come about by examining any single aspect of the problem but rather by encouraging more Maine students to enter medical education, providing financial support, utilizing existing educational systems during the medical school experience to place students in rural practices, and by building systems that support the recruitment and retention of primary care providers in underserved areas throughout the State.

The Advisory Committee makes the following specific recommendations related to recruitment.

1. Expand the areas designated as underserved.

The Department of Human Services (DHS) has responsibility for designating underserved areas. DHS presently utilizes federal criteria for evaluating Health Personnel Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) which are very restrictive. A federal HPSA designation is used to identify areas which have health provider shortages while the federal MUA designation identifies areas which are eligible for federal funds.

The Commissioner of DHS also may designate MUAs according to less restrictive criteria which can be defined by the State. A State MUA is designated for purposes of identifying areas eligible Contact or Osteopathic Loan forgiveness. An area may be designated as a Medically Underserved Area on the basis of geographic location or because a specific population group in a given area is experiencing barriers to receiving primary care. For example, a population group may experience ethnic, cultural, economic or language barriers which prevent them from receiving health care. A specialty may also be designated as underserved in a specified geographic area (e.g. psychiatry, dentistry, emergency medicine). However, most MUA's are designated because they are underserved by primary care providers, especially family practitioners.

It is recommended that the State be re-assessed to determine underservice to both rural areas and other more urban areas using the less restrictive criteria established by the State for MUA's.

2. Continue to provide financial assistance to Maine students and forgiveness of the loan provided through FAME for primary care physicians practicing in underserved areas of Maine.

If Maine hopes to recruit and retain primary care physicians, it is recommended that the State continue to provide financial assistance to its own medical students, then provide loan forgiveness for those students who practice in shortage areas, and expand the number of physicians benefiting from State Loan Repayment Program.

3. Expand the State Loan Repayment Program.

The State Loan Repayment Program (SLRP) utilizes repayment monies from the Contract Program to obtain federal matching funds which are used to repay the medical loans of physicians who are practicing in HPSA sites. Physicians participating in this program practice in HPSAs that have been unable to recruit primary care providers. Both family practice physicians and physician assistants are included in the loan repayment program. Rural sites are chosen which have the highest level of need. During the 1992 fiscal year, five physicians and two physician assistants will be recruited. Participants in this program are not limited to those who may have been Contract students or Osteopathic Loan students. Any board certified Family Practice physician may be recruited by the practice sites.

During 1989 and 1990, six physicians and four physician extenders were recruited. The sites benefiting from this program include: Milo, East Corinth, Dexter, Eastport, Jonesport, Eagle Lake, Harrington, Ashland, and Indian TWP.

FAME is recommending that Maine's share of the program monies be increased from $50,000 to at least $100,000; the federal matching share would also increase to $100,000.

4. Encourage educational linkage between the medical schools and existing medical education systems within the State.

The specific processes in medical education are critical to the recruitment process. The educational experiences of a medical student strongly influence his or her choice of specialty and practice location. Medical schools which have instituted curriculum changes dedicated to the creation of an increased number and percentage of primary care physicians have been successful in increasing the number of students who select primary care career tracts. The medical education of Maine students should include rotations, clerkships, and preceptorships in rural Maine to enhance the State's recruitment efforts. The probability of recruiting a student to practice in an underserved area is clearly increased by positive educational experiences and the opportunity to work with physician role models in such settings.

Cooperative relationships between the medical schools and the medical educational systems within the State are to be encouraged. A systematic effort between the medical schools and the medical education systems within the State to provide local training opportunities will increase the probability that students will select an underserved practice site in Maine. This probability is further increased for students who elect to train in a Maine residency program. Nationwide data supports this hypothesis and further indicates that more than 50% of residents who train in a region ultimately remain in that area to practice.

5. Support recruitment and retention by including rural practitioners in the educational process of Maine students.

Exposure to rural practices in Maine needs to become an integral component of the medical education of Maine students. Including rural practitioners in the educational process of students would be beneficial to both parties. The students motivate the rural practitioner and the practitioner serves as a positive role model for the student. The residency programs in Maine have the potential to provide support and assistance to physicians in rural areas. They should be encouraged to expand their role in the continuing education process and the exchange between their faculty, resident physicians and rural practitioners.

