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Closing the Gaps in the Rural Primary Care Workforce

An inadequate supply and uneven distribution of primary care providers (PCPs) currently exists in the United States. Before the Affordable Care Act was enacted in 2010, it was estimated that, by 2015, the nation's primary care physician shortage would reach 21,000. The law will bring an additional 32 million Americans into the pool of covered people, creating an increased demand for PCPs and placing an even greater strain on the primary health care workforce.

Research shows that those who obtain regular primary care receive more preventive services, comply with their prescribed treatments, and have lower rates of illness and premature death. This is due in part to the fact that an effective primary care system provides a team approach to patient care, which offers guidance to patients as they navigate the complex health care system. Such care increases patient engagement and compliance with provider instructions, such as taking medications as directed and making healthy lifestyle changes.

Approximately one-fifth of the nation's population lives in a rural area, but only about 10 percent of the nation's physicians are located there. This is considered to be one reason rural Americans have higher rates of death, disability and chronic disease than their urban counterparts. Of the 2,050 rural U.S. counties, 77 percent are designated as health professional shortage areas (HPSAs). Around 4,000 additional primary care practitioners are needed to meet current rural health care needs.

Challenges

Declining Interest in Primary Care. One factor contributing to the primary care practitioner shortage in rural America is that medical students have increasingly chosen non-primary care specialties. From the late 1990s to the mid 2000s, the percent of residents who specialized in general internal medicine decreased from 55 percent to 20 percent; by 2009, the number of family practice residencies filled with U.S. medical school graduates dropped to just 42 percent. One key reason for this shift is the growing disparity between pay for primary care practitioners and for specialists. Today, specialists can earn as much as three times more than primary care practitioners annually.

The news for primary care is not all bad, however. Data suggest that recent efforts to recruit more medical students to primary care residencies may be somewhat successful. In 2011, the number of U.S. medical students matched to family medicine residency positions increased slightly for the second straight year, rising by 11 percent over the 2010 numbers.

Aging Practitioners. Another challenge that likely will exacerbate the existing shortage of primary care practitioners in rural America is that a large number of rural primary care practitioners are nearing retirement age. A recent study found that nearly 30 percent of rural primary care practitioners are at or nearing retirement age, while younger practitioners (those under age 40) account for only 20 percent of the current workforce. This means that, in addition to the existing shortages, the number of new practitioners entering the workforce is well below the current replacement rate for retiring primary care practitioners.

Increased Demand. If the challenges of decreasing interest in primary care and the aging of existing practitioners weren't enough, these are set to coincide with one of the largest increases in demand U.S. medicine has ever seen. In 2011, the baby-boomer generation began reaching retirement age. It is estimated that the rural population of those ages 55 to 75 is set to increase by an estimated 30 percent between 2010 and 2020. This will have serious implications for the demand for services, since people tend to develop more medical needs as they age. As a result of the Affordable Care Act (ACA), an additional 5 million rural Americans (16 percent) are estimated to have health insurance coverage by 2019, either by way of a health insurance exchange or Medicaid. This expansion, combined with the increased demand of an aging population, will have dramatic effects for an already burdened rural health care delivery system.

Policy Options

Scholarship Programs, Medical School Recruiting Efforts. Studies show that physicians who grow up in rural areas are more likely to pursue careers there. Unfortunately, not enough rural students choose medical careers. To address this issue, a number of state legislatures have created programs to recruit and encourage high school students to pursue careers in rural medicine. At least 21 state legislatures have created such programs to recruit and provide incentives for medical students to practice in rural areas upon graduation by offering scholarships, grants and/or tuition breaks.

Rural Residency Training Programs. Expansion of medical residencies in rural areas presents another option for states. Medical students who graduate from rural residency programs are three times more likely to practice in rural areas than those who graduate from urban programs. Only 7 percent of U.S. family medicine residency programs currently are located in rural areas, and only 4 percent of urban residency programs offer rural training tracks.

Case Example: Mississippi Rural Physicians Scholarship Program
Created by the Legislature in 2007, the Mississippi Rural Physicians Scholarship Program provides rural students who wish to practice medicine in their home areas with financial support and mentoring opportunities with faculty and physicians in order to develop a strong rural workforce.

Student Loan Repayment. Many attractive aspects exist for practicing medicine in rural areas. One disadvantage, however, is that rural physicians typically earn less than their urban counterparts. For medical professionals who have thousands of dollars in student loan debt, the lower earning associated with rural practice can be cost-prohibitive. At least 16 state legislatures have attempted to address this issue by creating loan repayment programs for medical professionals who agree to practice in medically underserved areas of the state.

Case Example: North Dakota State Community Matching Physician Loan Repayment Program
In 1991, the North Dakota legislature enacted House Bill 1555, creating the State Community Matching Physician Loan Repayment Program. Designed to give physicians an incentive to practice in underserved rural areas of the state, the program matches up to $45,000 in state funds with an equal or greater amount from local communities for student loan repayment.

Non-Physician Primary Care Practitioners. Even with increased recruiting efforts and programs to encourage physicians to move to rural areas, rural America will still likely face significant shortages of primary care practitioners. Today, non-physician primary care practitioners make up nearly half (46 percent) of providers at rural federally qualified community health centers. Efforts to address the primary care shortage problems also include incentives for non-physician primary care practitioners such as nurse practitioners and physician assistants.

Other strategies include allowing non-physician primary care practitioners to assume more responsibility in meeting primary care needs. Nurse practitioners in Alaska, Arizona, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon, Washington and the District of Columbia, for example, can practice independently, and Maine allows nurse practitioners to practice independently after two years of supervision.

International Medical Students. In addition to non-physician primary care practitioners, some communities fill gaps with international medical graduates—those who earned a medical degree overseas. In the United States today, one in four (24.8 percent) primary care physicians earned their medical credentials in another country. The prevalence of international medical graduates practicing in rural areas varies, but as the nation attempts to increase the primary care workforce to meet demand, they are likely to play an increasing role and may offer one solution filling rural primary care needs.

Conclusion

States face significant challenges in meeting the health care needs of rural residents. These challenges are likely to increase considerably due to the aging baby-boomers and increased demand created by covering additional millions under the Affordable Care Act. Much of the responsibility falls to states to find new ways to fill existing and future gaps in the health care delivery system. No single approach will work to close the primary care gap in rural America. By using some of the approaches described in this brief, however, states are finding ways to improve future rural health care delivery.

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