The National Health Service Corps Scholarship Program

By Eve Shapiro, October 17, 2025

As long as there are people in this country who are denied essential health services because of poverty, or race, or lack of access for any reason, we have fallen short of our promise as a Nation.

-White House Report on Health Care Needs, July 10, 1969

What is the moral role of primary care in society?... Poor and rural communities... have been largely abandoned or neglected by contemporary medical practitioners.

-Fitzhugh Mullan, M.D., *Big Doctoring in America*, 2002

Primary care physicians and other clinicians serving in the National Health Service Corps (the NHSC or the Corps) tend to be idealists who are committed to social justice and feel a moral imperative to care for those who are marginalized, poor, uninsured, and neglected by the medical establishment. They deliver care in remote rural areas that are now losing hospitals and Federally Qualified Health Centers at an alarming rate. They deliver care to those living on the street, to migrant workers, to those living on tribal lands where the nearest hospital may be more than two hours away. They deliver care in cities that have become healthcare deserts and where patients cannot always afford the bus fare to get to their appointments or the medicines they're prescribed. They deliver care to pregnant women, children, and their parents throughout their lives. They are concerned with the health of the family and with the health of the communities in which they practice.

The NHSC Scholarship Program matches its mission to send doctors to practice primary care in areas where they are needed most with those who want to make such practice their life's work. The NHSC has provided scholarships to medical students and others who

commit to practicing primary care in poor and underserved areas in exchange for 2-4 years of service since 1972.

Five primary care physicians who served in the NHSC in exchange for their scholarships spoke to me about their experiences and the program that made their service possible. They spoke with reverence, joy, and, in one case, a voice cracking with emotion. They all said the NHSC Scholarship Program enabled them to practice where their hearts led without having to worry about medical school debt that otherwise would have taken decades to repay. One, who thought he'd be an orthopedist before fulfilling his NHSC commitment, decided after his service to pursue a career in primary care.

Their service in the NHSC may have been relatively short in the arc of their careers, but their experiences set them on a path they would follow for the rest of their lives. Whether serving and rising to leadership in the same Federally Qualified Health Center, practicing pediatrics and teaching, learning to handle emergency situations with little support, doing community organizing, or becoming Director of the NHSC, their experiences in the Corps shaped the rest of their lives and most certainly improved the health of the patients and communities they served and continue to serve.

Joe Panerio-Langer, M.D., is a primary care physician and Deputy CEO of the Brockton Neighborhood Health Center, a Federally Qualified Health Center in Brockton, Massachusetts. His upbringing primed him to work in service to others.

"My mom was a teacher, my father worked with farmers, and they met in the Peace Corps. They were big believers in social justice. My motivation in getting into healthcare was to be able to help communities and help people who may be struggling financially and in other ways. I wanted to be of service to people who need help."

He doesn't remember how he became aware of the National Health Service Corps, but it was sometime before he went to medical school at the University of Nebraska. The NHSC paid for Joe's medical school in exchange for his commitment to work in a Health Professional Shortage Area (HPSA).

He began fulfilling that commitment at the Brockton Neighborhood Health Center in 2009 and is still there, now as Deputy CEO.

"Working in the health center setting is like two sides of the same coin: it's very challenging, but it's also really rewarding. I can't imagine working in a setting where patients drive to your office for their appointment, get a prescription, and then drive to the pharmacy to pick it up."

Joe stresses that in a Federally Qualified Health Center like Brockton, attending to the social aspects of patients' lives is crucial to their healthcare.

"When patients come in to see me, a number of them are homeless, many of them aren't able to read, some of them have not used a pharmacy—or if they have used a pharmacy, they're accustomed to going to the doctor every time they need a medication as opposed to using a refill system. They might not have food or refrigeration to keep medicine cold. While I can make recommendations about food, the food I recommend may be too expensive for them to buy, or they may live so far away from a grocery store that the trip itself is a huge barrier. In a setting like this, navigating these social barriers becomes part of healthcare."

