

AN ANALYSIS OF THE PROBLEMS IN ATTRACTING
PRIMARY HEALTH PROFESSIONALS TO NORTHEAST
KANSAS

by

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CHAPTER 1

Introduction

Many obstacles stand between the citizen and the primary health care required in Northeast Kansas. Maldistribution of physicians, dentists and registered nurses complicates the fact that an increasing demand has caused shortages of these professionals. Add to this list other problem areas of health care--facilities, education, user cost, environmental standards and duplication of services--and the delivery of health services becomes complicated.

Purpose

It shall be the purpose of this project to investigate the problem of attracting the necessary primary health professionals to Northeast Kansas. The health professional has not been locating in the rural areas of Northeast Kansas. This trend has been heightened as the physicians in smaller communities approach the age of retirement. Replacement of these professionals and recruitment of others is the subject of this project. Consideration is given to the process of attraction and retention of physicians, dentists and registered nurses.

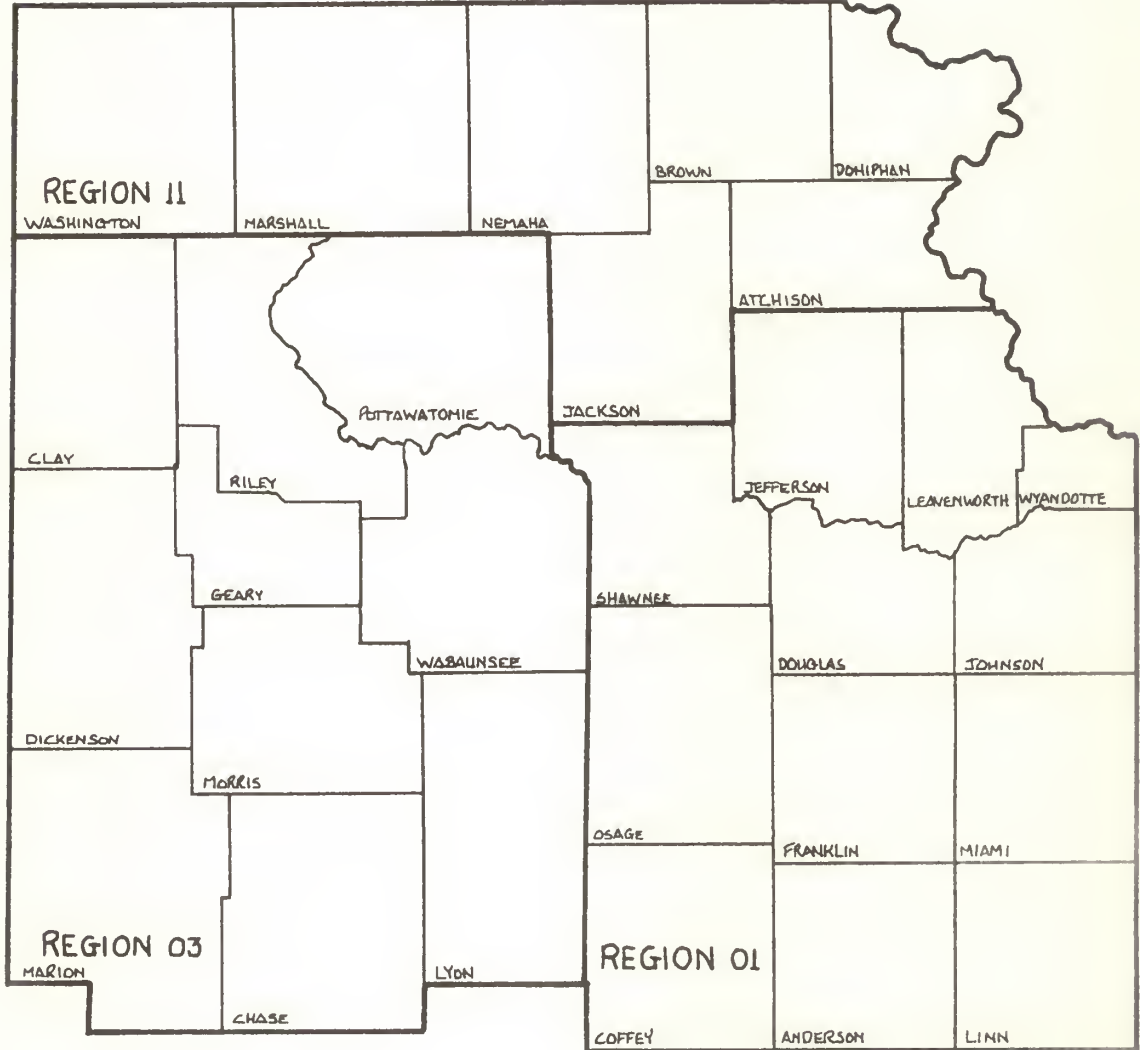
Method

The process of interviewing was chosen as best to

NORTHEAST KANSAS STUDY AREA

DELINEATED REGIONS 01, 03 & 11

MAP 0-2



understand the problems of attracting professionals to the study area. Views have been solicited through a series of interviews over a period of several months in early 1974. The interviews were of two types: one set of interviews was conducted with practicing regional health professionals. The other was to obtain statewide professional or administrative views. Twenty-three professionals and administrators were interviewed in an attempt to understand the current situation in Northeast Kansas.

Broad areas were discussed ranging from the actual process of attracting health professionals to the existing level of health care in the region. The interviews spanned both personal and professional thought on the unique situation in the study region.

Problem

Small communities in Northeast Kansas are prepared to offer substantial incomes to physicians to locate in their communities. Why? Because the townspeople either perceive a problem in health delivery in their area or they wish to use the physician as a drawing card for future city growth.

Geographical distribution of professionals are unequal by county in the study area. If these ratios are high, the citizens have a valid concern with medical coverage. Attraction or retention of professionals would then be strongly

advised.

The other possible reason for seeking a professional for a small community is to strengthen the economic character of the town. The economic stability and its attractiveness to investors is tied into the community's (or region's) ability to provide medical care for its citizens. Community leaders have a serious concern for economic well-being and therefore are concerned with medical and dental care for the labor market area.

Professionals are being recruited actively by small community leaders. A problem has arisen since these professionals have not felt smaller communities offered enough to relocate. The various reasons cited by professionals for not wishing to locate in a semi-rural or rural area will be listed in an attempt to open avenues for solution.

Current Situation

The unique situation in Northeast Kansas stems from the blend of urban, semi-rural and rural development existing in the various regions. Specific attention will be directed to the population patterns in Chapter 2 of this report. Generally, however, the situation may be described as one of grand contrast. Containing some of the largest cities in Kansas (Kansas City, Topeka, Overland Park, Lawrence and Manhattan), the area also has sparsely populated

counties.

Measures of population are at the base of most planning decisions. They determine the level of demand for future services and serve as the present indicator or regional imbalance. With this uneven population distribution, health care distribution remains a problem for the citizen of Kansas.

To mirror some of Northeast Kansas' problems in attaining adequate primary health coverage, a simple discussion should be undertaken. Health services are preferably consumed locally--that is to say that the distance that the consumer prefers to travel to arrive at these services is not very far. But, professionals and their clinics cannot be as numerous and well-distributed as supermarkets. The increased demand for these health services has grown not only with population but with changing consumer preference in types of health care. In short, as will be seen in later chapters, primary health professionals are not equally accessible to citizens of the study area.

Professional Roles

To allow the reader greater understanding of current medical care, various health professionals and their roles will be discussed. Ambiguity in the roles of several professionals and para-professionals has resulted in some

misunderstanding within the general public.

While most people will readily understand a medical doctor's, a dentist's or a registered nurse's role in health care, other lesser known roles exist. The Doctor of Osteopathy (D.O.), the Nurse Clinician and the Physician's Assistant are professionals who can be very useful to small community health care. Yet, these same roles are little understood or misunderstood by many individuals. In one case, that of the registered nurse, a bill was before the 1974 Kansas Senate (S.B. 935) to clarify the roles of these health workers.

The role of the medical doctor is in diagnosis and prescription. The M.D. (as with the D.O.) diagnoses illnesses and prescribes treatment by means of drugs or surgery. The doctor of osteopathy is a physician trained under a different philosophy of medical practice. However, training of D.O.'s for the particular role of family practitioner or general practitioner has interest to rural areas. The professional image and role of the D.O. has changed rapidly along with their usefulness to small communities.

The dentist or doctor of dental surgery (D.D.S.) is specially trained to prevent and treat diseases and malformations of the teeth, gums and oral cavity. The dentist is specialized so that little overlap with other professionals exists.

The area of the registered nurse and allied fields will lead to the largest problems in definition of roles. A registered nurse may be considered as such (R.N.) or as a Physician's Assistant (P.A.) or as a Nurse Clinician or as a Nurse Practitioner. Each will be considered:

- 1) In 1970 the American Medical Association Board of Trustees defined the P.A. as "a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."
- 2) The American Nurses' Association has defined the Nurse Practitioner as a nurse who has acquired increased knowledge and clinical experience leading to an expanded role including, but not limited to: a) obtaining a health history, b) assessing health-illness status, c) entering a person into the health care system.
- 3) The Department of Nursing Education, KUMC, defines a Nurse Clinician as functioning in an expanded role using cues obtained from physical assessments, health history taking, and knowledge of the natural and behavioral sciences. Each nurse clinician student would select an area of study in one of four clinical areas: community health, maternal-

child, medical-surgical or mental health.

What may be apparent is the understanding that each of these definitions are discussing the same role. In effect, they are all moving in the same direction, i.e. expanding the role of the registered nurse or trained para-professional.

Friction is visible in the area of redefinition of any role that might conflict with the physician. Senate Bill 935 was an attempt in the 1974 Legislature to sponsor a measure to expand the scope of nursing along with several other statutory changes. Testimony by the proponents of the bill failed to override objections by other professional organizations and the Legislature.

CHAPTER 2

Regional Characteristics

Study Area

The study area of this project includes Kansas Delineated Regions 01, 03, and 11 as defined by the Kansas Department of Economic Development in 1967 (see Maps 0-1 and 0-2). These three regions can generally be said to compose Northeast Kansas. The study area holds approximately one-half of the population and one-fourth of the total number of counties in the State of Kansas.

The study area has a diverse economic base ranging from agricultural/agribusiness to highly urbanized service and manufacturing industries. Kansas City and its outlying suburban cities serve as the cultural and economic magnet of the study area. Topeka, the State Capitol, is the governmental hub of the area. Lawrence and Manhattan are both sites of major state universities which include research facilities.

