YOU AND YOUR HEALTH

by Pat Patterson

North Carolina has a shortage of physicians, in both rural and well-populated areas. Statistics show that 21 counties in the state have only one general practitioner for every 6000 persons.

Relief for this problem is coming from at least one source - the North Carolina Medical Care Commission (MCC). Through the MCC, the state provides a scholarship program designed to send students through their medical training and out into needy areas. Approximately 400 applications have recently been received for this program for the September school term.

The MCC has also received $100,000 from the General Assembly as a pilot incentive program for doctors. In addition to that, $734,000 has been appropriated from the General Assembly toward the loan program. Of this amount, approximately $460,000 will go to students already in the program and $450,000 for new students.

According to Mrs. Janet M. Proctor, head of the loan program for the MCC, interviews for students interested in health related fields are conducted year-round, but the bulk of them are interviewed from January to May.

Since 1945, when the MCC program was begun, approximately 2000 students have been approved for loans. More than 1500 of these students have been approved since July 1, 1965.

For those interested in medicine, osteopathy, dentistry and optometry, the scholarship will pay up to $2,000 for each academic year and a maximum of $8,000 for four academic years. Nurses may receive $500 in their second and third years in hospital schools; $1,000 in the second year of an associate degree or for each full academic year in a baccalaureate program.

These medical loans are granted with the understanding that students will repay them by practicing in communities with 10,000 persons or less depending on the ratio of practitioners to the population and other characteristics of the community. Nurses can practice anywhere except in physician's offices, private duty practice, research, federal facilities and industrial and summer camp nursing.

Students in the MCC program are required to be residents of North Carolina, but they do not have to take their training in this state. However, 61 percent are enrolled in in-state four year or professional programs, 15 percent in hospital schools (in- and out-of-state), 12 percent in in-state technical schools or community colleges and about 12 percent in out-of-state four year or professional programs.

Should a student decide to drop out of the program, leave the state or not practice in his field, he must repay the MCC loan. Mrs. Proctor said, "The current rate of interest in a pay back loan is seven percent; however, we plan to bring interest rates more in line with the market rate. MCC loans are not intended for general loans."

Though dentists and physicians comprise the most crucial shortage area, the majority of the students are enrolled in the nursing program. Currently, there are 165 nurses in practice repaying their loans and there are 156 potentially available as manpower. There are also 197 physicians and 108 dentists potentially available to doctor-hungry counties.

Of the 400 new applicants, 35 are enrolled as dentists, 69 as physicians, 166 as nurses and the remainder in other health related fields. These other fields include clinical psychology, dental hygiene, dietetics, medical record library science, medical recreation, medical social work, medical sociology, medical technology, nurse anesthesia, occupational therapy, optometry, pharmacy, physical therapy and public health (physicians only).

outreach

Human Resources in Action in North Carolina

by Jacqueline M. Ransdell

The concept of caring for the mentally handicapped at the community level where the problem begins, and not placing the responsibility on the state institutions alone, has been in existence for about ten years.

It was in 1963 that Congress passed the Community Mental Health Centers Act which made available federal funds to supplement state and local monies to build and support community mental health centers.

That same year, the N.C. Department of Mental Health was created and given a mandate to provide services to meet the needs of the mentally ill, the alcoholic, the drug abuser, and the mentally retarded citizens of our state.

Over the years the thrust of mental health programming has focused on the community. The logic behind community responsibility for the mentally handicapped is sound: 1) the provision of community-based treatment and rehabilitation resources reduces the necessity for hospitalization in many instances, and 2) the availability of aftercare facilities in the community fosters a speedier return of hospitalized patients to their homes and families.

Particularly in the area of community care for its mentally retarded citizens has North Carolina advanced in recent years. The establishment of day care programs, special education classes for educable and trainable youngsters in the public school system, half-way houses and small group homes for adult retardates, sheltered workshops, diagnostic evaluation clinics, foster homes, and many other resources are just a few examples of alternatives to institutional care which are becoming more readily available within the communities of our state.

The 1973 General Assembly appropriated more money for new programming to the Department of Mental Health than ever before. Much of this money is designated for expanded programs for the mentally retarded at the community level.

The legislature appropriated funds providing for an increased subsidy to trainable and severely retarded children enrolled in day care centers across the state - from $40 per month to $80 per month per child. These funds can also be used for children above the trainable level if they are multiply-handicapped.

Because these funds were appropriated, many day care centers across the state that would have had to close their doors because of lack of funds can continue to provide needed services for our handicapped citizens.

Funds were also appropriated for the establishment of small group homes to serve adults and for sheltered workshops.

In addition, the Department of Mental Health received funds which will be used to implement the first stage of Caswell Center's plan to develop community services for the mentally retarded in the eastern region. This includes monies for the establishment of child day care centers, and day activity for adults.

In addition, the Department of Mental Health has been authorized to use community demonstration funds to develop three more early childhood intervention programs at the community level - programs similar to the outstanding P.A.C.T. (Parents and Children Together) program in Gastonia. These programs will provide help for developmentally disabled (mentally retarded) pre-school children and their families.

All of these programs will go a long way towards providing more comprehensive community care for the mentally retarded in North Carolina.

In addition, all of the federal funds provided through the Developmental Disabilities Services Act (DDSA) are used to provide alternatives to institutionalization for the mentally retarded at the community level with the majority of funds earmarked for day care and sheltered workshop programs. A portion of the funds, however, goes to local public school systems to establish classes for trainable mentally retarded children and some is used for programs for homebound retarded youngsters.

The concept of providing respite care for the retarded - providing day and overnight care so as to give the parents and family members of retarded individuals an opportunity for a few days' rest - is growing in North Carolina. All four of the state's mental retardation centers offer respite care.

According to Don Taylor, deputy commissioner for children's services with the division of mental retardation, Department of Mental Health, there are a number of problems in the area of community services for the retarded which need attention.

First, he says, there are not nearly enough community programs to meet the needs of our retarded citizens. However, the funds recently appropriated by the General Assembly will do much to ease this situation.

Second, there is the problem of quality control in our day care centers. Many do not have sufficient supervision, standards, or training and staff development programs.

Third, community-based services for the retarded need to be better coordinated and the roles of various programs and their relationship to one another need to be clearly defined. However, we must be careful to guard against "over-definement" so that services are not fragmented and that gaps between services are not created.

Fourth, attitudes on the part of the community and the families of our retarded citizens need to be improved. We need to strive for more acceptance of the retarded and their problems - particularly in regard to the establishment of small group homes for retarded adults in local communities.

Fifth, there is a need for one person or agency to be responsible to following up on the retarded who are returned to their communities from the state retardation centers, to see that adequate and appropriate protective services are being provided.

In commenting on community services for the mentally retarded, Dr. Ann Wolfe, deputy commissioner for mental retardation services with the Department of Mental Health, said, "People have a right to receive needed services in their community, and this includes the mentally retarded.

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