6. Support physician recruitment and retention through educational outreach programs.

FAME should support the educational activities of the existing medical educational entities in Maine by keeping Contract Program participants apprised of the educational opportunities offered by these organizations and of any innovative projects which may interest students and residents in rural or underserved practices within the State.

SUMMARY

The probability of recruiting Maine physicians back to the State is a function of many variables. Physicians make practice decisions based on criteria that include but are not limited to: family ties, geography, climate, population base, medical community, anticipated practice style, referral sources, availability of consultation, social amenities, housing, public schools, spouse's preference, career opportunities for spouse, educational debt level and potential earnings. Public policy can only modify or influence a few of the variables included in the individual physician's decision. These variables include: the medical education experience, educational debt, exposure to Maine practice areas during the educational process, attractiveness of Maine residency programs, and continuing medical education opportunities.

The Advisory Committee On Medical Education believes that the recommended revisions to the Contract Program will facilitate the recruitment of physicians to Maine, thereby increasing access to health care for Maine people.

SUMMARY OF PROPOSED CHANGES

		Present Program		Proposed Program	
		Per Yr	Total #	Per Yr	Total #
1.	Preferred Access				
	Medical Students	18	72	20	80
	Dental	2	8	---	---
	Veterinary	2	8	---	---
	Optometry	1	4	---	---
	Total Students	23	92	20	80
2.	$ Paid Directly To Institution For Capitation	$1,476,180		$ 600,000	
3.	# Of Non-Need Based Direct Loans	30 to 35		---	
4.	# Of Need Based Loans	---		60 to 75	
5.	State Loan Repayment Program	$ 50,000		$100,000	
6.	Required Rural Rotations/Preceptorships	- --		20	
7.	Loan Forgiveness Eligibility Designated Underserved Areas or Groups	*All Specialties *25% or $10,000 Per Practice Yr		*Primary Care *25% or $7,500 Per Practice Yr	
8.	Cash Repayment Required				
	*Primary Care In Maine		P + 9% Int.		P w/ 0% Int.
	*Other Specialties In Maine		P + 9% Int.		P + X % Int.
	*Out Of State Practice		P + 9% Int.		P + X % Int.

ANTICIPATED COSTS FOR REVISED PROGRAM

ACCESS TO MEDICAL EDUCATION

First year		Fourth year
$ 150,000	20 medical seats: 15 allopathic, 5 osteopathic with flexibility between the groups contingent upon available applicant pools (fee should include $ for rural clerkship/preceptorships. Other disciplines will not be eligible for this program component.	$ 600,000

NEED BASED LOAN PROGRAM

$ 125,000	Need based loans of up to $10,000 per student; 90% of available funds shall be dedicated to medical students; up to 10% shall be available to dental, veterinary, and optometry students. Eligible Maine students: individuals attending any accredited U.S. institution in any of the aforementioned disciplines are eligible to participate.	$ 500,000

STATE LOAN REPAYMENT PROGRAM

$ 100,000	Increase the amount of the state contribution to SLRP from $50,000 to $100,000, thereby increasing the federal match to $100,000.	$ 100,000

$ 375,000	Total First Year Cost (1 Class)	Total Cost For 4 Classes	$1,200,000

MEDICAL PROGRAM COSTS

PHASEOUT	Current Year	1st Year	2nd Year	3rd Year	4th Year
UVM	1,029,500	824,690	542,100	271,050	-----
Other Contract Schools	446,680	336,420	232,990	109,900	-----
Osteopathic Loan Program	155,000	90,000	55,000	15,000	-----
SLRP	50,000	-----	-----	-----	-----
Subtotal	$1,681,180	$1,251,110	$830,090	$395,950	
PHASE IN					
Access Fee	-----	$150,000	$300,000	$450,000	$600,000
Loan Program	-----	125,000	250,000	375,000	500,000
SLRP	-----	100,000	100,000	100,000	100,000
Subtotal		$375,000	$650,000	$925,000	$1,200,000
Total Program Costs	$1,681,180	$1,626,110	$1,480,090	$1,320,950	$1,200,000