The Kansas River flows directly through the center of the three delineated regions on the east-west axis. This river is the basis for settlement and transportation routes within the study area. Historically, the Kansas River was convenient for trade and travel and it has left its heritage long after the waterway's importance diminished.

Urban growth has occurred primarily on the Kansas River with Kansas City, Lawrence, Topeka and Manhattan located directly along the river. Several other cities are located in the vicinity of this major tributary of the Missouri River system. If the river is considered the growth corridor of the area, one can begin to understand the population distribution pattern of the three regions (see Maps 2-1, 2-1(a) and 2-1(b)).

It may generally be stated that as one moves away from the Kansas River Valley, one will find declining population. The urban centers have tended to locate on the river and the population living in the area has generated several important Kansas centers. The State Capitol, two major state universities and the second through the fifth largest cities in Kansas are located along the river.

Population

Region 01

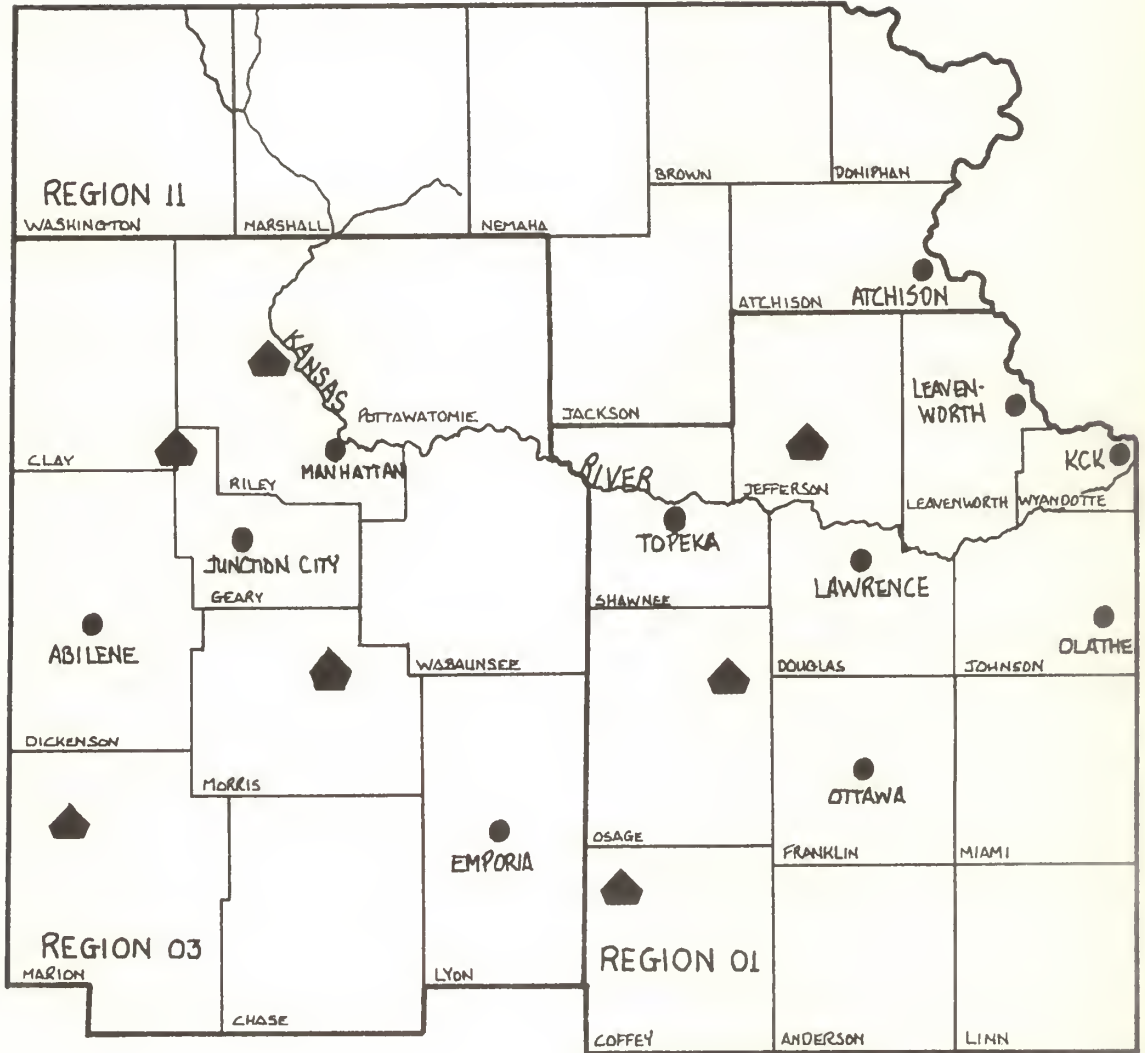
Primarily the most urban of the regions, East Central Region 01 is a study in contrasts. The northern one-half of the region has a well-developed economy, culture and recreation base. The southern tier of counties remains less-populated and more agriculture oriented. For a reference line, US-56 Highway seems to be a good dividing line for growth patterns in this region.

NORTHEAST KANSAS STUDY AREA

REGIONAL SETTLEMENT & RECREATION

14

MAP 2-1(b)



LEGEND: ● REGIONAL CITY
◆ REGIONAL WATER AND
OUTDOOR RECREATION AREA

SOURCE: REGIONAL REVIEW FOR PLANNING IN KANSAS
KANSAS DEPARTMENT OF ECONOMIC DEVELOPMENT, 1967

Major cities in this region are Kansas City, Topeka, Overland Park, Lawrence, Leavenworth, Olathe and Ottawa. These six cities alone make up nearly sixty percent of the region's population.

Looking at Table 2-1, the more urban counties of Douglas, Johnson, Leavenworth, Shawnee and Wyandotte all registered substantial net changes in both the past decades. Migration and natural increase (births minus deaths) have played differing roles in the overall regional population change, but it would seem safe to estimate that in-migration has been the key to area growth.

Future population growth for the region should occur. This increase will place further demands on the health delivery system and may force increasing maldistribution of services and professionals.

Region 03

The Flint Hills Region 03 is named for its outstanding topographical feature--the rolling hills. The Flint Hills are best known for the excellent qualities of the grasslands. The pasturing and feeding of beef cattle on the hills has allowed over one-half of the region's land to remain in grassland.

Population growth in the region has been positive in absolute terms; yet, the growth had been extremely concen-

Northeast Kansas Study Area
Components of Population Change, 1950-1970
By County and Region

Table 2-1

Region or County	1950 to 1960			1960 to 1970		
	Net Change	Natural Increase	Net Migration	Net Change	Natural Increase	Net Migration
Region 01	147,884	96,093	51,791	109,639	79,162	30,477
Anderson	-1,232	834	-2,066	-534	245	-779
Coffey	-2,005	282	-2,287	-1,006	214	-792
Douglas	9,634	5,522	4,112	14,212	5,252	8,960
Franklin	-380	1,452	-1,832	459	659	-200
Jefferson	168	819	-651	693	476	217
Johnson	81,009	22,987	58,022	76,281	23,924	52,357
Leavenworth	6,163	5,148	1,015	4,816	3,822	994
Linn	-1,779	269	-2,048	-504	-336	-168
Miami	186	1,480	-1,294	-630	596	-1,226
Osage	75	834	-759	466	249	217
Shawnee	35,868	24,173	11,695	14,036	20,693	-6,657
Wyandotte	20,177	32,293	-12,116	1,350	23,796	-22,446
Region 03	11,211	25,774	-14,563	13,851	17,641	-3,790
Chase	-910	293	-1,203	-513	7	-520
Clay	-1,022	629	-1,651	-785	-70	-715
Dickenson	382	2,310	-1,928	-1,579	580	-2,159
Geary	7,108	7,959	851	-668	7,837	-8,505
Lyon	352	2,730	-2,378	5,143	2,116	3,027
Marion	-1,164	1,496	-2,660	-1,208	326	-1,534
Morris	-1,093	614	-1,707	-960	41	-1,001
Pottawatomie	-387	1,063	-1,450	-202	355	-557
Riley	8,509	8,209	300	14,874	6,419	8,455
Wabaunsee	-564	471	-1,035	-251	30	-281
Region 11	-9,744	8,056	-17,800	-8,732	2,020	-10,752
Atchison	-598	1,994	-2,592	-1,733	986	-2,719
Brown	-1,422	835	-2,257	-1,544	-92	-1,452
Doniphan	-925	853	-1,778	-467	489	-956
Jackson	-789	702	-1,491	33	81	-48
Marshall	-2,328	1,223	-3,551	-2,459	-105	-2,354
Nemaha	-1,444	1,665	-3,109	-1,072	602	-1,674
Washington	-2,238	784	-3,022	-1,490	59	-1,549
Kansas	271,070	314,685	-43,615	70,460	200,933	-130,473

Source: Kansas Statistical Abstract, 1972 pp. 9-11.

trated on certain cities. Table 2-1 illustrates the fact that Manhattan and Emporia located in Riley and Lyon Counties, respectively, are the only consistent growth centers in the region. All of the other counties show an absolute decline in population from 1960 to 1970. The prime reason is out-migration of semi-rural and rural inhabitants. The population either migrates to a larger city in Kansas or out-of-state.

Rural out-migration remains a problem in bidding for the services of health professionals. The smaller population centers are finding difficulty in attracting services to an area in decline. The two cities that have made absolute increases in population are also the sites of Kansas State University and Emporia State Teachers' College. The one county in relative flux (Geary) is also the site of a large military post--Ft. Riley. Department of Defense manpower requirements dictate the population changes in this county.

Region 11

Northeast Kansas Region 11 is a humid agricultural area composed of seven counties. The region is predominantly rural with the only population concentration in the far eastern areas.

The cities are dispersed and small in comparison to the remainder of the study area in Northeast Kansas. The

population has been in decline for several decades as indicated by Table 2-1. The trend goes back farther than these two decades. Population loss from this region reaches back to the 1940's. Atchison is the only larger city within the region and contains less population today than in 1900 or any subsequent year.

Distribution of the population is uneven. Most of the regional population is on the eastern and southern edges of the area. As one approaches the western edge and the Nebraska border, the population thins considerably.

