

IMPLICATIONS OF AN AGING PRIMARY CARE PHYSICIAN WORKFORCE IN KANSAS

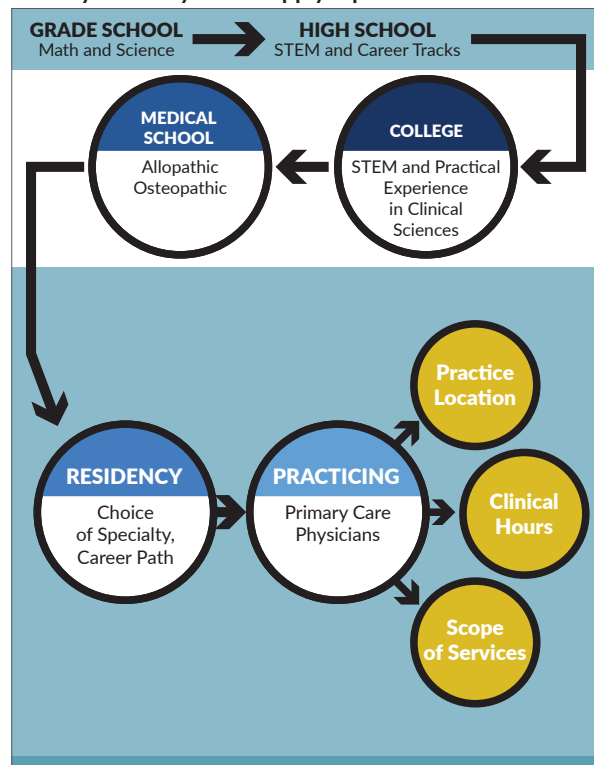
This issue brief is the second of a two-part series examining the primary care workforce in Kansas. It describes the age and geographic distribution of primary care physicians in Kansas. The first, [Defining the Primary Care Workforce in Kansas](#), describes the clinicians who comprise the primary care workforce.

As doctors retire and the population ages, the demand for primary care providers in Kansas is expected to outpace the supply. Kansas has a shortage of primary care physicians (PCP) and that shortage has serious implications for an aging population. By 2039, nearly one-quarter (22.5 percent) of Kansans will be age 65 or older, and likely will have increasing medical needs. Using 2019 licensure data from the Kansas State Board of Healing Arts (BOHA), this issue brief examines the current number of PCPs in Kansas, where they are practicing and the number approaching retirement age.

The estimates presented in this brief are based upon the best available data from the state. Information on physician specialty is not precisely and consistently collected to delineate which physicians are delivering primary care. Further, physicians are not required to report data such as secondary practice locations, how many hours per week they work and how many patients they treat. This information is critical to better understanding the PCP workforce in Kansas.

While many other clinicians deliver primary care, including physician assistants (PA) and

Primary Care Physician Supply Pipeline



nurse practitioners (NP), this issue brief focuses on the availability of primary care physicians. Future studies should explore the availability of other providers comprising the primary care workforce in Kansas.

KEY POINTS

- ✓ The geographic distribution of primary care physicians (PCP) varies widely across the state. Generally, the southeast and southwest regions of Kansas have fewer PCPs available to serve the population.
- ✓ The PCP shortage has serious implications for an aging population — by 2039, nearly one-quarter (22.5 percent) of Kansans will be age 65 or older, and likely will have increasing medical needs.
- ✓ Aging of the physician workforce could further intensify the primary care workforce shortage as nearly 4 in 10 (39.2 percent) PCPs in Kansas are over the age of 55. Nearly half (45.2 percent) of PCPs practicing in southwest Kansas are age 55 and older, as are 42.5 percent of those practicing in southeast Kansas.
- ✓ A multi-pronged approach to train, recruit and retain PCPs in Kansas is necessary to maintain and improve access to care across the state.

Geographic Distribution

Access to high-quality health care requires sufficient availability of PCPs to provide preventive and primary care services for a population. One way to measure access to care is to calculate PCP ratios, which represent the number of individuals per each PCP in a geographic area. A lower PCP ratio indicates fewer patients per physician in that region, which is generally associated with better access to care. The geographic distribution of PCPs across Kansas (Figure 1, page 2) could lead to disparities in health outcomes.