MAINE DATA

ALLOPATHIC*	1988	1989	1990	1991	1990 Tuition and Fees**
Total Applicants	39	54	75	72	
Total Matriculated	26	35	34	38	
% of Attending Contract Schools	65.4%	54.3%	70.6%	50.0%	
School Matriculated					
Tufts	4	3	8	3	24,466
U Vermont	13	16	16	16	20,086
Stanford		1			
Georgetown		1			
George Washington			1		
Morehouse		1			
Chicago Medical		1			
U Chicago Pritzker	1				
Iowa	1				
Kansas		1		1	14,121
U Maryland			2		24,100
Boston U		3	2	1	
Harvard		1			
Michigan State		1			
MN/Minneapolis	1				
Dartmouth	1	2	1	2	21,350
Columbia	1				
SUNY/Brooklyn	1				
New York U	1			2	19,325
Rochester		1		1	18,225
U N Carolina		1			
Oral Roberts		1			
U Pennsylvania		1	1	1	19,040
Temple			1		
Medical Coll of Penn	1				
Brown			1		
U Texas/Houston	1				
U Washington/Seattle			1		
Northwestern				1	19,965
Johns Hopkins				2	18,405
Mayo				1	17,650
Albany				1	18,900
Cornell				1	19,300
Albert Einstein				1	19,610
E. Virginia				1	17,886
Duke				1	14,855
Hahnemann				1	20,050
Uniform Services, U Health Services				1	0
OSTEOPATHIC***					
U of NewEng. COM	9	12	14	10	16,400
Chicago COM		1			
Kirksville COM			1		
Philadelphia COM			1		

*Source for all Allopathic Data: American Association of Medical Colleges. Maine Residency is self reported and may not constitute eligibility for the Contract Program.

**Tuition and fees are listed for only those schools where entering 1991 students matriculated.

***Osteopathic Applicant Data unavailable at this time

ADVISORY COMMITTEE ON MEDICAL EDUCATION

M E M B E R S

Robert P. Smith, M.D.
Director of Medical Education
Maine Medical Center
22 Bramhall Street
Portland, ME 04102

F. Stephen Larned, M.D.
Vice President, Medical Affairs
Maine Medical Center
22 Bramhall Street
Portland, ME 04102

Shirley Weaver, Ph.D
AHEC Program
University of New England
Hills Beach Road
Biddeford, ME 04005

David DeTurk
Maine Osteopathic Association
RR #2, Box 1920
Manchester, ME 04351

Duska J. Thurston
UVM, Class of 1993
Given, Box 371
University of Vermont
Burlington, VT 05405

Douglas Thompson, Ph.D.
Department of Applied
Medical Science
University of Southern Maine
96 Falmouth Street
Portland, ME 04103

Paul D. Weston
Katahdin AHEC
Washington County
Technical College
River Road
Calais, ME 04652

Bonnie Post
Executive Director
Maine Ambulatory Care Coalition
P.O. Box 390
Manchester, ME 04351

Nancy Weingarten
Administrator, Maine-Dartmouth
Family Practice
Residency Program
21 East Chestnut Street
Augusta, ME 04330

James Raczek, M.D.
Director
Family Practice Center
417 State Street
Bangor, ME 04401

John A. LaCasse, Eng.Sc.D.
President
Medical Care Development
11 Parkwood Drive
Augusta, ME 04330

EX OFFICIO MEMBERS

David Dineen, D.V.M.
Department of Agriculture
State House Station 28
Augusta, ME 04333

Richard T. Chamberlin, M.D.
V.P. & Chief Medical Officer
Maine Blue Cross & Blue Shield
110 Free Street
Portland, ME 04101

Timothy P. Agnew
Chief Executive Officer
Finance Authority of Maine
P.O. Box 949
Augusta, ME 04330

Sophie Glidden
Office of Rural Health, DHS
State House Station 11
Augusta, ME 04333
(Nominated for Membership)

Judy Paradis
Representative
Station House Station 2
Seat 123
Augusta, ME 04333