Rural Health Policy Briefs

Access to Primary Care

Status of Rural Primary Care

One of the most significant health issues facing rural America is simply having adequate access to essential providers. In rural areas, essential providers can be found in a variety of organizational settings: hospitals, clinics, nursing homes, ambulance units, and public health units. The focus of this policy brief will be on two categories of health professionals providing essential services: primary care physicians (e.g. specialties in family practice, general practice, general internal medicine, pediatrics, and obstetric/gynecology) and non-physician providers (e.g. physician assistants, nurse practitioners, and certified nurse midwives).

Approximately 51 million Americans (20 percent) live in a non-metropolitan area (the term non-metropolitan will be used interchangeably with the term rural); however, only about 11 percent of the practicing physicians practice in these rural areas (Office of Rural Health Policy, ORHP and National Rural Health Association, NRHA). Rural populations can be characterized as being older, economically poorer, less likely to have health insurance, and having poorer health status than their urban counterparts (NRHA and Capital Area Rural Health Roundtable, CARHR). All of these factors contribute to and exacerbate the problem of rural primary care access.

The availability of providers also contribute to the access issue. Approximately 40 percent of people living in a non-metropolitan area reside in a federally designated primary care physician shortage area (ORHP). The federal government estimates that more than 2,200 physicians would be needed in non-metropolitan areas to eliminate the primary care health professional shortage area. Rural people are four times as likely as urban residents to live in a federal shortage area (ORHP).

Even within rural areas one can identify subgroups experiencing even greater access problems. Between 1975 and 1995, the smallest counties, those of 2,500 people or less, experienced a drop in the ratio of physicians to population (ORHP). These are the most vulnerable rural areas and typically fall into another classification referred to as "frontier."

In addition to physicians, another important provider group is the non-physician provider. This group is composed of nurse practitioners, physician assistants, and certified nurse midwives. Non-physician providers typically work either in a collaborative relationship with a primary care physician or are supervised by a physician. Research shows that these providers can provide from 60 to 80 percent of a patient's primary care needs or functions performed by physicians (Rural Information Center Health Service, RICHS). Non-physician providers are in heavy demand in rural and frontier areas either to augment physician services in a tight market or, where physician recruitment and retention has become prohibitive, to replace physician services.
The rapid growth in the number of federally certified rural health clinics, which require the employment of a non-physician provider, has directly impacted the demand for this critically important provider group. While demand is high, the supply, as measured by practice location, has not kept pace. As of 1997, 38 percent of physician assistants and less than 15 percent of nurse practitioners were practicing in a non-metropolitan area (The Nurse Practitioner, 1997). As of 1992, 22 percent of certified nurse midwives were in a rural practice (RICHS).

Primary Care Provider Issues

A number of issues kindle the rural primary care provider situation contributing to problems of access, facility viability, and health system stability.

Economics: Rural providers are more dependent upon public payers, such as Medicare and Medicaid than are urban providers. Public programs typically pay at a lower rate than private payers. Overall, rural providers typically earn less income in a year than their urban counterparts.

Work Environment: Rural providers typically work longer hours and have more patient visits per week than urban providers. For example, rural primary care physicians have 38 percent more patient visits per week than metropolitan physicians (ORHP). Rural providers are dependent upon health facilities (e.g. rural hospitals and rural health clinics) that are experiencing their own viability problems.

Isolation: Rural providers must sometimes contend with both family and professional isolation. Family issues (e.g. significant other's wishes/employment, recreation/culture, proximity to family/friends,) are significant variables in the physicians' decision making process on practice location following residency training (Geyman, 2000). In some cases, providers from other countries (e.g. J-1 Visa waiver) or from urban backgrounds must confront cultural adjustments. For non-physician providers there are still isolated cases of physician and community resistance to what is seen as a non-traditional provider. New technology in the form of telemedicine networks, provider list serves, and the Internet are heralded as ways to help address professional isolation.

Health Policy: Health policy can significantly impact the environment in which providers operate. One such policy change involves federal regulations affecting the methodology for health professional shortage area and medically underserved area designations. Both are critically important designations as they allow for a variety of federal assistance. The preliminary 1999 rules produced a serious response from rural providers as a number of shortage and underserved areas would have been eliminated. For example, 52 percent of North Dakota's shortage areas would have been lost. After strong efforts on the part of rural health advocates, new designation rules are being developed. Comprehensive budget reform such as the Balanced Budget Act (BBA) of 1997 and the Balance Budget Refinement Act (BBRA) of 1999 have had significant impact on providers. A general "rachet-down" effect was noted in Medicare payments under the BBA. Current federal policy is set to expand a prospective payment methodology to outpatient, nursing home, and home health services. The BBRA was an attempt to ameliorate some of the more negative impacts of the BBA and it is expected that future policy will continue
the refinement; thus, health policy, including primary care, will continue to be impacted by legislative and regulatory changes. The BBA also created a new safety net provider group, the Critical Access Hospital program which is expected to help stabilize some small hospitals, expand or create hospital networks, and strengthen rural emergency medical services.

**Education:** While the number of medical students selecting a primary care residency has increased significantly, this does not necessarily translate into an increase in the number of rural physicians. More work, particularly during the educational experience, must be done to expose students to rural health settings. The medical and health sciences' education system must continue to open doors to direct rural-based training. Students of all health disciplines can and do benefit from a rural experience as the benefits of rural practice can be witnessed on a first hand basis. Multi-disciplinary and inter-disciplinary training efforts afford students new opportunities to learn from different health professionals.

In conclusion, an individual's access to primary care is influenced by the viability of the local and area health system, financial resources, and an adequate supply of direct providers. Rural areas struggle with these access issues; moreover, primary care provider issues (e.g. economics, work environment, isolation, policy, and education) are systemic and pervasive issues that demand the attention of rural health advocates and health policy makers.

**References**


Rural Information Center Health Service. "Rural Health ...in Brief, Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives: Primary Care Providers in Rural Areas." July, 1994.