Incentivized Public Service Response to COVID-19 in Rural and Marginalized Urban Communities

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COVID-19 has strained health care systems across much of the developed world, including the United States, which is now one of the epicenters of the pandemic. Limitations in medical attention, testing capacity, and local epidemiological surveillance are expected to substantially intensify health impacts in rural and marginalized urban communities, in particular because of the increased risk in people with comorbidities. In such a context, there have been calls for exceptional measures to aid in bridging gaps in the health workforce, such as potentially mandatory service for medical, nursing, and public health students at various stages of their training.

Indeed, the US response during the current COVID-19 emergency, and its aftermath, may benefit from deployment of health workers to confront potential and actual transmission of SARS-CoV-2. However, the high degree of unpredictability brought by COVID-19—clinically, epidemiologically, and socially—may multiply the challenges for which health students and novice health personnel may not be fully prepared. Further, a major risk factor of rural and marginalized urban populations in the COVID-19 pandemic is the lack of longer-term solutions to health personnel shortages. We briefly address how an incentivized public health service

intervention could aid in the response through a community-based approach. This strategy could offer a more permanent solution to recruitment and retention of health personnel, which could be adopted through governmental programs aimed at communities in need.

Incentivized health service programs for doctors, nurses, midwives, and health students and workers exist around the world largely to serve rural or marginalized urban communities in low- and middle-income countries, as well as in high-income countries such as Japan and Canada.[1] Depending on the country, these programs may be designed as a requisite to work in the public sector or to enroll in postgraduate or specialization programs, as part of training or in exchange for educational support. Some countries add incentives such as higher pay grade, housing provisions, or career advancement. In a fragmented, unequal, and fragile health care system as exists in the United States, which has shown poorer performance and health outcomes,[2] students in the health professions and recent graduates could take an active part in supporting community-based prevention of COVID-19, including early detection strategies. As they adjust to the moving COVID-19 landscape, they would gradually become more technically grounded and empowered to also give attention to wider health and health promotion demands.

Of particular importance to rural areas and marginalized urban communities is the need to build upon community strengths toward adequately, and responsibly, contextualizing strategies and actions.[3] The value of cultural and social expertise gained through firsthand contact is irreplaceable at the primary level of care, especially since building a relationship of trust is fundamental in a health emergency and, even more so, in these communities.[3] Hence,

any proposal to create a service program should encourage participants to work close to home, thus ensuring a more effective community-based, socially accountable approach.

Protests against lockdown have shown that centrally mandated measures can be easily disrupted, thus exposing various population groups, including health personnel, to unnecessary risk. In particular, it would seem that the greatest contribution personnel enrolled in such an incentivized service program can initially make is to channel the flow of much-needed local epidemiological surveillance,[4] alongside an educational component. Focusing on health promotion, rather than solely on health care provision, may be a more robust option, and could reduce obstacles and errors inherent in implementing a rapidly prepared, large-scale intervention in the midst of a pandemic. Accordingly, relying on evidence-based, community-oriented, and cost-saving approaches, such as engaging community health workers from the same areas that are underserved, could strengthen an incentivized public service program. While focusing on equity, community health workers working in their own localities may be able to effectively counteract mistrust and fear of governmental intervention.[5] Furthermore, in clinical settings, community health workers (also known as patient navigators) can facilitate patient-centered efforts across the care continuum.[6]

The United States has at least one functioning service program, AmeriCorps, that could be expanded to strengthen primary care systems by following the Public Health Service Commissioned Corps model. In fact, Senators Elizabeth Warren and Chris Van Hollen recently sent a letter to the surgeon general and the assistant secretary of the US Department of Health and Human Services urging them to more fully engage the Corps. The federal government could

do so by directing medical, nursing, and other health professionals and students toward underserved areas, and supporting them to stay in the longer term. Consequently, once resource-intensive COVID-19 mitigation efforts are no longer necessary, the health care sector should have in place clearer career pathways that build on firsthand experiences of these community-based health efforts. First, admission should assess how participants' preferences, inclinations, and capabilities are aligned with the goals and conditions of the health service program they apply to. Second, well-articulated pathways across the public and private health care systems should be able to objectively value empirical and knowledge-based achievements, which would also serve as an additional incentive beyond economic compensation.

Learning from rural medical education programs, whose graduates are more likely to remain in rural areas,[7] community-based placements could be introduced as a requirement for training or career advancement.[1] If students and recent graduates are enrolled to work largely as guides for patients and community members to navigate the health care system and access needed health care services within the COVID-19 response, they should still be prepared to document specific milestones that advance their training and career goals. And, because field experience is not gained in a void, local community expectations should also be clear for participants. In this context, community health workers could play a critical role in designing, monitoring, and evaluating mandatory service programs; facilitating community stakeholder engagement; addressing patient navigation issues; and adjusting implementation based on community and health personnel input.[5]

An extreme need for health personnel, even in normal conditions, has justified mandatory service programs at the primary care level around the world.[1] However, without consideration for local realities and existing capacity, there is the risk of doing more harm than good, particularly among rural and marginalized urban communities. The COVID-19 response should not be limited to reactive, immediate approaches that may become exhausted once the pandemic emergency subsides. Rather, countries like the United States should engage in a sustained, coordinated effort to strengthen their public health infrastructure to better tackle the current and future potential crises, such as chronic disease disparities. Although this is a tragic moment for many populations across the world, we must all engage in developing a more humanistic, family- and community-based provision of care, away from disease-specific and for-profit-oriented medical systems. Such an approach suggests that federal and state governments should consider the option of incentivized public health service in their emergency and longer-term budgets, in connection with clearly articulated educational pathways.

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Conflicts of Interest

The authors have no conflicts of interest to declare.

References

1. Frehywot S, Mullan F, Payne PW, Ross H. Compulsory service programmes for recruiting health workers in remote and rural areas: do they work? Bull World Health Organ. 2010;88(5):364–370.
2. Schneider EC, Sarnak DO, Squires D, Shah A. Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better US Health Care. New York, NY: The Commonwealth Fund; 2017.
3. Prusaczyk B. Strategies for disseminating and implementing COVID-19 public health prevention practices in rural areas. J Rural Health. 2020.
4. Souch JM, Cossman JS. A commentary on rural–urban disparities in COVID-19 testing rates per 100,000 and risk factors. J Rural Health. 2020.
5. Balcazar H, Lee Rosenthal E, Nell Brownstein J, Rush CH, Matos S, Hernandez L. Community health workers can be a public health force for change in the United States: three actions for a new paradigm. Am J Public Health. 2011;101(12):2199–2203.
6. Volkmann K, Castañares T. Clinical community health workers: linchpin of the medical home. J Ambul Care Manage. 2011;34(3):221–233. b
7. Rabinowitz HK, Diamond JJ, Markham FW, Santana AJ. Increasing the supply of rural family physicians: recent outcomes from Jefferson Medical College's Physician Shortage Area Program (PSAP). Acad Med. 2011;86(2):264–269.