Providing care means helping the up to 24 patients Joe sees in a day—50% of whom speak a language other than English—find ways to overcome the social barriers to getting to the clinic and trying to help them get there. It means helping them find a location where they can buy healthy food, teaching them how to use a pharmacy, how to use a refill system, and how to navigate other challenges.

"A lot of the patients really don't have anywhere else to go. I feel very rewarded practicing here. I don't view medicine as pills. I view it holistically: you've got to treat the whole person. And that has to include the social aspects. I really can't imagine being anywhere else."

David Keller, M.D., is a pediatrician and professor of pediatrics at the University of Colorado Anschutz Medical Campus in Aurora. He applied for an NHSC scholarship because he'd always wanted to practice pediatrics in an underserved community and because he wanted to declare his intention to Harvard Medical School early, where he knew they'd try to make him into a specialist.

When he applied for a scholarship in his first year of medical school his application was rejected. When he reapplied in his second year, he was accepted. His scholarship supported him from 1980-1983. When it came time to serve in the NHSC after medical school and residency, David chose to practice pediatrics at Crusaders Clinic in Rockford, Illinois.

"It was a great group of people who were committed to primary care, committed to and entrenched in the community, had privileges at the local hospitals. There was a branch of the medical school, and they were doing a little bit of teaching, but it was very community focused. I served at that great place for 3 years, from 1986-1989.

"I was the second pediatrician they hired. There were two pediatricians, two family docs, four internists, and an Ob/Gyn. They didn't have room for me at the main clinic, so they

purchased the nearby practice of someone who had gone out of business in the same service area, so I got to open a new office.

“I learned how to build a practice, I walked the neighborhood, I visited the schools and said, hey, there’s a new doctor just down the road, come see me, because we didn’t have a budget for publicity. I learned a lot. I was on staff at two hospitals. I learned a lot about community health, I got invited to be on a couple of community boards, and learned how to write grants. Then I decided I wanted to teach community pediatrics.”

In the years since, David has worked in maternal and child health, worked in the Obama administration on the Affordable Care Act, and worked as a healthcare reform expert. He teaches at the Children’s Hospital Colorado Anshutz Medical Campus in Aurora, works with Medicaid, and still practices one day a week.

“All of my medical education work has been about how to work with community to improve the health of kids in the community. The Corps first cemented that for me. That was the important thing. I give the Corps credit for my entire career. The Corps is an incredible opportunity to learn, and it was an incredible opportunity to not have the economics of debt drive where my career went.”

Bradford Mersereau, M.D., is a primary care physician and Service Chief of Primary Care at the Veterans Affairs Hospital in Buffalo, New York. He applied for an NHSC scholarship in his second year at the State University of New York-Upstate Medical University, and the scholarship covered his third and fourth years. When he learned about the NHSC Scholarship Program he thought that would be a way to ease the burden of medical school, “even though compared to today it was nothing.”

Before serving in the NHSC he’d been interested in orthopedics, but after serving his commitment in the Indian Health Service in Crow Agency, Montana from 1983-1985, primary care medicine became his passion. At first, he was skeptical that he would want to do anything other than orthopedics after his NHSC service. But he became hooked on primary care by the variety, severity, and unique challenges of practicing in a remote tribal area of the country.

“It was high prairie, about a mile from the site of the Battle of Little Bighorn. It was wild. We had an emergency room that was really a room. We had an operating room and a delivery room. I got out there and they must have been waiting for me, because after one day of orientation they told me I’d be on call. Being on call I’d be there all day, all night, and about half of the next day, and would basically take care of whatever needed to be taken care of. It was a 30-bed hospital, obstetrics patients in labor, babies, and routine adult medical

admissions. Out there, if I suspected appendicitis or cystitis, I'd admit them and had to decide whether to ship them off for surgery to Billings, which was about 60 miles away.

"We had no obstetricians then, so if I thought a patient needed a C-section, I had to get an ambulance to pick us up and take us 73 miles away to a hospital in Sheridan, Wyoming, where our obstetrical consultants were. That was the scariest part of working there. The drive to Sheridan took at least 90 minutes. The time between making that decision and arriving at the obstetrician's hospital was stressful."