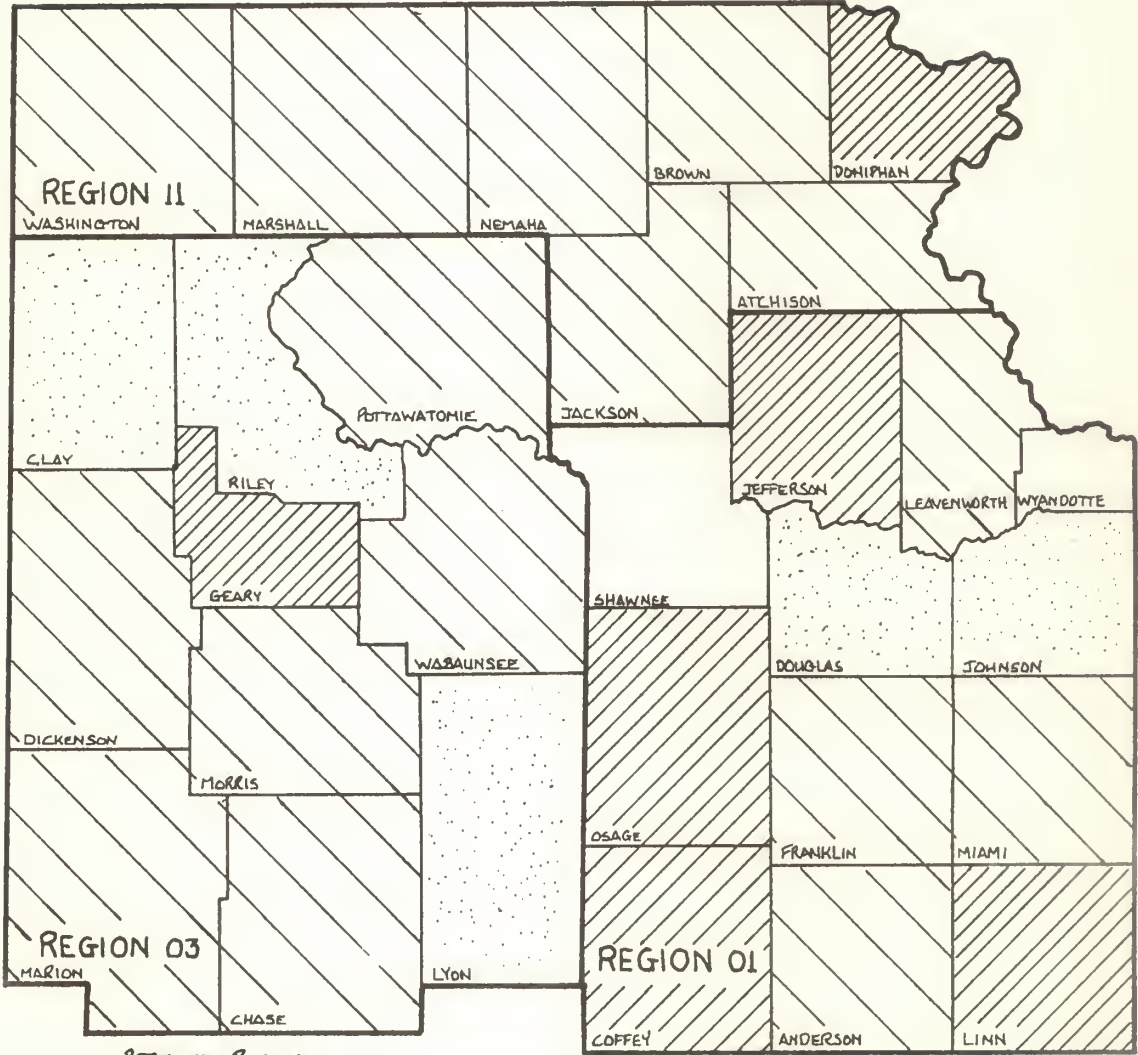
The sparse and uneven population again plays a determining role in the ease of access to health facilities and the comparative advantage of the region in attracting any professionals.

Health Professionals and Facilities

The distribution of professionals and facilities throughout the study area is unequal. To demonstrate this phenomenon, several maps have been prepared from a variety of sources. Medical doctors, doctors of osteopathy, dentists and registered nurses will be aggregated by county either through maps or tables provided in this study. Hospital facilities and number of admissions by county and region are also displayed. Care should be taken in reading those maps and tables as they graphically display the distribution of

NORTHEAST KANSAS STUDY AREA
 RATIO OF MEDICAL DOCTORS TO PATIENTS
 BY COUNTY & REGION

MAP 2-2



REGIONAL RATIOS

REGION 01	1:1021
REGION 03	1:1436
REGION 11	1:1798

LEGEND: M.D. to PATIENT

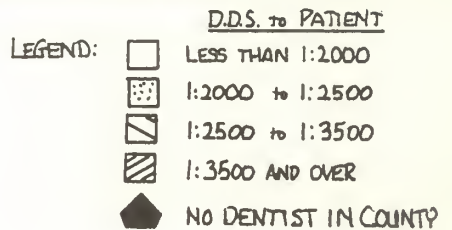
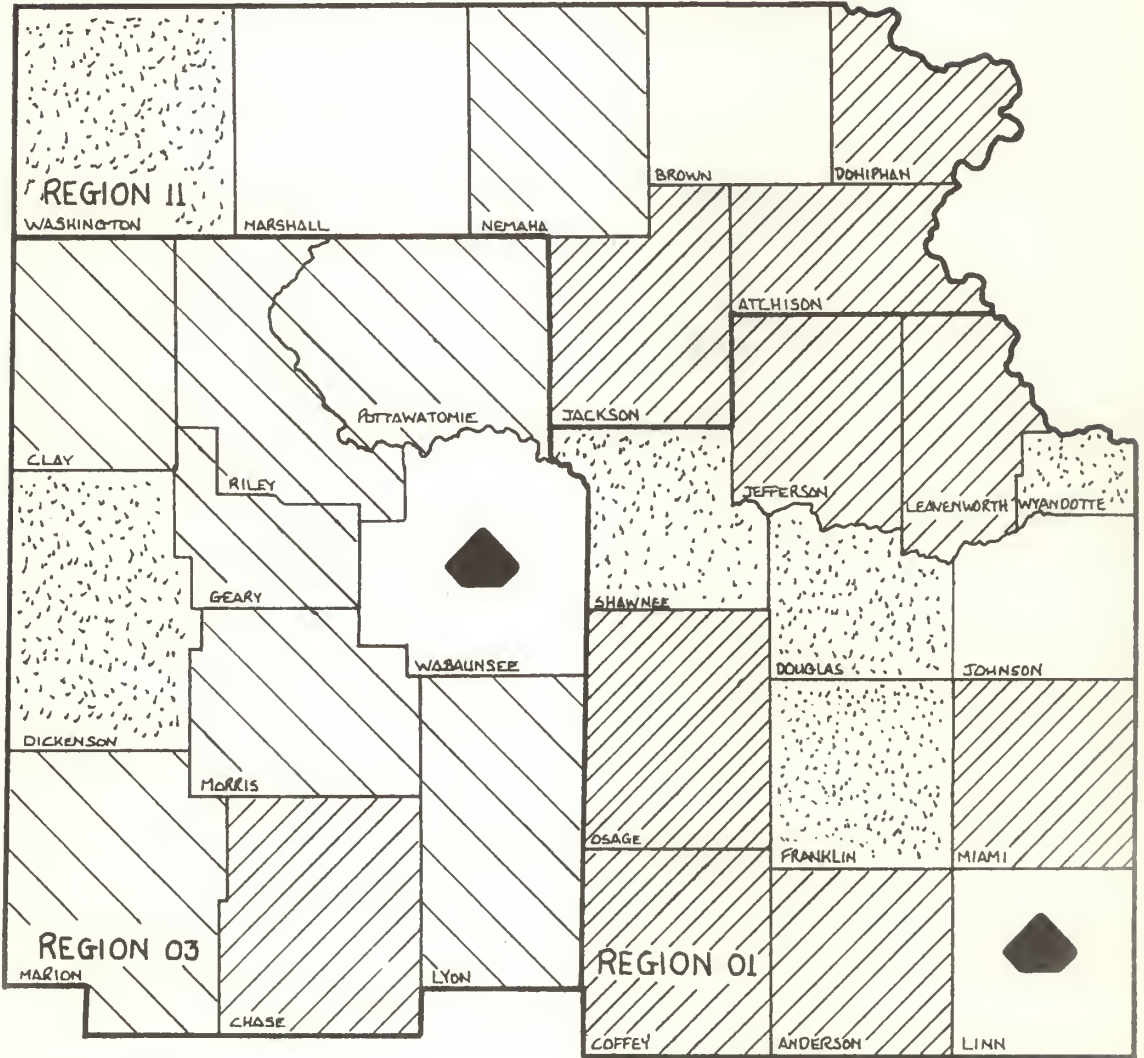
	LESS THAN 1:750
	1:750 TO 1:1,500
	1:1,500 TO 1:3,000
	1:3,000 AND OVER

