**Georgia is positioned to lead national strategies for the retention and distribution of physicians.**

**Problem: Georgia has a quantity and distribution problem for the physician workforce.**

**Solution: adopt strategies with accountability and metrics to help appropriators understand the return on investment.**

Rural communities face a shrinking healthcare workforce, particularly with primary care physicians, which can lead to delayed preventive care, higher emergency room use, higher travel time, and higher unmet needs[[1]](#footnote-2). Every state except for West Virginia has grown its overall physician workforce over the last decade, but rural physician decline is plaguing over 80% of states as nearly all physicians are going to work in urban areas[[2]](#footnote-3). Georgia has increased its statewide physician workforce by 1,093 from 2010 to 2021, but not enough to keep up with population growth, and most physicians have stayed within urban counties, as rural counties have seen a decrease of 62 physicians within the same time2.

The growing problem has been documented for decades, with recommendations provided to states for nearly the same amount of time[[3]](#footnote-4),[[4]](#footnote-5). These recommendations focus on strengthening what is known as the Graduate Medical Education (GME) pipeline, which ranges from generating interest in the healthcare workforce for pre-college students to retaining established physicians to continue practicing in rural areas.

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Georgia may follow these best practices if it aims to grow the rural physician workforce:

1. Learn from other state initiatives and implement successful programs aligned with Georgia values. This will create competitive funding and improved incentives for physicians. Examples include loan repayment programs, medical school admissions initiatives, contractual arrangements, and the inclusion of rural areas in GME rotations.
2. Ensure that outcome and ROI analyses are written into the programs and that funding is allocated specifically for that purpose. This could strengthen partnerships between the state and medical colleges/universities by generating research and publishing opportunities.
3. Rather than relying on non-Georgia examples, create a positive feedback loop to incrementally improve programs by conducting analyses on Georgia-specific programs.

Georgia has an opportunity to be a national leader to improve the GME pipeline. Nearly all states implement programs to recruit and retain physicians in rural areas but do not include return on investment analysis to verify outcomes and understand the best tactics to increase the rural physician workforce.

1. Zolotor, A. J., Galloway, E., Beal, M., & Fraher, E. P. (2022). Primary Care Clinicians in Low-Access Counties. *North Carolina medical journal*, *83*(3), 163–168. <https://doi.org/10.18043/ncm.83.3.163> [↑](#footnote-ref-2)
2. Health Resources & Services Administration. Data Downloads:Area Health Resources Files. <https://data.hrsa.gov/data/download> [↑](#footnote-ref-3)
3. Fraher EP, Spero JC. The State of the Physician Workforce in North Carolina: Overall Physician Supply Will Likely Be Sufficient But Is Maldistributed by Specialty and Geography. Program on Health Workforce Research and Policy, The Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. August 2015.

   Oregon Office of Rural Health. (2011). Report: Oregon Federally Certified Rural Health Clinics.  [↑](#footnote-ref-4)
4. [↑](#footnote-ref-5)