The state of Kansas has an estimated PCP ratio of 1,512:1, with the PCP ratio varying widely across regions. Generally, the southeast and southwest regions of Kansas have fewer PCPs available to serve the population (i.e., higher PCP ratios). Southeast Kansas has the highest estimated PCP ratio at 1,991:1, which is 31.7 percent higher than the state

of Kansas overall. Southwest Kansas has the second highest estimated PCP ratio at 1,729:1.

Although PCP ratio is a widely used measure of access, it has limitations. First, the ratio does not consider distance; for example, PCPs might be concentrated within a city in a region, creating access issues for individuals who live far from that city. PCPs also might practice in multiple locations and see patients residing in other regions of the state, but not adequately report this to BOHA. The ratio does not account for differences in health insurance coverage, other clinicians who could deliver primary care services, or population differences (e.g., age, chronic conditions) that might affect how often people need care. Lastly, it does not consider PCPs providing direct primary care or concierge medicine, who typically choose to serve a smaller number of patients for a monthly or annual fee.

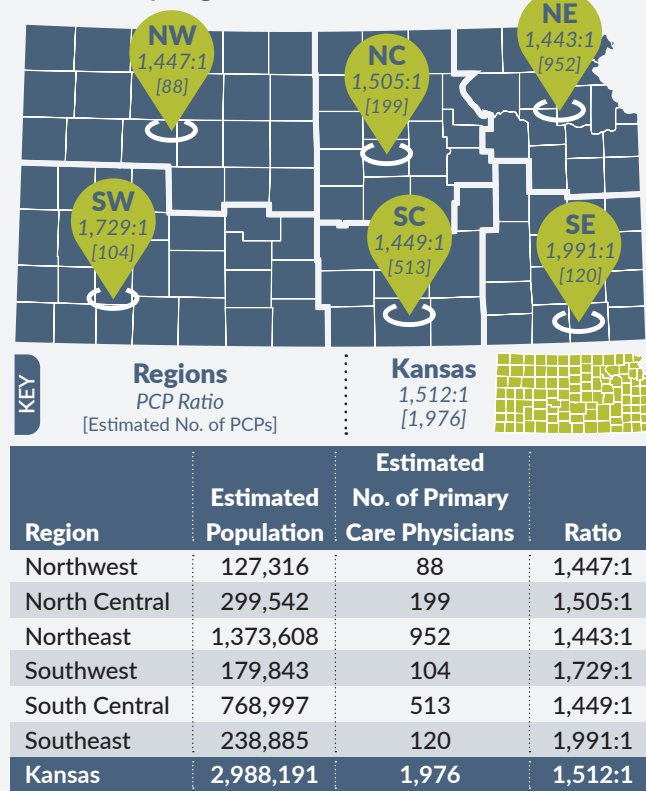
Age and Retirement

An aging physician workforce can signal an impending shortage in physician access because of retirements and reduced workloads as physicians tend to slow their practices. According to 2019 data from BOHA, 105 Kansas PCPs indicated on their licensing forms that they plan to retire in the next five years. While this is not mandatory for physicians to report for licensing purposes, the information is useful to better understand where gaps in the workforce could arise.

An estimated 15.6 percent of PCPs in Kansas are already age 65 and older, ranging by region from 12.1 percent to 21.2 percent in 2019 (Figure 2, page 3). Furthermore, nearly four in 10 (39.2 percent) PCPs are over the age of 55. In the next 10 years, these providers might retire or at least slow their practice. Having complete full-time equivalent (FTE) data would provide a more accurate picture of the practice habits of these providers, to understand if PCPs over age 55 have already begun to slow their practices.

Depending on the number of PCPs entering the workforce in Kansas and where they choose to practice, retirement might significantly affect the shortage of PCPs around the state. Nearly half (45.2 percent) of PCPs practicing in southwest Kansas are age 55 and older, while PCPs age 25-39 account for only one-quarter (26.0 percent) of the workforce in that region. Southeast Kansas also has a high proportion of PCPs age 55 and older (42.5 percent)

Figure 1. Population Per Primary Care Physician in Kansas, by Region, 2019



Note: The estimated primary care physician (PCP) ratio is calculated by dividing the estimated population by the estimated number of primary care physicians. Regions are designated using the Kansas Department of Health and Environment District Office Map Boundaries. This analysis is limited because it does not include full-time equivalent (FTE) information.