SOURCE: KANSAS HEALTH DEPARTMENT
 OZARKS PLANNING PROJECT

NORTHEAST KANSAS STUDY AREA

RATIO OF DENTISTS TO PATIENTS BY COUNTY & REGION

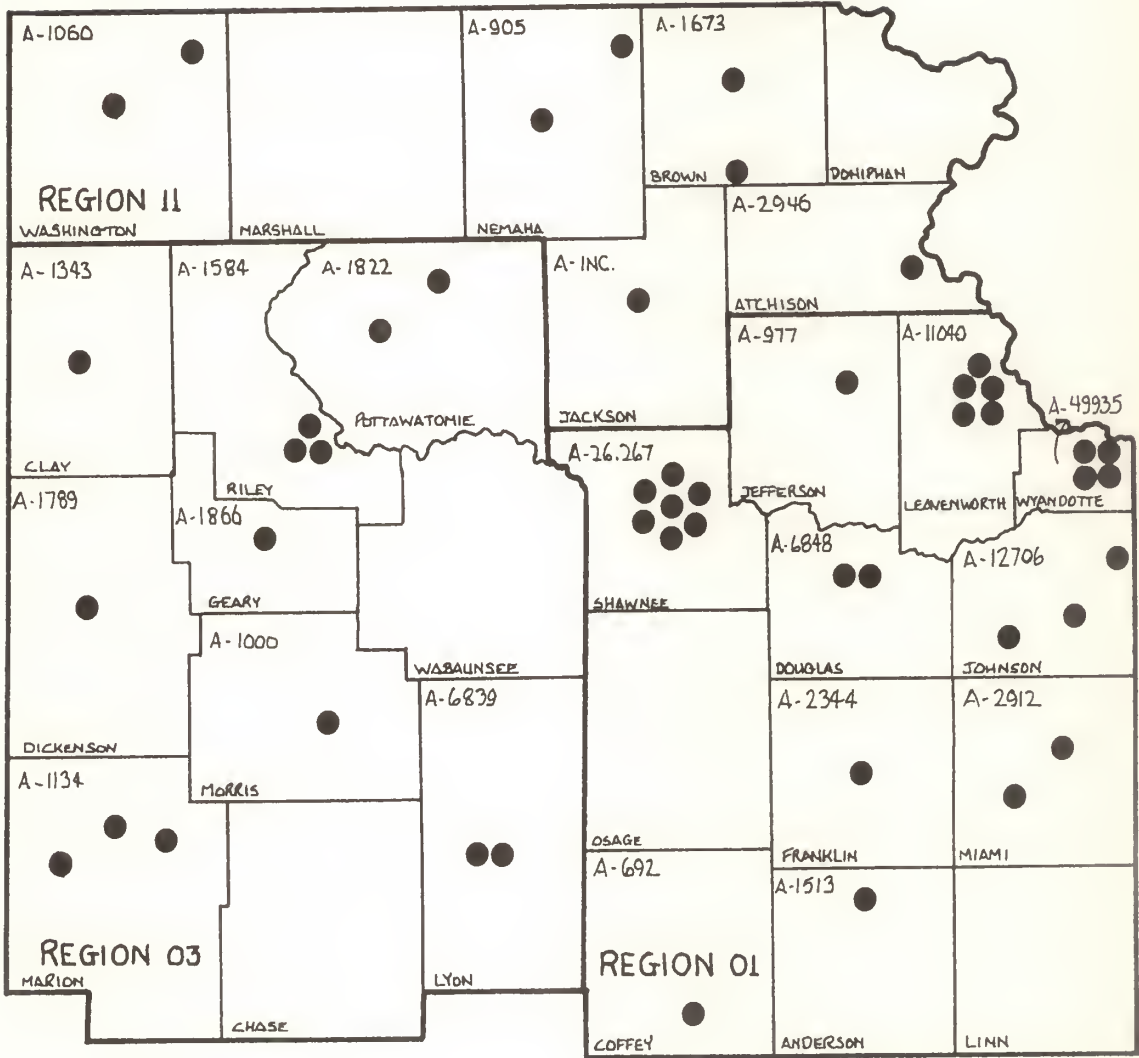
MAP 2-3



NORTHEAST KANSAS STUDY AREA

HOSPITAL FACILITIES/ADMISSIONS, 1971

MAP 2-4



LEGEND: ● - HOSPITAL
 A - NUMBER OF ADMISSIONS BY COUNTY

SOURCE: KANSAS STATISTICAL ABSTRACT, 1972.
 pp. 35,36,38.

health services and professionals in Northeast Kansas. Maps 2-1, 2-2, 2-3 and Tables 2-1 and 2-2 depict the recent situation in the study area.

In Table 2-2, Health Manpower Profile of Physicians and Dentists, Region 01 is shown to have the vast majority of these professionals. Even though this is the most populous region, the ratios of M.D.'s to population reveal that the rate of M.D.'s is also best in this region. Dentists have also settled in this region with Johnson County having a disproportionately large amount. This may be attributed to a larger population of specialists along with differing dental health care patterns in Johnson County.

In region 03 the average age of the M.D. is sixty years. While this will not be critical for the next five years, any time after that might produce a severe shortage of the M.D.'s due to retirement or death.

Region 11 approaches a critical M.D. to patient ratio. One favorable aspect of this region is the relatively lower age of their medical doctors. Dentists seem to be evenly distributed with relation to geographical distance.

Table 2-3, Health Manpower Profile of Registered Nurses, is a simple chart of the distribution of nurses within the employment sectors. There are no startling facts to be gathered from this table; but, several items are worthy of notice. The heavy pattern of government employment (Hospital,

Northeast Kansas Study Area
Health Manpower Profile
Physicians and Dentists

Table 2-2

Region or County	# M.D.	Ave. Age	# 60+	Ratio M.D.:Pop	# D.O.	Ave. Age	# 60+	# D.D.S.
Region 01	727	54	138	1:1021	60	59	20	343
Anderson	5	46	0	1:1700	1	59	0	2
Coffey	1	82	1	1:7397	2	48	1	1
Douglas	46	52	10	1:1259	3	45	0	25
Franklin	12	53	4	1:1667	3	59	2	9
Jefferson	3	60	2	1:3982	1	80	1	3
Johnson	155	48	21	1:1404	29	51	8	131
Leavenworth	29	54	10	1:1561	3	57	1	11
Linn	1	43	0	1:7770	1	70	1	0
Miami	9	53	2	1:2139	1	79	1	5
Osage	3	56	1	1:5551	0	0	0	3
Shawnee	206	52	45	1: 712	5	42	1	72
Wyandotte	257	49	42	1: 727	11	56	4	81
Region 03	116	60	42	1:1436	10	66	8	61
Chase	2	72	1	1:1704	0	0	0	1
Clay	7	58	3	1:1413	1	79	1	4
Dickenson	12	57	6	1:1666	3	57	2	10
Geary	7	66	3	1:3042	2	46	0	7
Lyon	29	52	8	1:1106	1	74	1	12
Marion	11	63	6	1:1267	1	73	1	6
Morris	3	49	0	1:2144	2	67	1	2
Pottawatomie	9	54	3	1:1306	0	0	0	4
Riley	33	53	9	1:1254	0	0	0	15
Wabaunsee	3	76	3	1:2132	0	0	0	0
Region 11	47	54	23	1:1798	4	68	4	28
Atchison	15	59	9	1:1278	1	76	1	4
Brown	6	55	3	1:1948	0	0	0	4
Doniphan	3	46	0	1:3036	0	0	0	1
Jackson	4	56	2	1:2586	1	66	1	3
Marshall	8	54	2	1:1642	1	65	1	8
Nemaha	6	62	5	1:1971	1	64	1	4
Washington	5	48	2	1:1850	0	0	0	4

Source: Kansas Department of Health
Ozarks Planning Project, 1974.

Northeast Kansas Study Area
Health Manpower Profile
Registered Nurses

Table 2-3

Region or County	# of R.N.'s	Place of Work					
		Hosp. & Instit.	Health Depts.	School	Nursing Home	Doctor's Office	Other
Region 01	3,761	1,850	143	134	142	243	1249
Anderson	33	15	1	1	3	3	10
Coffey	20	9	1	0	0	1	9
Douglas	248	127	3	9	6	21	82
Franklin	65	26	3	4	6	3	23
Jefferson	59	31	6	1	3	0	18
Johnson	1,137	480	30	68	36	87	436
Leavenworth	225	121	7	4	9	13	71
Linn	17	5	1	1	3	3	4
Miami	59	39	0	1	4	0	15
Osage	31	14	4	0	6	2	5
Shawnee	1,098	555	61	22	49	67	344
Wyandotte	769	428	26	23	17	43	232
Region 03	797	362	17	27	63	60	268
Chase	9	4	0	2	1	0	2
Clay	52	18	1	1	4	6	22
Dickenson	90	35	1	3	12	8	31
Geary	77	39	4	4	2	2	26
Lyon	164	79	2	7	4	11	61
Marion	73	33	2	2	11	5	20
Morris	20	7	1	0	1	2	9
Pottawatomie	57	25	1	2	6	8	15
Riley	223	113	4	5	14	16	71
Wabaunsee	32	9	1	1	8	2	11
Region 11	329	160	8	14	20	11	116
Atchison	86	45	2	4	4	0	31
Brown	50	25	2	1	2	2	18
Doniphan	21	4	0	2	2	3	10
Jackson	26	15	3	0	0	0	8
Marshall	51	23	0	2	4	3	19
Nemaha	65	28	0	4	3	3	27
Washington	30	20	1	1	5	0	3

Source: Kansas Department of Health
Ozarks Planning Project, 1974.

Institutional, Health Department, School) reflects the concentration of the State and Federal government facilities in Northeast Kansas. In addition, the column "Other" in Region 01 is disproportionately large. This may be accounted for in the realization that many of these are females who are trained for that occupation and are not practicing. Child-rearing and early marriage responsibilities can withhold the potential nurse from the labor market and community service.

Health care and delivery of services is a point of concern to Kansans and comments made in the past are relevant to this study. The comments listed below should be read in context with the tables and maps on the preceeding pages. In a publication prepared for the Kansas Legislative Council in 1967, general statements were made on the existing level of health care. These comments were based on selected indicators of health status:¹

Region 01

Characteristics of Region 01 indicate that it is the most urban of all regions, has a younger and more affluent population than most other regions and has favorable

¹Kansas Legislative Council, A Plan For The Development of Health Resources--State of Kansas, vol. III--Appendices, Topeka: State Printers Office, 1967. pp. 8-30.

health resources. The hospitals of Region 01 are generally larger than most in Kansas and appear to be utilized effectively. Although morbidity and mortality rates for this region are generally low, the incidence of a few diseases is high.

Region 03

Region 03 appears to be an average region in Kansas. Although the population of Region 03 is on the decrease, the socio-economic indicators compare favorably with other regions. Health manpower resources are generally low compared with other regions of the state. Availability and use of health service facilities compares favorably with other regions.

Region 11

The population is slowly decreasing in size; the death rate and median age are relatively high. The level of education and the average income are low and the welfare recipient rate is high. The number of doctors and nurses per 100,000 population is lower than for most regions and the health facilities are lacking in most areas (except psychiatric in-patient care).

CHAPTER 3

Trends in Medical EducationOverview

The American health care system is the subject of criticism. It encompasses the high and steeply rising cost of medical treatment, the inequality of care, the use of inadequate facilities and the critical shortage of primary health professionals. A shortage of these professionals would be a serious impediment to any effort designed to improve the delivery of essential care; it would also be that aspect of the problem most easily solved. Existing medical education facilities could be expanded, completely new ones established, or the curriculum modified. However, large amounts of money, administrative and planning effort would be expended. Opportunity costs in other areas would be high. It is, therefore, essential to examine the idea that a mere increase in production will alleviate the problem.