He experienced other, less stressful challenges. "Somebody would come in with a dislocated ankle, for instance, and I'd never reduced a dislocated ankle. So, I'd call the orthopedic surgeon and talk to him over the phone, and I'd reduce it and cast it. Things like that I hadn't done before I did in contemporaneous consultation with a specialist.

"I set up a surgery clinic for itinerant surgeons. A fair number of patients came in with cholecystitis. I took care of them medically and assisted with surgeries for patients who needed surgery. It was pretty much the same thing with tubal ligations. There was a whole process for that too because there had been a history of forced sterilization of the indigenous population, so we had to be really careful about being sure that we got consents and that patients understood what was going on.

"Then there was the trauma. If you see something only once in your life it can be kind of a big deal. Once I'd been away for the weekend and when I got in my phone was ringing. The doc on call had a guy who had been stabbed in the chest by his girlfriend and he was deteriorating due to tamponade. So, I did a pericardiocentesis. It was the first and only time I've ever done it. The guy's blood pressure came up and he survived the helicopter flight to Billings, and he did fine.

"Then there was the time a 25-year-old woman came in with vaginal bleeding and had no idea she was pregnant. I thought she was 28 weeks pregnant. I was really nervous about that. So, I flew the pediatrician down on a helicopter and he brought a neonatal nurse and delivered this tiny baby. Turns out it was closer to 32 weeks. Then they realized there was another baby in there, so I delivered twins. They were only prepared to take care of one, but they figured it out. Years later those two girls came over and interacted in our house with our children.

"By the time I got done with my two years out there, I felt I'd be able to take care of whatever came through the door. I could either take care of the problem myself or immediately call for a helicopter to fly down from Billings if a patient was really sick. It grew on me, this idea of being able to do primary care in that setting."

A number of years and several career twists and turns later, Bradford married a nurse, and they went back to Crow Agency, Montana. They'd intended to stay for only one year but ended up staying four.

He started working at the Veterans Affairs Medical Center in Buffalo in 2001 and has been there ever since.

"They had a program working to get veterans housed and to get them other kinds of support but there was nobody providing primary care to them. So, I thought, why don't I bring primary care to veterans who were already at the VA for other reasons?

"The NHSC had a big influence on my career path. I did my service to the NHSC wanting to go into orthopedics and get it done as quickly as I could, do my obligation and get on with my life. And it changed me. I was really stressed out with some of the things that happened there, but I also felt I was providing care that others weren't. I'm always advocating for primary care."

Michael Fine, M.D., is a writer, community organizer, and family physician. He has been president and board chair member of Primary Care for All Americans since 2023 and is the board vice chair and co-founder of the Scituate Health Alliance. He remembers living in England writing fiction when one moment changed his life.

"I remember the chair I was sitting in, in a dinky little cottage in the Cotswolds, reading *The Guardian*. In *The Guardian* was an article about Teddy Kennedy and the National Health Service Corps, and about how people were going to be able to go to medical school for free with a living stipend. It said you'll have no debt. You'll owe us a year for every year of support you take. And I thought, I can do that.

"Until that moment, I grew up thinking doctors were people who played golf on Wednesdays and drove Cadillacs, and I wanted nothing to do with that culture. I came out of the '60s and early '70s with the ethos of serving people.

"It was my first inclination that I could do this without being coopted by that culture, which I so desperately didn't want. So I came back, took the courses I needed, and ended up going to Case Western Reserve School of Medicine. It was the Corps and the Corps alone that led me to think about this.

"The Corps paid for me to go to medical school, and then I owed the Corps that obligation after all the training they paid for. I had three years to pay back."

He paid the Corps back by serving in Sneedville, Tennessee between 1986 and 1989.

“I got an assignment. It meant being in a place with people who I didn’t have much history with, and who didn’t have much history with me. That by itself was an education in humility. It was learning to do something with nothing. It was dealing with healthcare in a way that was sometimes scary. I got to this little town in a county of 6,000 in one of the poorest places in the United States. It was a 20-25 bed hospital that was leased from the county.