Source: KHI analysis of 2019 Kansas State Board of Healing Arts licensure data and Wichita State University 2019 population projections.

and the lowest proportion of PCPs age 25-39 (16.7 percent). In contrast, north central Kansas has the highest proportion of PCPs age 25-39 (29.1 percent) and the lowest age 55 and older (33.2 percent).

Strategies to Address the Workforce Shortage

The state should consider collaborative and innovative approaches to efficiently deliver primary care services and address regional disparities. A combination of efforts to train more primary care physicians in Kansas, recruit more to the state and retain current physicians will be necessary.

Training

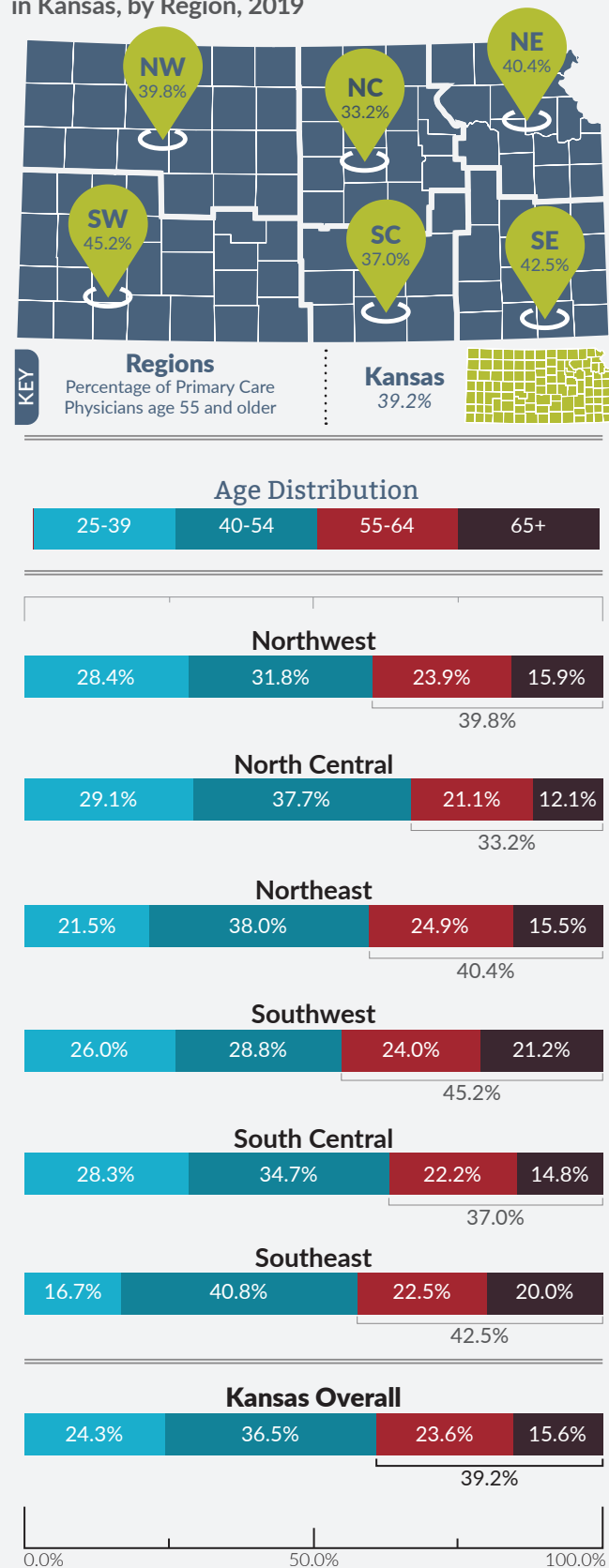
To increase the number of PCPs practicing in Kansas, one strategy could be to increase the number of medical school and residency positions in the state which have not kept pace with increases nationally. Recent developments hold promise for increasing the number of PCPs in Kansas:

- The bipartisan Resident Physician Shortage Reduction Act of 2019 (S. 348, H.R. 1763) was introduced to increase the number of medical resident training positions by 15,000 over the next five years. A provision of the bill states that at least 50 percent of the new residency slots are to be used for a shortage specialty residency program.
- The Community Health Center of Southeast Kansas (CHC/SEK) received a \$750,000 grant from the Health Resources and Services Administration (HRSA) for its new Rural Residency Planning and Development Program (RRPD) in Family Medicine, a collaboration with the University of Kansas School of Medicine. The residency program will initially train two physicians annually, with a plan to eventually graduate four physicians from the program each year.
- Increasing the number of medical students trained in Kansas either at the KU campuses or through the proposed new osteopathic medical school in Wichita.