Medical education in the United States has been the finest available training for the production of medical and dental professionals on a large scale. This system of education has come under stern attack in the area of primary health care:

"there are some notable problems in medical education, some major failures in medical training which require satisfactory investigation. Medical education is, to borrow the phrase I used earlier, characterized by an 'iron man in wooden ships' attitude. We train physicians as highly responsible, individually capable, solo operators. Although the concept of a health-team approach to health care has received generous discussion, medical education in most institutions would not implement it. Nor are the medical schools sufficiently involved as yet in needed research and experimentation in this area. What can the nurse do and not do? What is the appropriate role of the social worker, the rehabilitation counselor, the community health aide? What other health workers are needed? How do they relate to the physician and the physician to them? How might they all best interrelate for optimal provision of health care?

"Medical education has failed to give sufficient priority to the training of primary physicians. Clinical training is largely centered on acute care in university hospitals and large municipal hospital wards, with heavy emphasis on the functions of the subspecialist. I am not so sure that ward rounds are the best way to teach health care. Distinctly insufficient attention is given to preventive care, the tasks of health care promotion, the complex problems of chronic illness management and secondary prevention and rehabilitation. Nor is sufficient research effort currently directed toward attaining the greater skills and knowledge needed in these areas."¹

Stages of Health Care Development

The overall development of health care can be seen in five distinct stages:² indigenous medicine; medicine for the elite; mass medicine; increase in professionals; and progress

¹Dr. David Werdegar, M.D., University of California, from Reform Of Medical Education, Peter G. Condliffe and Arthur H. Furnia (eds.), Washington: Government Printing Office, 1970. pp. 34-35.

²Carl E. Taylor, M.D., D.P.H., "Pertinent But Neglected Considerations", Journal of the American Medical Association, vol. 201, no. 11, (Sept. 11, 1967).

to higher quality. Examination of this process will ease the understanding of the dilemma of medical education in the United States.

--the first stage of development is the indigenous practice of medicine by faith healers, witch doctors, herbalists and such. It must be remembered that there was and still is unmet demand for the unscientific "approach" to primary health.

--the second stage is the practice of medicine for the elite. The social and political elite can afford to purchase first-class medical care. This stage is seen in the colonial governments and emerging nations at this time.

--the third stage is the beginning of mass medical care with regard to preventive procedures. Mass immunization, sanitation and environmental controls are early targets.

--the fourth stage is a rapid increase in health professionals to meet the newly found "demand" for health care due to mass education. This quantity-oriented stage can stretch the faculties of teaching institutions thin and lead to a crisis in quality.

--the last stage is a progressive shift to higher quality in professional training. Stages four and five then repeat in a quantitative-qualitative dilemma. The goal of medical education is to plan programs to keep abrupt cyclical swings to a minimum.

Dilemma

Medical education in the United States was primarily focused on training professionals of the highest quality. However, recent cries of shortages (specifically physicians) have led to a reevaluation of the numbers that could graduate from a medical school each year.

The dilemma in physician education could be summarized in the following manner: Practitioners have criticized their academic colleagues for preoccupation with research at the expense of teaching, for adhering to an inflexible curriculum, for influencing students to become ultra-specialists instead of general practitioners, and for influencing them to pursue careers in research and teaching rather than active practice. On the other hand, the academician views the practitioner as an entrepreneur with complete economic orientation, as obsolete upon graduation, and as somewhat incompetent in the diagnosis of complicated illnesses.

These arguments may have merit for the two sides, but other points must be considered. This medical system has developed excellent health care in many cities of the United States. This same system is becoming acutely aware of its social relationships to the community. This system is also trying to do something about the supply of health professionals--but is it doing enough?

National Supply Considerations

The supply of health professionals has been termed a "shortage" area by many in the United States. If the market were allowed to compensate for this shortage,

"...Specific remedies can be prescribed to cure particular types of shortages. For example, were there a shortage of expensive automobiles or yachts or hotel rooms in Acapulco (that is, if short-run demand exceeded supply), the shortage could be solved by raising the price and thus rationing demand. But health is different. Society has chosen to define health as a 'human right.' Whether those words have been translated into actions to insure the availability of adequate medical care to all is questionable at best.... In the health area the concept of shortage is, therefore, often derived from a feeling that regardless of their circumstances, individuals should have available sufficient care, though of course, the adjectives 'sufficient' or 'adequate' or 'necessary' are hard to define."³

In the final analysis the schools of medicine must react to the charges of overspecialization and underproduction in some manner. Or, there is the alternative of redefining or substituting medical services.

Health services do not necessarily mean physician's or dentist's services. And, today's physicians' or dentists' services need not be the same as tomorrow's. If history repeats, services offered by doctors today will be offered by other professionals in the future. In a

³Rashi Fein, PhD., "An Economist's View", Journal of the American Medical Association, vol. 201, no. 11, (Sept. 11, 1967). p. 171.

stricter economic sense, it would seem that a skilled-craft (medical) industry is on the verge of publicly moving to mass production in the United States. To accomplish this task, a more rational division of labor must be accomplished. The redefinition of the roles of physicians, dentists and registered nurses will be imperative in this resolution.

Kansas

Health professionals are trained in several institutions in Kansas. The Kansas University Medical Center (KUMC) is the leader in comprehensive health training in Kansas. KUMC is located in Kansas City, Kansas, on the eastern edge of the study area. Over 1,770 students each year gain experience in the 530-bed hospital.

The medical school is a part of this large complex. The school graduates classes of 100 to 125 medical doctors annually. The total fall enrollment in the medical school is 580. The size of this teaching hospital is shown in the fact that there are 20,000 admissions per year, along with 245,000 out-patient visits annually. An expansion to an 800-bed facility is planned.⁴

The doctor of osteopathy receives training at one of seven major educational facilities in the United States.

⁴Office of Informational Services, Kansas University Medical Center, "Facts and Figures About The University of Kansas Medical Center", February, 1974 (Revised). p. 2.

Kansas and the Midwest are fortunate in having one of these schools of osteopathic medicine located in Kansas City, Missouri. The facility graduates in excess of 100 doctors annually.

Wichita State University offers a clinical extension of KUMC medical school. This program was instituted at the beginning of 1974 with fifteen students. The areas of specialization are no different than the parent school; however, the emphasis is on family practice. Family practice is encouraged with relief to the smaller cities a major concern. A community-based program is envisioned for Kansas cities in the future.

A school of dentistry is not available to the Kansas residents in-state; however, a reciprocal arrangement between other states and Kansas allows the Kansas students to attend dental school. Many Kansans attend the University of Missouri Dental School and Missouri students attend Kansas and Kansas State University's Schools of Architecture. Under the agreement, approximately 35 to 40 Kansans are accepted yearly into the Dental School.

Registered Nurses are trained in several locations in Kansas, too numerous to mention separately. Most major hospitals in the larger population centers provide training in addition to the university-based programs.

Education of health professionals in Kansas is by no means excessive. Yet, the point may not be how many health professionals the state trains yearly, but how many the state retains. With a graduating class of 117, the KUMC Medical School alumni count rose only 14 last year (from 1,254 on January 1, 1973 to 1,268 on January 1, 1974).⁵ On the other hand, approximately one-third of the total graduates since 1906 practice in Kansas (1,268 of 3,852 living graduates).

Student Loan Programs

The federal government recognized shortage in Kansas within Section 741(f) of the Public Health Service Act. This section allows the partial or complete cancellation of student loans for schooling made prior to November 18, 1971. The cancellation depends on the length of stay in the shortage area. A map is provided detailing the counties in Kansas experiencing the shortage of physicians and dentists (see Map 3-1). Normally, 50 percent of the loan would be cancelled at the rate of ten percent per year of practice in the designated area. If the area is characterized

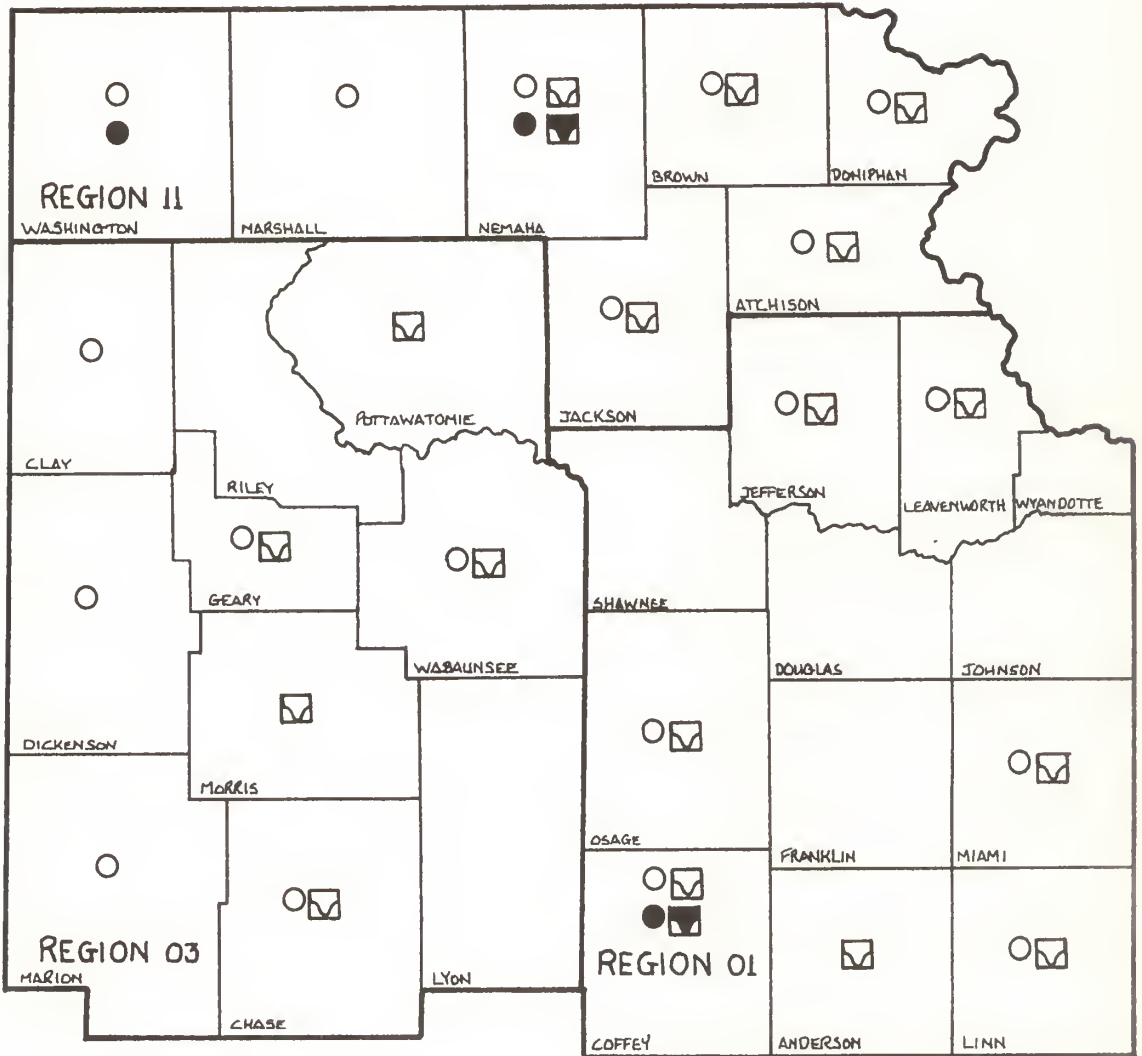
⁵Office of Informational Services, Kansas University Medical Center, extracted from a "Geographical Survey of Graduates of the University of Kansas School of Medicine." January 1, 1974.

