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Great Variability in Geographic Access to Primary Care Facilities

Primary care physicians play an integral role within the U.S. healthcare delivery system, in part, because they promote communication with patients and encourage them to become a partner in health care by being more informed about their health needs.[1] For this reason, an appropriate primary care physician population is crucial for the healthcare system to be effective and efficient.[2] Too few primary care physicians would result in increased costs due to delayed care, worsened health conditions, and increased hospital and emergency room usage.[3] However, having too many primary care physicians could potentially increase healthcare spending due to the possibility that individuals would receive unnecessary health services.[4] Currently, the U.S. is experiencing uneven levels of access to primary care physicians, which could negatively impact health outcomes for persons lacking access to primary care services. The *Health Resources and Services Administration* (HRSA) identified 6,282 *Health Professional Shortage Areas* (HPSA) in primary care as of October 2015.[5] This Health Capital Topics article will discuss how, in light of the *Patient Protection and Affordable Care Act* (ACA) provisions promoting utilization of primary care, great geographic variability exists in many parts of the United States regarding access to primary care physicians. This article will also detail how geographic variability impacts access to healthcare services and overall community health while providing certain practices health systems can incorporate to address geographic variability in primary care access.

The expansion of health insurance coverage under the ACA has increased the ability of more members of the U.S. population to access primary care services. As of May 2015, 17 to 18 million Americans are newly insured as a result of the ACA's expansion of private insurance coverage and expansions to Medicaid eligibility.[6] The increase in new health insurance enrollees will likely exacerbate the already-existing healthcare workforce shortage, particularly in primary care facilities,[7] because the ACA, once fully implemented, is projected to increase the number of Americans who are able to obtain health insurance coverage by 30 to 34 million.[8] Due to the increase in the number of Americans who are able to obtain health insurance coverage, concerns have been raised about the capacity and availability of the primary care physician workforce.[9] HRSA noted that, to reach a ratio of one primary care physician for every 2,000 members of the population (which is often found to be a suitable level of primary care access), over 16,000 primary care physicians would be needed.[10] However, other observers who are incorporating projected increases in the number of persons with health insurance call for the recruitment of much higher numbers of primary care physicians. For example, a study by the Annals of Family Medicine, estimated that, after incorporating coverage expansion and projecting the resulting increase in physician office visits, an additional 52,000 primary care physicians would be needed by 2025.[11]

Satisfying the ACA's aim of increasing primary care utilization may be hindered by geographic maldistribution of primary care physicians. As stated above, over 6,200 primary care HPSAs currently exist in the United States;[12] in the past, many of these primary care HPSAs have been located in rural areas as defined by the U.S. Census Bureau.[13] However, new research is beginning to demonstrate that persons living in urban census tracts may also lack meaningful access to primary care services. In May 2015, a study conducted by members of the University of Pennsylvania's Leonard Davis Institute of Health Economics found significant variability in access to primary care for persons living in different neighborhoods in Philadelphia. While finding that, as a whole, Philadelphia's population to primary care provider ratio sat as an acceptable 863:1 level, the range of access between Philadelphia neighborhoods varied from approximately 250:1 to in excess of 2600:1.[14] Many of the neighborhoods identified by the study were clustered into six larger areas of the city, which had varying rates of public insurance utilization, unemployment, and poverty.[15] The study noted the need for continuing research regarding the role of unemployment, poverty, racial makeup, and public insurance utilization as factors influencing access to primary care services but stated that "*these factors and others are likely to be inter-related and explain…the available primary care supply.*"[16]

A number of factors have contributed to the geographic maldistribution of primary care physicians. Physicians, in deciding where to practice and what specialty to practice, often are motivated by legitimate personal needs and goals.[17] These factors include location preferences, projected workloads,[18] and specialty

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preferences.[19] In determining location preference, primary care physicians frequently consider: (1) the type of lifestyle they would like to achieve; (2) quality of schools and education for their children; (3) housing preferences; and, (4) stability of community.[20] Together, these factors help push primary care physicians to live in more affluent areas, which often leaves rural areas and poorer urban areas underserved.[21] In conjunction with location preferences, medical students consider the potential compensation primary care physicians can expect after graduation, which is often lower than specialty physician compensation.[22] When considering student loan debts in relation to potential primary care physician salaries, specialty practice is often viewed as the more lucrative and more attractive option.[23]

With the increase in the number of Americans eligible for private and public health insurance, primary care physicians are expected to increase their caseloads, which may also discourage primary care physicians from practicing in certain areas.[24] The increase in persons with health insurance as a result of the ACA has reduced many geographic and economic variances in health insurance coverage; however, many U.S. regions currently experiencing significant growth in the number of insured individuals, particularly less affluent urban regions, are also facing the most extreme shortages in primary care physicians.[25] The authors of the University of Pennsylvania study note that, in urban areas, the "*distribution of providers may be more of a problem than the absolute number*," noting that "*the latest evidence suggests that urban areas are relatively oversupplied, and rural areas undersupplied*."[26]

The lack of meaningful access to primary care providers contributes to an increase of morbidity and mortality for underserved areas.[27] Due to the limited availability of primary care physicians in certain areas, waiting times in physician offices may increase, patients may need to travel longer distances for care, and further resources, such as specialty physicians, needed to treat more complex conditions may not be accessible.[28] Further, aging baby boomers will also create a strain on the primary care workforce as older adults tend to suffer from chronic diseases, which often require more frequent primary care visits.[29] Finally, as physicians become more dissatisfied with increased regulatory scrutiny and the financial costs of private practice, physicians may sell their practices, which may lead to increased coordination of care but also may reduce the impact of competitive forces on improving care quality.[30]

The ACA has included several provisions to address geographic differences in access to primary care.[31] A number of the provisions provide grants, scholarships, loan repayment, and fellowship programs to underrepresented minorities from rural areas and students of disadvantaged backgrounds to pursue careers in the healthcare profession.[32] For example, Section 5403 amended the *Area Health Education Program* (AHEP) to authorize grants that support physician recruitment and retention in underserved areas.[33] In addition, Section 10501(l) has authorized medical schools to play a more proactive role in promoting students to practice in underserved communities through focused training and experiences in rural and urban HPSAs.[34] Little data is available to determine the impact of these and other ACA provisions in attracting new primary care physicians and utilizing primary care physicians to address geographic variability in access to primary care.

Even though primary care accessibility varies throughout the U.S., health systems can help reduce this variability in access. First, health systems can expand the roles of nurse practitioners and physician assistants within the bounds of their licensure as well as within Medicare supervision requirements.[35] By utilizing a diverse clinician workforce, health systems can expand a primary care physician's workload capacity and allow more patients to access primary care services.[36] Additionally, health systems can improve access to primary care by removing physicians from performing many necessary but inefficient tasks common within primary care, including counseling on lifestyle issues and the refusal to utilize "*panel management*" processes for routine services.[37] Under a "*panel management*" process, primary care physicians develop a database of routine, preventive services commonly administered or prescribed by a primary care physician, such as colorectal cancer screenings, mammograms, and immunizations.[38] From this database, mid-level providers cross a patient's medical record with the database to determine whether a routine service is needed, thereby freeing the physician to perform more complex medical duties.[39] Promoting these efficiencies could not only reduce costs to health systems but also allow health systems to make smarter investments in primary care HPSAs for the provision of primary care services.

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