“They ran quite the operation. Scarier than anything I’d ever seen. There was only a licensed practical nurse in the emergency department at night. Everybody who came to the emergency room got the same 3-drug treatment. They tried to deliver babies, but they didn’t have a lab or an operating room. So, when a delivery started to go bad, they called the helicopter and hoped for the best. I decided pretty quickly that I wasn’t comfortable delivering babies there.

“I’m a family doctor so instead of delivering babies, I did all the other family doctor stuff. In the county health department, there was a visiting nurse, a physical therapist, and an NHSC dentist. We organized a little team, and we’d meet once a week and talk about the people we were worried about. And that was spectacular because I’d never seen anything like that. In fact, I’ve been spending the rest of my life trying to replicate it, because it’s a great way to do population-based healthcare. I was responsible in a certain way for thinking about the health of everybody who lived in that county—not just for people who had a little insurance, because most people didn’t have much—but for everybody, the people without insurance.

“When I was there, the HIV epidemic broke, so I did things like go and visit the barbers and hairdressers and tell them how to think about the precautions they should take during the time of HIV. Nobody ever thought there was going to be HIV up there, but there was plenty.

“There was an organization called Rural Health Associates of Upper East Tennessee, which was a 501(c)(3) nonprofit that had been set up by the Tennessee Department of Health to bring NHSC doctors to East Tennessee. I think there were between six and eight of us who came all at once, so there was some social connectedness. We felt like we were doing God’s work and helping people.

“I did some organizing work among my NHSC colleagues to see that people were treated fairly. And that didn’t endear me to anyone in the clinic administration. I wasn’t asked to stay after my obligation, which was okay because I was ready to come home, and some people who ran the place were happy to see the back of me. But there were many other people who did what I did and stayed in isolated and poor places all around the country.”

After fulfilling his commitment to the Corps Michael worked in a private practice, a hospital, took time off to write fiction, and then started a community health center look-alike in which he always focused on creating multidisciplinary teams.

“I started my own practice on the East side of Providence, Rhode Island, which became the largest family practice in the state. We focused on public health, which we saw nobody else was doing. I got involved in my own community and helped start the Scituate Health Alliance in Scituate, Rhode Island. This made Scituate the only place in the United States where everyone was entitled to medical and dental care. I became the Medical Director of the state prison system and then went to the Department of Health and used that opportunity to develop a proposal for the Rhode Island Primary Care Trust, to try to get people to understand the value of providing primary care to everyone.

“I finished medical school without any debt, so when I was done with the Corps, I could do some of the things that maybe I wouldn’t have done otherwise, like start that practice. I always felt my education was owned by the country, not by me. It was. I’d been given a gift, and my job was to give back.”

Donald L. Weaver, M.D., launched his career as a volunteer in the National Health Service Corps in 1975. He served as Director of the NHSC from 1989-2005, and in 2009 served as Acting Surgeon General of the United States. Now retired from the Public Health Service, he is a senior partner with Martin, Blanck & Associates and Board Chair of the Social Mission Alliance.

“I started my career in the Public Health Service as a National Health Service Corps volunteer in 1975. At that time, the NHSC was an all-volunteer service (the NHSC Scholarship Program did not exist). Having been deferred from military service during medical school and residency, the NHSC provided an opportunity to serve my country. NHSC assignees were all federal employees, either in the civil service or commissioned corps. I chose the commissioned corps. What I thought would be a two-year tour resulted in a career as a Commissioned Officer in the United States Public Health Service (USPHS).

“Prior to entering the NHSC, I had completed two years of a pediatric residency in Boston, with plans to return for a third year of residency and become a pediatrician in Maine, New Hampshire, or Vermont.

“My NHSC assignment was at the Family Practice Group of Tooele, in Tooele, Utah. It was a team of five primary care clinicians (three physicians, a nurse practitioner, and a physician assistant). We later added a certified nurse midwife. Those three years provided an interprofessional experience that I realized, in retrospect, many people did not have.

“Adjacent to our clinic was a 32-bed hospital, which included obstetrical services. Given my residency training in pediatrics and the need to cover obstetrical care in the hospital, the NHSC arranged for a month-long mini-residency in Salt Lake City. This provided me with delivery skills and enabled me to develop relationships with OB/GYNs, which proved invaluable for telephone consultations and referrals.