NORTHEAST KANSAS STUDY AREA

PHYSICIAN & DENTIST SHORTAGE COUNTIES - JULY, 1973.

FOR PURPOSES OF STUDENT LOAN CANCELLATION

MAP 3-1



- SHORTAGE AREA
- LEGEND: ○ PHYSICIAN
 ◻ DENTIST
 ● RURAL PHYSICIAN } LOW INCOME
 ◻ RURAL DENTIST }

SOURCE: PUBLIC SERVICES ACT (HEALTH)
 SEC 741 (f)
 DEPARTMENT OF HEALTH, EDUCATION & WELFARE

by a rural, low-income base, the loans would be absolutely cancelled at a rate of 15 percent per year.

The Kansas Legislature confronted a similar issue in SB 268 (1971 session) by reviewing the problem in subcommittee. The bill was reported unfavorably. The bill was designed to provide scholarships and loans (not to exceed \$5,000/year/student) to encourage rural medical practice. Rural was defined as a county population of less than 7,000 persons.

A survey of third and fourth year medical students at KUMC with regard to S.B. 268 demonstrated that the persons who would take advantage of the bill were already planning to practice in Kansas. Also, it was felt to be inconsistent that the period of contractual service would be the same for each student regardless of the amount of money received. Because of these facts and survey of other states who have enacted laws similar to this, "SB 268, though a laudable effort, simply cannot, in its present form, reduce the physician shortage in rural Kansas."⁶

Future

Recognizing the urgency for the recruitment of more professionals in rural and low-income areas is not necessarily limiting a solution to the increase in production of

⁶State of Kansas, extracted from Reports and Recommendations, Kansas Legislature, Topeka: State Printers Office, 1971. pp. 156-159.

professionals. Maldistribution and misuse of primary health workers can be a large problem area. Medical education cannot dictate geographical preference in student location.

The medical schools can help in several ways: encourage the maximum number of students to enroll in their program, train generalists as well as specialists, allow student exposure to small community practice and actively involve the faculty in small community affairs. The strategy of expecting the medical school to change the graduate's choice of location by simply producing more graduates has little logic.

Beyond the description of health care given above, a new concept has entered public debate in the past several years. The system named Health Maintenance Organization (HMO) will be discussed in this section as the concept may be applicable to less populous areas.

An HMO is an organized system, including both health manpower and facilities, which takes the responsibility of providing health service to its members. A set number of persons are enrolled in a program or HMO in a formal contractual arrangement. The contract stipulates that the person shall pay a flat monthly fee for service whether the service is used or not. While similar to health insurance in the financial prepayment, an HMO provides the primary health professionals and facilities for care.

The financial payment plan is an incentive for both the enrollee and the managing organization. The enrollee is induced to contact the organization when health problems arise, not when they reach a critical stage. In other words, the enrollee should find adequate emergency and preventive treatment in an HMO. The management will be induced to work toward prevention to keep cost of care to a minimum.

In short, the HMO should provide an alternative to the present fee for service private practice health system. It will assist in cost control of medical services along with a redistribution of health services and professionals. Finally, an HMO is expected to provide incentives for health maintenance and prevention rather than a continuance of curative medicine.

CHAPTER 4

Problems in Attracting Primary Health Professionals

Primary health care is one of prevention and treatment of the common illnesses in any society. Good primary care begins with adequate professional advice and continues with preventive and curative techniques. A problem common to many sparsely populated areas is the attraction of professionals to provide the type of diagnostic health care that is demanded in the United States.

Method

One method of analyzing the situation in Northeast Kansas is to become familiar with the many different groups involved in the health delivery process. This project has elicited the views of medical doctors, dentists, registered nurses, health administrators, pharmacists, professional organizations, statewide agencies and economic development staffs. The appendix lists the respondents in alphabetical order.

Comments by the interviewees were taken during the months of January, February and March, 1974. In virtually all cases the interviews were conducted at the office of the interviewee. Interviews were scheduled for fifteen minutes but the subject matter allowed discussion far in

excess of this period. Very little encouragement was needed to arrange for the interviews, as the subject has currency in Northeast Kansas.

Individual comments were not taken verbatim and general views, rather than specific statements, will be used in this project. Most of the interviewee were quite candid about their situation. This project will not attempt to isolate problems peculiar to a single community.

Organization

In this study, the views of the participants are arrayed by professional blocs, i.e. medical doctor's comments are grouped together, as are state agencies, and so on. A narrative that best describes the answers of the interviewees has been included.

Questions were tailored to each individual. However, the background of each question came from several large subject-areas. The first area included personal reasons why professionals wished to remain in urban areas. The second subject-area dealt with the specific methods of attracting professionals (physicians especially) to Northeast Kansas. Another large subject was the general level of interest in attracting more professionals to Kansas.

The attempt to be quantitative in the gathering of material in this project was diminished in order to obtain

the most candid qualitative reply. The information necessary for this study could best be obtained in a free-flowing discussion that was limited only by broad subject areas. Generally, the interviewee was extremely responsive in light of the subject matter and the personal stake in the solutions of health care delivery.

Results

A point of interest was agreement in the selection of problem areas. Consistent answers were given to questions in many cases. When colleague's views were relayed to the interviewees, concurrence was the rule rather than the exception. Far from the expected results when interviewing professional thought, opinions varied little. Concern was voiced by each participant, but assessment of the problem was consistent.

In the sections that follows several of the health care professionals (Doctor of Osteopathy, Nurse Clinician and Physician's Assistant) were not interviewed specifically in relation to their roles in Kansas. In each case the professionals who were not interviewed as a group were felt to be represented by other professional views. Doctor's of Osteopathy were not contacted (though their professional organization was consulted) as the researcher felt that the D.O. and M.D. face comparable cultural and social problems.

However, the D.O. has the special problem of acceptance in some areas of Kansas. Osteopathy has maintained its emphasis on the general practitioner, while medical schools shifted to a specialized education. The schools of osteopathy hold many students who will be valuable to the primary care crisis in the United States and Kansas in particular.

The Nurse Clinician or Physician's Assistants are not numerous in Kansas, though they do exist. Legal definition is needed to point to exact duties and responsibilities. Since these roles are similar to the registered nurse, their problems (P.A. and Nurse Clinician) should be based on the nurse's reaction to the questions of the researcher. Though these professionals are trying to change their role, any change in attitude will be a long term proposition.

Physicians: The most highly trained of the health care professionals is the physician. Six physicians (all M.D.'s) were interviewed, though not all were in active practice at this time.

The first topic was "why don't physicians care to locate in small communities in Northeast Kansas?" The answers varied by physician, yet the categories could be characterized as follows:

-- the spouse or the physician may not be able to adjust to the semi-rural or rural attitudes. This category ranges from lack of cultural amenities (theaters,

galleries, museums) to recreation activities in general. Education of the children of the physician is seriously considered in locational choice. Changes in culture from super-urban to semi-rural takes life-style attitudes that have not been prevalent in the United States in the past years. However, this may be reversing due to urban complexities.

-- the active physician cannot secure relief from constant practice. When the situation of isolation in a smaller town is pondered, it may be enough to discourage any potential physician. The fact of being on-call 24 hours per day is well-known to physicians and they have obvious reasons for avoiding that situation.

A personal story of a western Kansas physician was related to this researcher several times. That physician and his spouse had to spend any free time in a motel room sixty miles from their home. The townspeople would not leave them alone and free from patient calls. The simple fact that rural physicians cannot remove themselves from their practice and secure some semblance of a private life is a major deterrent to location.

-- the isolation is felt in another way. The small community physician is deprived of professional consultation in daily practice. A newly-graduated physician may need the reinforcement of colleagues in the initial years of

active practice. Also, older physicians may be in need of the continuing education lacking in the rural setting. -- while income is contemplated in each case, this area did not seem to be the prime mover of the physician's interviewed. The consensus was that a physician could make an adequate living in almost any setting. Specific income requirements of each individual physician are common; yet, small communities could meet and probably exceed the figure, if necessary. In other words, income is an important incentive to locate--but, in and of itself, will not be pivotal. To the contrary, a physician in a rural situation reported a declining salary due to rising overhead costs. Yet, he remains.

The second question dealt with specific methods of attracting physicians to Northeast Kansas. A listing of various methods is given with a specific discussion of income guarantees:

-- the Kansas Medical Society offers a placement listing of both physicians (nationally) who are inclined to relocate and the Kansas communities actively searching for medical coverage. The service is updated continuously.

-- the University of Kansas Medical Center is actively involved in recruitment of physicians for Kansas communities. Community leaders contact the Medical Center frequently.

-- communities in Kansas either collectively or singularly promote physician recruitment. The communities differ not in their desire for a doctor, but in the approaches to the prospective physicians. Many possible combinations are seen in physician recruitment. A committee of the Chamber of Commerce devoted to recruitment is the most common arrangement. Usually, if the town has a physician, the physician spearheads the drive for other professionals.

If no formal committee is active, informal arrangements between the wealthier elements in the community are created. Personal contact and letters are most often used in approaching potential physicians. The point of any recruitment effort usually boils down to the types of inducements to be offered prospective physicians.

Guaranteed income is a standard inducement to locate. Fringe benefits are also varied and consistently are employed with the promised income. The income level has been \$30,000 to \$50,000/year guaranteed base for the Northeast Kansas study area. On the lower end of this guaranteed range, fringe benefits are more prevalent. Reduced rates on loans, major appliances, cars and homes are frequent in the location package. A construction loan or simple gift of a clinic tailored to the individual physician is often discussed.

