

# Chapter 1

## Introduction

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The World Organization of Family Doctors recently observed that rural residents throughout the world “generally have reduced access to health care and less favorable health status and outcomes when compared to urban populations” (WONCA, 2003). This situation is common to both developing and developed countries, including the United States. Rural U.S. residents deserve the same health care access and quality available to people living in urban and suburban settings, but often, they don’t receive it.

This disparity results in large part from the difficulty in creating, supporting, and maintaining an adequate and appropriately trained rural health care workforce. Correcting the inequities in access to care across the rural-

urban divide requires an understanding of both the general issues that confront rural health care and of the substantial variations in the nature and severity of the problem across different rural communities. The specific needs of rural areas in the United States vary widely. Health workforce solutions require sensitivity to these issues of rural diversity. “One size fits all” rural solutions are unlikely to fit anybody very well.

More than 22 million rural Americans now live in federally designated Health Professional Shortage Areas, where fewer than one primary care physician serves 3,500 people or more. (In contrast, the average primary care physician-to-population ratio in the urban United States is about 1:1,285.) These Americans, who comprise more than 10

percent of the U.S. population, may not only have less access to medical care than their urban counterparts—they may lack it altogether.

Physicians illustrate the rural health workforce problems of shortage and maldistribution particularly well. However, nurses, nurse practitioners, physician assistants, dentists, pharmacists, and various allied health professionals are also in short supply in many rural areas (COGME, 1998; Hart et al., 2002).

Health policy makers who want to ensure better access to care for rural residents must find ways to improve the supply and distribution of providers willing to practice in rural settings. This requires knowledge of the unique environments in which care is delivered and of the demography and health care needs of rural populations. Rural hospitals and clinics are smaller than urban ones, so local access to specialty and sophisticated high-technology care may be limited. Rural poverty rates often exceed



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those in urban areas, a situation that contributes to high rates of uninsured and underinsured residents and limited capacity to pay out-of-pocket costs for care. In addition, rural populations are often older, sicker, and less educated than urban populations.

In this volume, we describe the rural health workforce within and across the 50 states and address concepts, trends, and issues that are important in rural workforce analysis. The book is organized as follows.

**Chapter 2** introduces concepts and trends that are central to understanding and analyzing the status of the rural health care workforce. Topics include provider supply, quality of care, the effect of the increasing proportion of female physicians on the rural physician supply, recruitment and retention of providers, rural training and reimbursement, and managed care. The chapter provides an overview of national health workforce trends that influence the rural workforce, and it identifies critical emerging issues in the rural workforce.

**Chapter 3** discusses key methodological issues in rural workforce analysis. These issues include defining rural areas and populations, regionalizing care, designating shortage areas, and estimating the supply of providers.

**Chapter 4** provides selected state comparisons in demography and health workforce supply and training. Figures illustrate wide variations across the states on key indicators. Policy makers and analysts may use this chapter to compare their states with others in key health workforce

areas and to adopt its presentation methods to create their own comparisons using related data.

**Chapter 5** is the heart of this book. It offers a two-page profile of the health workforce of each state and details both rural-urban and intrarural variations in the availability of health care providers. Policy makers, program managers, and analysts may use data from the state profiles to enhance their understanding of how each state's workforce varies across different areas and over time. The profiles also show how each state ranks compared to the other 49 states. The profiles present comparable data for all states, so readers may use this information to make selective comparisons of states and topics of interest.

In **Chapter 6**, the conclusion to this monograph, we highlight primary issues in rural health workforce research and policy.

At the end of this volume, we provide resources and Web sites with additional information on a variety of health workforce topics and issues.

The rural health care workforce serves a population that would constitute the 23rd largest nation in the world. Ensuring an adequate supply and appropriate distribution of health providers to serve this population is a complex and important policy issue at both the state and federal levels. The information and analysis we provide will assist those concerned with rural health workforce issues in seeking effective policy solutions and improving the state of health care in rural America.