“I stayed in Tooele for 3 years, worked in the Region VIII office in Denver for 5 years supporting NHSC clinicians in six states, and was then assigned to the NHSC Headquarters in Rockville, Maryland. One of the highlights of my career was the privilege to serve as Director of the National Health Service Corps for 15 years.

“I think of the NHSC as an opportunity for clinicians who have a ‘heart to heal’ serve and make a difference in communities that lack an adequate supply of health professionals, and go where others choose not to go. NHSC clinicians may remain in their assigned communities for an entire career or meet the needs of an underserved population for a period of time and then pursue other paths. Either way, the individual is indelibly imprinted by the experience and will have an improved understanding of the health needs of underserved rural, frontier, and inner-city communities.

“The NHSC is about caring, compassion, community, and health. I cannot think of a better program than the NHSC for a clinician to demonstrate these characteristics. The NHSC has contributed to the improvement of the health of individuals and communities across the nation and shaped careers of a multitude of primary care clinicians.

“Committing to the NHSC Scholarship Program means the clinician is willing to go to wherever the needs are greatest. If for personal or professional reasons an individual has ties to a specific geographic location, the variety of NHSC loan repayments may be a better option. Either way, an individual can pursue a primary care career and serve as one of America’s health care heroes.”

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The NHSC—which matches its mission to bring primary care to the underserved with those who want to practice primary care where they are needed most—sounds like a win-win. And for a time it was. In 1985, 1600 primary care physicians and other health professionals who received NHSC scholarships were sent to practice in Health Professional Shortage Areas (Table 1). That number has waxed and waned over time. By 2023, the most recent year for which numbers have been made public, the number of NHSC scholarships awarded fell to 228 for all primary care clinicians combined—that is, physicians, nurse practitioners, physician assistants, certified nurse midwives, mental and behavioral health professionals, dental hygienists, and dentists.

The reduction in NHSC scholarships reflects, in part, how much money Congress appropriates for the NHSC each year. But since loan repayment programs were added to the NHSC in 1987, loan repayment has become the vehicle of choice for the NHSC to place primary care physicians and others in underserved areas.

With a budget of close to $400 million in fiscal year 2023, the NHSC made 7,302 loan repayment awards and only 228 scholarship awards to all medical, dental, and mental health professionals.

With a budget of $345 million in mandatory funding for 2026, HRSA expects the number of scholarships to drop to 180 for all primary care clinicians combined.

On average, it takes students 7 years to complete medical school and residency training. David Keller surmises that the government doesn't want to make the investment in a medical student's education and then wait 7 years to begin reaping the benefits.

He says, "The scholarships awarded have been low for a long time. The loan repayments have been bigger. They seem to be the preferred method. From the government's standpoint, they don't give you loan repayment until you've done the work. You take a job at a community health center, and you work there for a year, and then you get to apply for loan repayment. I think the government's concern with scholarships is that people are going to welch on them and not do the work."

Joe Panerio-Langer highlights another obstacle to placing NHSC scholars as opposed to those who've received loans. "We've had more physicians come to us [at the Brockton Neighborhood Health Center] through the Loan Repayment Program than through the Scholarship Program. The Scholarship Program has stricter criteria—a health center's HPSA score has to be high enough—so qualifying for this program is a lot more difficult, and we haven't qualified for that since 2012. Not everyone at our clinic qualifies for the Scholarship Program but they do qualify for loan repayment."

The decreasing number of NHSC scholarships being awarded worries Joe because of what it portends for patient care. "Whenever you decrease the number of scholarships, you're going to have fewer doctors in the clinic. We have a very difficult time recruiting. The Scholarship Program has been a big help for our clinic and others in terms of getting providers in. And when we don't have those providers, the patients don't get in. And when they don't get in, their chronic diseases like diabetes are going to get much worse."

Michael Fine gets the last word. "Here's what changed in the late '80s: the NHSC stopped awarding as many scholarships and switched to loan repayment. So now, for most people, if you want to do things like work in community health centers, *you* pay for medical school,

you take out big loans, and then once you finish medical school and residency you have to pay back loans all during residency.

