

# Workforce Development Along the Border



## Economic Impact of Medicine Is Significant

The business of medicine and health care is a significant economic contributor to Texas, and a critically needed component of the workforce.

- › Active patient-care physicians in Texas → **>56,765**
- › Total number of jobs → **>670,000**
- › Average number of jobs created per physician → **13.1**
- › Total annual output in Texas → **Almost \$118 billion**
- › Industry comparisons → **Home Health: \$22.4 billion**  
**Legal Services: \$43.5 billion**  
**Higher Education: \$10.98 billion**



## Challenges Along the Border

Facing a significant socioeconomic disparity to the rest of the state, our border has real challenges.

The vast majority of the border region is designated as a health professional shortage area and a medically underserved area. More than \$3 billion in productivity is lost annually to chronic illness, which is widespread in the border region. Nearly half of the population has no health insurance, and Medicaid is the primary coverage provider where coverage exists.

The border is disproportionately affected by more complex pathologies, including higher obesity, diabetes mellitus, cervical cancer, caesarian section delivery rates, and certain contagious diseases including tuberculosis. Simultaneously, care is more fractured and less continuous, which is complicated by lower reading and writing skill levels and a more transitory population.

Like other parts of Texas, rapid growth poses multiple challenges including the development of a sufficient health workforce and access to primary, preventive, and specialty care.

Texas is recruiting more physicians to the state but still ranks 42nd in ratio of physicians per capita (all specialties); 47th for primary care; and 46th for general surgeons.

TEXAS BORDER	VS	TEXAS NONBORDER
<b>2.9 million</b>	Population	<b>27.8 million</b>
<b>87 %</b>	Hispanic ethnicity	<b>35%</b>
<b>24.7 %</b>	Below poverty level	<b>13.1 %</b>
<b>38.5 %</b>	Adults aged 19-64, no health insurance	<b>21.9 %</b>
<b>29.7 %</b>	Do not speak English very well	<b>11.5 %</b>
<b>28.9 %</b>	No high school diploma, ages 25+	<b>14.3 %</b>

Data sources: Population size and percent of Hispanic ethnicity from [Texas Population Projections Program](#), July 2018 projections for 2022. Most recent projections available as of June 23, 2022.

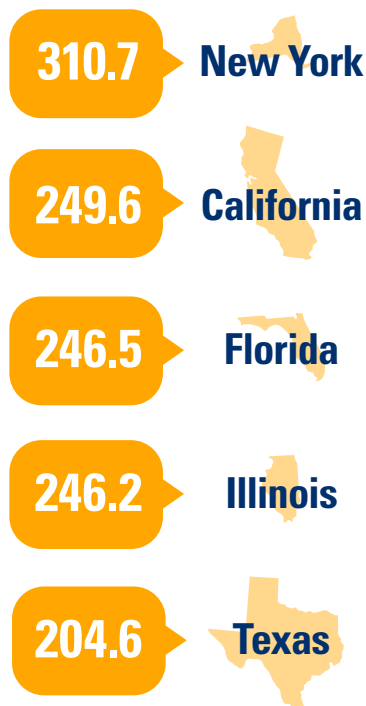
Remaining data from [U.S. Census Bureau](#), 2016-2020 American Community Survey 5-Year Estimates. Percentages computed from files S1701 Poverty Status in the Past 12 Months, S2701 Selected Characteristics of Health Insurance Coverage in the United States, S1601 Language Spoken at Home, B15003 Educational Attainment for the Population 25 Years and Over. Most recent 5-year estimates available as of June 23, 2022.

From DSHS website: [Texas Department of State Health Services \(DSHS\) Office of Border Public Health](#)

## Improving Access to Care

Texas still lags all other populous states in the ratio of physicians per capita despite the fact that more than 5,000 new physicians are licensed each year in the state.

### Ratio of Patient Care Physicians Per 100K Five Most Populous States, 2020



And direct patient care ratios starkly demonstrate an even more desperate need for more primary care physicians in Texas, with only 67.5 per 100,000 population.

Texas is leading the nation in population growth. More residency positions are needed to train physicians to keep up with this growth. This requires more federal support for growing residency positions.

Hospitals that train new physicians are limited in the number of training positions that Medicare will pay for through the graduate medical education (GME) funding program – the number of positions has been capped at 1996 levels. Medical schools report concern about enrollment growth outpacing GME opportunities and clinical training sites.



## Congress Can Help With Some Necessary Fixes

- ✓ Increase or eliminate the Medicare residency cap, which is still based on residency training numbers from more than 25 years ago.
- ✓ Increase indirect medical education payments to teaching hospitals.
- ✓ Increase GME training capacity at rural hospitals and in underserved areas.
- ✓ Incentivize primary care GME training.
- ✓ Address the significant imbalance in the Medicare GME funding base rates for many states, including Texas.
- ✓ Facilitate the development of new teaching hospitals by allowing hospitals in underserved communities and/or economically depressed areas to have flexibility in the Medicare GME cap-setting schedule. Rather than establishing the Medicare GME funding caps after five years, allow up to 10 years in areas that face greater challenges in establishing new residency programs.



[www.texmed.org/Border](http://www.texmed.org/Border)

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