Efforts, such as described, are not uncommon in Northeast Kansas. The citizens recognize that the physician requires an above-average income. Many debts are incurred in the lengthy medical schooling process. Most students are in financial difficulty upon graduation.

-- the final inducement to locate is provided nationally by the Public Health Service Act. As previously mentioned, student loans are cancelled at a specified rate for locating in a rural or ghetto setting. In the study area, twenty of twenty-nine counties are eligible for potential loan cancellation. Of these, Coffey County (Region 01), and Nemaha and Washington Counties (Region 11) are considered rural and low-income. These three counties qualify for total student loan cancellation, if the new physician practices approximately seven years -- fifteen percent/year is cancelled.

The last area of questions dealt with the general level of interest in attracting professionals to Northeast Kansas.

-- interest was high for physician attraction especially in the smaller towns. The issue was more economic as city size enlarged. In fact, physician recruitment was integrated into local economic development. Small communities desire a physician for development reasons as well as for increased health care.

An education process about primary health care may be going on in the smallest communities. As they find their possibilities for physician attraction limited, so are they realizing that regional facilities may take care of their most serious needs. The education is just beginning, though. Along the same lines, it was felt by the respondents that towns in the 3,000 to 5,000 population range seemed to be the smallest size that could reasonably expect to attract a doctor.

As a final statement on physician attraction, the point must be made that doctors are actively sought in Northeast Kansas. An official with the Kansas Association of Commerce and Industry made the assertion that professional recruitment rated second only to improved housing as the most frequent desire in smaller communities.

Dentists

Three dentists were interviewed in the months of February and March, 1974. Subject areas in the interviews changed slightly for their benefit. Since the physicians dealt with interpersonal and cultural problems in location, it may reasonably be assumed that dentists would share the feeling in some degree. Amenities appeal as much to dentists as physicians.

However, office hours allow a dentist more time for a private life than the small community physician.

One area of questioning was in the level of dental care offered in each local area:

- areawide care could not be accurately estimated by each interviewee because of the special and individual nature of dental care. However, each was knowledgeable about the patient/dentist ratio in his area. As an indicator of the level of care, the ratios were higher than for other areas of the United States. The consensus was that the level of care was not critical. In fact it was adequate.
- special emphasis should be placed on the pattern of dental care in Kansas. Patients do not think personal travel for dental work out of place. Since dental problems rarely pose permanently disabling injury, the dentist is viewed as a specialist in terms of availability. The situation whereby a patient will have silver filling work done locally, bridgework in a larger town, false teeth formed in a still larger city and cap-work done in Kansas City is not uncommon. Though the patient may be working under erroneous assumptions about ability, the specialized care is available. And, the patient is willing to transport himself a good distance for dental care.

The second major area of concern was the method of

attraction and the size of community that could support a dentist:

-- the first comment to be made is that dentists are not actively being recruited in Northeast Kansas to this researcher's knowledge. This was explained in a variety of ways: 1) the concentration of the smaller communities is focused on physicians and their recruitment; 2) the expense of setting up in private practice in any small community is extremely high (estimates ran between \$30,000 to \$50,000 for initial equipment and office furniture); and, 3) the competition for dentists is high from outside sources.

-- the armed services have begun lucrative programs for attraction and retention of dentists. High entrance (First Lieutenant) and quick promotion (Captain) are added to medical pay as inducements to enlist. A large bonus is offered to dentists for extended enlistment. This program is not to be taken lightly by civilian populations, as one respondent felt that next year's class would flock to the military. The general economic conditions were cited as the major reason for this situation. Another interviewee felt that military and institutional opportunities would attract the newly-graduated dental students for several years.

-- a practice of at least 1,000 patients was felt to

be necessary to economic survival. This means a population of 2,000 persons minimum with half of the population actively seeing a dentist. If the dentist has any specialty (though the D.D.S. is usually not specialized), the practice must be much larger to support the professional. -- it is interesting to note that Kansas does not offer a placement service in dentistry, in contrast to the Kansas Medical Society. Added to this is the fact that little encouragement is given to military dentists to locate in the area. It was reported that military colleagues discouraged a prospect from locating in Kansas.

Registered Nurses

Registered nurses were contacted primarily through public health offices though informal comments were taken from several office nurses. The nurse is charged with the care of patients and with following physician directions in that care. The role of the nurse is changing rapidly, though most of the pressure was felt in the larger cities and teaching institutions, not in the rural area.

Questions asked of nurses were changed, again for their benefit. Two simple subject areas were approached in the interviews:

The first area was "are there enough R.N.'s in your region?"

-- definite answers were not given to this question, but accompanying information gave many clues to the situation. Most nurses cited no critical shortages. Yet, at the same time, they felt that more nurses could be used efficiently within their areas. This apparent conflict can be explained in several ways: 1) the transient nature of registered nurses causes uncertainty in supply. Registered nurses are commonly females who are motivated to relocate by their spouses' career opportunities; 2) each R.N. could think of very few nurses who were trained and not employed in the area; 3) the salary levels are not sufficient to retain the registered nurse in the smaller community. The smaller communities rely on the labor pool created by marriage, rather than by financial assurance.

The second area discussed was the changing role of the nurse in Northeast Kansas:

-- the role of the nurse in Northeast Kansas had not changed drastically. The opportunity to change is opening in the future through the Nurse Clinician/Practitioner programs. The Nurse Clinician has not been defined in relation to responsibilities and legal position at the writing of this report. Kansas Senate Bill 935 by the Committee on Public Health and Welfare was introduced in the 1974 session of the Kansas Legislature. The

primary purpose was to amend the Kansas Statutes that pertain to the examination, licensure and regulation of nursing. The feeling among nurses seemed to run high in favor of the redefinition of the registered nurse in Kansas.

-- a Nurse Clinician can be expected to perform a variety of duties and be allowed responsibility previously reserved entirely for a physician. Though exact definition is lacking, a Nurse Clinician may perform duties short of medical diagnosis and prescription of therapeutic or corrective measures.

The role may be performed in one of two basic arrangements. The registered Nurse Clinician may work independently of any physician and refer the patient to any practicing physician for diagnosis. On the other hand, the nurse may work under the auspices of one physician. The Nurse Clinician would then perform certain tasks in conjunction with the physician (most probably in an outlying community). Several communities in Kansas have similar projects in operation. Legal definition is hopefully forthcoming.

-- a view voiced by a physician in assessing the nurses' role in relation to the M.D. or D.O. was to stress the point that decision-making is downgraded for registered nurses. Several reasons were cited and blame was laid

at no one spot however, this situation must change for the Nurse Clinician to operate in the climate accompanying changing health demands.

Statewide Agencies or Organizations

The Health Department personnel employed in Comprehensive Health Planning, the Ozarks Planning Project and the Department of Epidemiology were interviewed and were generous with their time and statistics.

The state agencies mirrored the problem in Northeast Kansas in their analysis and data. Material given to this researcher was used extensively in earlier chapters. One comment that was made which had not appeared in other conversations was the warning against contracting for physician services.

Private agencies have begun to offer the services of physicians on a contractual basis. A community may purchase a guarantee of a physician, though the individual physicians may come and go. These firms were beginning to contact Kansas communities at the time of the interview.

Possible problem areas were in the contract fulfillment and quality of physicians offered to the cities. The warning consisted of requesting that small communities contact the Kansas Medical Society or Department of Health before actually signing the contract for services.

The Kansas Medical Society, Kansas Department of Economic Development and the Kansas Association of Commerce and Industry were all contacted. These agencies had as a common denominator the fact that they are often the first point of statewide assistance for small cities. While the Medical Society is the only agency actively participating in professional recruitment, the Kansas Economic Development Commission has an active interest in health professional recruitment, and expects to pursue it more vigorously. The Kansas Association of Commerce and Industry deals directly with the local Chambers of Commerce and is aware of the concern for health professional recruitment.

A very informative interview for this study was held with the Vice-Chancellor for Health Affairs at the University of Kansas Medical Center. The Vice-Chancellor outlined the physician problem in Kansas as: 1) not enough practicing medical doctors; 2) not the right type of specialists in practice or training; and, 3) less than optimal geographic location of physicians. The problem may now be one of production, but more important, retention of graduates.

In response to the question "what is KUMC doing about this problem?", the Vice-Chancellor cited an outreach program involving residencies under full-faculty members. Practicing faculty members in various cities have set up this residency program. It is operational in Goodland and Topeka

with plans for Concordia, Ft. Scott, Great Bend and Parsons. Another program created to combat the problem was the Wichita State University Extension of KUMC. This program will also be an attempt to persuade graduates to remain in Kansas. The Family Practice program was also instituted at KUMC in 1971 for the professional career of family physician. Two further ideas are in the planning stage: one, a requirement of a three-month residency as a prerequisite to graduation, allowing a lengthy exposure to Kansas practice; and two, creation of a model for primary health care in a regionalized setting in Kansas, allowing optimum utilization of the physicians and other health care personnel in Kansas.

Summary

The most obvious problem that Northeast Kansas faces is that of unmet demand for health care. Though this demand is most acute in the physician category, other professionals are necessary to the total health care package. Economic development in Kansas is involved in professional recruitment as suggested by the active concern of the Kansas Economic Development Commission.

Problems in attraction of any professional to Northeast Kansas involved culture; amenities; professional consultation and support; income prospects; and a desire by both parties to serve each other. An important fact remains that

monetary inducement is only a part of recruiting, not the sum of a successful effort. It was the feeling of one physician that income was important in location, but even more important was the genuine concern and support of the community. And, he felt that concern must be with the physician, too. His simplistic formula would be that both sides must be extremely eager and concerned with the way-of-life in a small community to enable the physician to remain in the semi-rural setting of Northeast Kansas.

CHAPTER 5

Formation of Guidelines

Conclusions may be drawn from the field research done in the past months in Northeast Kansas. These conclusions are separated into five simple statements and are used as the basis for the recommendations found later in the chapter.

-- Northeast Kansas is acutely aware of the need to attract all health professionals, though the physician is the only professional actively recruited. The economic development of the community is so closely tied to health care that the communities have a great awareness of the problem of locating physicians in small towns.

-- The efforts of several communities have been unsuccessful in attracting primary health professionals. These activities can be coordinated in a more efficient manner, either through better city-wide or regional organization. Opportunity exists for increased regional health planning in Northeast Kansas.

-- Contrary to the main thrust of several recruiting drives in the area, guaranteed income for physicians may not be the prime inducement to locate in a small community. Social and cultural inducements are to be considered.