“Once you finish medical school and residency, if you take a job in a medically underserved area, then you can qualify for the repayment of your loans each year. Sometimes it’s $25,000, sometimes it’s $50,000. If you work in those places for 3, 4, 5, 6 years you can get your medical school loans paid down. That’s what the government is doing for most people most of the time.

“The NHSC Scholarship Program that I went into still exists, but it’s much smaller. For example, in 2023, 228 primary care clinicians from all disciplines were awarded new scholarships. Only about 27 of these, or 11.7% of that total, were primary care physicians (Table 2 and Figure 2).

“But scholarships and loan repayment offer different things for different people. Scholarships help people sitting on the fence who may never have chosen to go to medical school at all. This is particularly true for first-generation college students and those from immigrant families who might be frightened off by the cost of medical school and all those years of study.

“Loan repayment helps Federally Qualified Community Health Centers and other public organizations recruit people who have already chosen medical school and made it through, so Community Health Centers can successfully compete for workforce.

“Now, if you’re poor and growing up in Baltimore or South Providence or the South Bronx and want to go to medical school, you’ll have 4 years of medical school and 3 years of residency. That’s half a million dollars’ worth of debt. I think that discourages lots of young people from our communities from even thinking about going to medical school. And if you try, are you going to choose to work for $210,000 or $220,000 a year against that half a million-dollar debt? And take 10 to 20 years to pay down your debt, all while trying to buy a house and maybe saving for the education of your children? Or are you going to become an orthopedist or a neurosurgeon and make $800,000 or $900,000 a year? These differences help explain why so many medical students choose to become specialists, and why we have the terrible primary care shortage we have today.

“We’d have more primary care folks if we still had an NHSC of 1600 or 2000 or 2500 scholarships a year. I think the social construction of scholarships and loan repayment is entirely different today—we need scholarships with obligations to practice primary care more than ever. And that has not been really understood by anyone in government.

“I work in the city of Central Falls, the poorest city in the state of Rhode Island, so I have a sense of what first-generation kids have to think about and how they think. In the city of

Central Falls, a city of 21,000, 80% are people of color, and probably another 5,000-10,000 undocumented, there have been only 4—count them, 4—people to go to medical school in the last 30 years. See why we have trouble recruiting physicians who look like the communities they serve and who speak the languages they speak?

“There’s a whole cadre of people my age who did the Corps. By and large I think it was a great experience for most of us. And I think it was great for the country. Using public resources to get clinicians to HPSAs reduced the total number of medically underserved areas over time. If there hadn’t been the Corps there wouldn’t be Federally Qualified Health Centers, at least in their early years. If we were smarter as a country, we could provide scholarships with obligations to practice primary care to everybody who wants to go to medical school. Could we not quadruple the number of people who go to medical school and not have a shortage of primary care doctors by doing this? Sure, we could.

“Twenty percent of our primary care doctors used to come through the NHSC. And we just gave it up.

“Still, in the absence of federal funding for medical school scholarships, there’s no reason why communities can’t do this for themselves. In fact, communities *can* do this for themselves**.** The NHSC is a great model.

“You can go to medical school and get a job that will pay back your loans. We have a catch-as-catch-can health service market. We do not have a system that’s organized to provide the same set of services to every person in every neighborhood in every community. And the market does what markets are designed to do, which is create profit for investors. But creating profits for investors is not the same thing as creating health for communities.

“We need to help communities see that the cavalry isn’t coming. That they can provide primary care to everyone who lives there, on their own, without help from the state or Federal government if they choose to do so. That they can create their own scholarships with obligations to practice primary care, thus creating their own primary care workforce of young people and give those young people and the community itself a better life.

“The actual cost of primary care is no greater per-person-per-year than the cost of police and fire protection, or water and sewage, or roads. They’re all on the same order of magnitude as primary care, which the city you live in provides. Providing primary care to everyone would drop the cost of healthcare by 50%. Everybody would be healthier, and there would be fewer disparities on the basis of race, language, culture. The problem is, nobody has told communities how to do it. That’s why Primary Care for All Americans exists.”

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