Recruiting

Training strategies could be coupled with recruitment strategies to bring more PCPs to the state and to encourage students to pursue a career in medicine

Figure 2. Age Distribution for Primary Care Physicians in Kansas, by Region, 2019



Note: Total number of estimated primary care physicians = 1,976. Percentages may not sum to 100 percent because of rounding. Regions are designated using the Kansas Department of Health and Environment District Office Map Boundaries. Source: KHI analysis of Kansas State Board of Healing Arts licensure data, 2019.

and primary care. For example, some programs target high school students to encourage them to consider health professions as a potential career, particularly in rural areas. Another option to strengthen the primary care workforce includes recruiting medical professionals via federal and state loan repayment programs.

The National Health Services Corps (NHSC) helps repay qualified loans in exchange for a two-year commitment to provide health care services in eligible Health Professional Shortage Areas (HPSA). There were 84 Kansas participants — including physicians, dentists and other clinicians — in the NHSC program in 2018. The State Loan Repayment Program (SLRP) offers similar assistance, and from 2011 to 2018 there were 13 physician awardees of the SLRP in Kansas. While more provider specialties have been made eligible for the SLRP, federal funding was reduced from \$150,000 to \$135,000 in 2018, while state funding remained the same at \$150,000.

The Kansas Medical Student Loan Program (MSLP) offers full tuition payment and a \$2,000 monthly stipend for up to 30 students each year (120 at any given time) in return for agreements to practice primary care in underserved areas in Kansas. Under the Kansas Bridging Plan (KBP), the state funds up to 13 PCP slots annually in exchange for a three-year commitment to practice in rural communities. Since 1991, 337 residents have enrolled in KBP, and of the 245 physicians that have completed the program, 85 percent continue to practice in Kansas. Finding new funding sources or increasing state funds for loan repayment programs might improve recruitment of PCPs.

Kansas also has recruited international medical graduates, physicians who earned their degrees in another country. Kansas participates in the J-1 Visa Exchange Visitor Program, which allows up to 30 international medical graduates to practice medicine

full-time for a minimum of three years in a federally designated HPSA in Kansas.

Retaining

Retaining physicians is an important way to reduce workforce shortages. Ways to retain physicians might include lowering the cost of medical malpractice insurance, allowing flexible work schedules or finding other ways to address provider wellness. While few promising strategies have yet emerged to address provider wellness, one strategy could be collaborative team-based practice. Research suggests PCPs could increase the number of patients they can serve — referred to as panel size — using health care teams comprised of clinical (i.e., physician assistants and nurse practitioners) and nonclinical staff, who offer a broad set of skills which complement and improve the efficiency of PCPs. The PCP could achieve a reasonable panel size through effective team-based task delegation and potentially avoid burnout or other stressors. Recent federal policies are designed to reward value and care coordination, reinforcing the need for a reasonable panel size to ensure high-quality outcomes.

In addition, some states, such as Alabama, offer tax credits to encourage PCPs to practice in a federally designated HPSA. Finally, adopting and streamlining new technological innovations under telemedicine or telehealth tools could increase access to care and reduce administrative burden.

Conclusion

While the need to expand the PCP workforce is heightened by both an aging workforce and an aging population, innovative approaches could help better prepare the state for future needs, especially in rural areas. Further, more consistent collection and analysis of critical information by licensing authorities is needed to effectively understand, manage and build the PCP workforce.

ABOUT THE ISSUE BRIEF

This brief is based on work done by Hina B. Shah, M.P.H., Sydney McClendon, and Madison Hoover, M.P.H. It is available online at khi.org/policy/article/20-22.

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KANSAS HEALTH INSTITUTE

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