-- Changing and emerging professional roles (Doctor of Osteopathy, Physician's Assistant and Nurse Clinician) have yet to make full impact on Northeast Kansas. Legislative efforts to redefine the role of the nurse were made in the 1974 Kansas Session.

-- Possibility of expansion of state medical programs exists to increase the supply of all primary professionals. However, this expansion will produce more professionals not necessarily retain them in Kansas. Better methods of retention are as high in priority as expansion of programs.

Although many positive comments can be made about the current status of health services in Kansas, this conclusion must suggest improvements. Small communities in Northeast Kansas could most improve in the attraction of primary health care professionals. An educated and concerted effort by smaller cities in Northeast Kansas would do much to overcome the problems cited in the previous analysis.

The major thrust of any increase in health service within small communities should include several key elements. Education, self-examination, promotion and honesty are those keywords. Education among the citizens is needed to comprehend fully the problem of attracting professionals. Self-examination will highlight each community's strong and weak characteristics. Promotion will express the desires of the

community in attracting a professional. Finally, honesty with the citizens and the prospective professional will assure a cordial and lasting relationship for the Northeast Kansas study area.

Kansas, as elsewhere, has fragmented responsibility with regard to the recruitment of health professionals. Responsibility for organizing and providing recruitment services is unequally dispersed. The smaller cities do not know all possible alternatives open with respect to future health delivery. The city-by-city method of attracting a physician as compared to regional attraction may not be apparent. If it is apparent, in this example, it may not be presented in a forceful manner. Many alternative levels of care and forms of attraction are available. The understanding of current practice will enhance any community effort.

The Problem Restated

"(Health manpower)...shortages are particularly acute in rural areas of the state. Health personnel have traditionally been low paid, which has reduced the attractiveness of health careers. Working conditions in the health industry generally do not appear as desirable as those in some other industries.

"Ineffective use of health workers adds to the health manpower shortage. Fragmentation of responsibility for providing health services among numerous agencies results in ineffective use of health personnel. The organization and design of health facilities prevent health personnel from operating at optimum efficiency in many situations.

"Distribution of health manpower throughout the state is unequal. Physicians, dentists, nurses, and other highly skilled health professionals tend to practice in more densely populated areas because of greater opportunities for financial reward, better facilities, more opportunity for research and continuing education, and more advantageous living conditions for their families. Needs for family physicians are particularly acute, or are becoming acute, among sparsely populated areas of the state. There is also a critical shortage of professional health planners to initiate and coordinate the kind of broad-based planning needed in Kansas."¹

The picture has not changed appreciably in Kansas since the above statements were made in 1967. Kansas appears to have held its own, at best.

Guidelines

Northeast Kansas cities can begin to provide, both for themselves and for their region, partial solution to the apparent crisis in professional recruitment. Systematic solution to the area's problem is not at hand. However, a critical evaluation of each city will start a process to alleviate this shortage. By performing the guidelines provided below, each community will begin to catalog its regional position. Education and self-examination would take place. Alternatives for promotion would become apparent:

¹Kansas Legislative Council, A Plan For The Development of Health Resources--State of Kansas, vol. 1, Topeka: State Printers Office, 1967. p. 8.

-- Do area problems stem from lack of professional help? Or, should the changing roles of the nurse or physician assistant be considered for the smaller community? Each town must decide that attracting a new professional will improve local health care, not simply make the drive to a doctor's office shorter.

-- Is attraction of professionals foremost in all minds in the community? Make certain that present local and area professionals are consulted about the need for additional manpower. If the manpower is actually needed, will it be welcomed by the practicing professionals? by local hospitals?

-- If the more influential citizens of the city are convinced that professional recruitment is mandatory, what are they willing to do about it? Many actions are possible and each will add to the special package that the community will be able to offer:

1) has the town registered with the statewide professional societies? The Kansas Medical Society and others offer expert assistance in recruiting professionals.

2) has the town formed a professional recruiting team with defined responsibilities? Do the citizens who are willing to assist financially realize the exact nature of their offer? Simple costs like traveling to interview prospects or entertaining must be discussed in

advance. Pledging money, influence or time should not be done in a blind manner--responsibility should be spelled out in each community.

3) are interested citizens willing to go beyond income guarantees and into the area of construction of clinics or offices? If they are ready, will they be so enthusiastic after hearing of cities in Northeast Kansas with a hospital and no doctors? If they wish to build clinics or nursing homes, will they be gifts or loans to the incoming professionals? Ironing out these details allows promotion to proceed on firm footing.

4) has the committee made a checklist of alternative benefits for a professional? Incentives on insurance programs, vacations, automobiles, homes and local investments are to be considered specifically--by type and amount of discount.

5) has the committee made any study of local medical or dental patient demand? Simple population studies will determine the growth potential for any town or area. As any industry would wish to know the market area potential, so would any incoming professional.

6) has the committee completed studies cataloging city or regional attractions? Many factors weigh heavily on the mind of a prospective professional. Culture, education and recreation are prime inducements to

locate. Housing, shopping, schools, colleges, reservoirs, hunting and fishing areas, parks, libraries, concerts and spectator events are a few of the possible reasons for living in one area. If the individual cities in Northeast Kansas do not possess these attributes, then it might be time to consider regional attraction schemes.

7) has the committee contacted local or regional students attending medical schools or technical schools? Has the area considered paying the tuition of a student as an inducement to locate? In the same manner, has anyone visited a medical school or larger medical center to investigate the possible relocation of professionals? Because a student or practicing professional is now in an urban area does not mean that they would not consider relocation.

-- Once the team has been formed and has educated itself about local strengths and weaknesses, actual promotion begins. One to two years is not an uncommon period for recruitment team formation. When the team is ready, promotion will be much smoother and give the professional appearance that will influence many potential prospects.

-- Finally, involve the entire community in the effort. Once the health professional locates, the rest of the community will be as important as the small group that attracted the professional in the first place. Community

acceptance will insure the continued practice of a primary health professional in the Northeast Kansas area.

The primary problems of locating professionals in Kansas communities stem from lack of cultural, educational and medical opportunity. These areas must be attacked as rigorously as a guaranteed income for the prospect. To "buy" a professional will work only as long as that professional feels at ease in a community. If the community does not allow the health professional to grow inside that community, the attraction committee will be forced into action yearly.

State Intervention

Possible state action in this matter was discussed and is uncertain. During the interviewing process, a question was put to the respondent concerning state intervention. Answers ranged from creation of a new and completely independent medical school in Wichita to the other extreme of continued support of programs.

One positive program was suggested by Senate Bill 807 introduced in the 1974 session of the Kansas Legislature. This bill failed to pass, but it would have provided for a small public staff responsible for coordinating community efforts in recruiting professionals. Such an activity could have been adapted to a regional planning activity.

Regional attraction of health care professionals can best be instituted within the framework of existing area-wide planning agencies. These agencies have been established through intergovernmental cooperation or state agency organization (health planning organizations). Northeast Kansas does not have the regional planning structure that might be instrumental in attraction of physicians or other primary professionals.

A concerted drive to form regional planning jurisdictions in Northeast Kansas might lend itself to attraction schemes in the future. The most important task of a regional planning agency would be securing the cooperation of their area in several courses of action.

The proposal for a second medical facility in Wichita brings out an important idea---competition. Does Kansas need competition in medical schools or service? Duplication of services is rightfully out of the question. The emphasis might best be shifted from production to the retention of medical school graduates. It would not take a new medical school to retain newly-graduated physicians. Instead, a greater effort by the existing institution would be in order.

The answer concerning the continued positive attitude in the Kansas Legislature is noteworthy. Awareness and sympathy for any problem are two prerequisites to action.

In the interviewee's view, the Legislature had been aware and responsive. The plea was for continuation of that view. The question always arises, could the Legislature do more?

Conclusion

Problems in attracting the professional to Northeast Kansas are complex. Not only is the individual community dealing with growth problems and increasing health delivery costs, they are coping with a poor public image. Smaller communities in Kansas do not have the reputation for gracious living that will attract the highly motivated professionals. But, reputations are not always correct or if they are, they can be changed. Kansas life-styles are important to the citizens who spend their lives here and to professionals who will locate here. This writer cannot portray this sentiment as well as the wife of a physician who stated,

"After living in California and two large cities, we somehow were under the impression that we could have a slower, less complex, less mobile type of life in a small town. Also, we welcomed a situation where we could know what was going on pretty easily and where our children didn't have to grow up too fast.

"In other words, Ottawa seemed like a very good place to raise a family when we moved here seven years ago. I've come to love Ottawa, its many solid people with good common sense and homespun philosophies...."²

²Mrs. D. C. Hadley, from an editorial published in the Ottawa Herald, Thursday, February 14, 1974, p. 2.

It may be concluded that both professionals and communities must be prepared to practice together. The best way to foster this inclination is to have mutual understanding of the problems in attracting primary health care professionals to Northeast Kansas communities. Through education, self-examination, promotion and honesty both sides will realize the long term benefits involved in successful health delivery.

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APPENDIX

Persons interviewed in alphabetical order:

James E. Agin	Kansas Medical Society, Topeka
P. R. Annamalai, M.D.	Sabetha, Kansas
Marilyn Atkinson, R.N.	Public Health Nurse, Council Grove, Kansas
Paul L. Boatwright, D.D.S.	Orthodontist, Topeka
Emalene Correll	Principal Analyst, Legislative Research Council
Lloyd L. Hall	Kansas State Osteopathic Association
Bonnie McIntyre	Assistant Director, Health Activities Program
Margaret Meier, R.N.	Public Health Nurse, Holton
Gerald Oglivie, D.D.S.	Holton, Kansas
Rosalie Osborn, R.N.	Public Health Nurse, Ottawa
Stephen N. Paige	Coordinator, Ozarks Planning Project
Donald E. Philgreen, M.D.	Ottawa, Kansas
Walter C. Powers	Administrator, Geary County Health Department
William O. Rieke, M.D.	Vice-Chancellor, Kansas University Medical Center
Larry Rogers, RPh	Wamego, Kansas
James L. Ruble, M.D.	Overbrook, Kansas
Judy Runnels	Lobbyist, Kansas State Nurses Association
Judy Schrock, R.N.	Public Health Nurse, Manhattan

Alex Scott, N.C.	Junction City, Kansas
Raymond R. Solee	Director, Comprehensive Health Planning
Michael C. Wangsgaard, D.D.S.	Manhattan, Kansas
Donald E. Wilcox, M.D.	Kansas Health Department, Epidemiology
Gary N. Zook	Kansas Association Commerce and Industry