Primary Care Needs Assessment

South Carolina

2026

September 2026

Prepared by the
South Carolina Office for Healthcare Workforce (SCOHW)
on behalf of the South Carolina Department of Public Health (DPH)
Primary Care Office (PCO).

Report Preparation:

This report was prepared by the South Carolina Office for Healthcare Workforce (SCOHW) at the request of the South Carolina Department of Public Health (DPH) Primary Care Office (PCO).

SCOHW is a division of the South Carolina Area Health Education Consortium Program Office (SC AHEC). SCOHW analyzes data and provides policy-relevant information about the healthcare workforce in South Carolina.

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Funding:

Funding for this report was made available through the HRSA State Primary Care Office Grant awarded to SC DPH.

Suggested Citation:

Palmer C, Chastain-Brown A, Fu B, Gaul K. Primary Care Needs Assessment, South Carolina, 2026. Charleston, SC: South Carolina Office for Healthcare Workforce, South Carolina AHEC. September 2026.

SOUTH CAROLINA Office for HEALTHCARE WORKFORCE
A division of South Carolina AHEC

DPH
SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Table of Contents

Executive Summary i

Background 1

A Description of the Target Populations in South Carolina and Their Unmet Health Needs 1

Figure 1. Metropolitan Status and DPH Regions, SC, 2023 2
Table 1. Population Characteristics, SC, 2023 2
Table 2. Standard Morbidity and Mortality Rates, SC, 2020-2024 3
Table 3. Poverty Rates and Socioeconomic Characteristics, SC, 2023 3
Unmet Health Needs 4
Health Disparities 4

The Primary Care Workforce in South Carolina 5

Supply, Geographic Distribution, and Demographic Characteristics 5
Table 4. Demographic Characteristics of Primary Care Physicians, SC, 2013 and 2023 7
Table 5. Demographic Characteristics of Physician Assistants, SC, 2014 and 2024 8
Table 6. Demographic Characteristics of Nurse Practitioners, SC, 2014 and 2024 9
Figure 2. Distribution of Primary Care Physicians by Primary Practice Location, SC, 2023 10
Figure 3. Distribution of Physician Assistants by Primary Practice Location, SC, 2024 10
Figure 4. Distribution of Nurse Practitioners by Primary Practice Location, SC, 2024 11
Practice Characteristics 11
Table 7. Practice Characteristics of Primary Care Physicians, SC, 2013 and 2023 13
Table 8. Practice Characteristics of Physician Assistants, SC, 2014 and 2024 14
Table 9. Practice Characteristics of Nurse Practitioners, SC, 2014 and 2024 15
Provider Participation and Utilization of Medicaid Services 16
Table 10. Medicaid Participation Rates by Primary Care Specialty, SC, FY2025 16
Table 11. Medicaid Patients and Visits Billed by Primary Care Specialty, SC, FY2025 16

Barriers to Primary Health Care 17

Transportation and Travel Time 17
Figure 5. Area Covered Within 30-Minute Drive Time of a Primary Care Provider, SC, 2023 18
Description of Challenges Facing the Target Population 18
Figure 6. Race/Ethnicity of Primary Care Providers by Rural/Urban Status, SC, 2023-2024 19
Figure 7. Broadband Access, SC, December 2025 20
Description of Challenges Healthcare Providers Face 21
Current Political and Fiscal Climate in the State 22
State and Federal Programs that Might Affect the State's Ability to Achieve its Goals 23
Figure 8. Location of Community Health Centers in SC, 2025 30

Plan for Ongoing Collaboration with Stakeholders in South Carolina 31

Strategic, Long-Term Plan to Reduce Shortage Designations 31

Appendices 33

Appendix 1: Methods and Data Sources 33
Appendix 2: Primary Care Advisory Committee 36
Appendix 3: Primary Care Health Professional Shortage Areas, SC, 2026 37

Primary Care Needs Assessment
South Carolina, 2026

Executive Summary

To better understand the health needs of South Carolinians and guide future programs and investments, the South Carolina Department of Public Health (DPH) Office of Primary Care (PCO) engaged the South Carolina Office for Healthcare Workforce (SCOHW) within the South Carolina Area Health Education Consortium (SC AHEC) to assist in developing statewide primary care, oral health, and mental health needs assessments. SCOHW convened an advisory committee that included representation from SC DPH, SC Office of Rural Health (SCORH), SC Primary Health Care Association (SCPHCA), SC Thrive, and SC AHEC. Members of the advisory committee served as subject matter experts and data sources throughout the development of this report.

Key Takeaways

- South Carolina ranks 36th in overall health, 40th in premature death, and 24th in frequent physical distress.[1]
- Nearly 80% of the need for services was met in the state's Primary Care Health Professional Shortage Areas (HPSAs) in 2025 (by dividing the number of physicians available to serve the population by the number of physicians necessary to eliminate the primary care HPSAs).[2]
- In 2025, South Carolina ranked 37th in number of primary care providers, with 276 primary care providers per 100,000 population compared to 291 in the U.S.[1]
- There were 5,400 primary care physicians actively practicing in South Carolina in 2023. At least one primary care physician had a primary practice location in every county.[3]
- While the overall number of primary care physicians has increased from 2013 to 2023, the number of primary care physicians in the state's nonmetropolitan counties is declining. Meanwhile, physician assistants and nurse practitioners are growing rapidly in the state.[3]

Conclusions

South Carolina has rich partnerships and many programs in place with the mission to grow and support rural primary care providers, yet the state still has disparities in access to health care and health outcomes. Current HPSA methodology does not account for nurse practitioners and physician assistants, which may impact the accuracy of determining need in the state. Continued work is needed to sustain partnerships; train, recruit, and retain providers for rural and medically underserved populations; and explore payment and policy changes to improve overall health outcomes.

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[1] America's Health Rankings. 2025 Annual Report: State Summaries. America's Health Rankings, United Health Foundation. Accessed February 23, 2026. https://assets.americashealthrankings.org/ahr_2025annualreport-statesummaries_all.pdf. Note: Primary care providers include primary care physicians, PAs, and NPs in this report.

[2] Kaiser Family Foundation. Primary Care Health Professional Shortage Areas (HPSAs) website. https://www.kff.org/other-health/state-indicator/primary-care-health-professional-shortage-areas-hpsas. Updated December 21, 2025. Accessed February 24, 2026.

[3] Fu B, Chastain-Brown A, Campbell C, Palmer C, Fluharty M, Gaul K. *2026 South Carolina Health Professions Data Book.* South Carolina Office for Healthcare Workforce, South Carolina AHEC. January 2026. https://www.scahec.net/scohw/reports/149. Accessed March 10, 2026.

Background

To better understand the health needs of South Carolinians and guide future programs and investments, the South Carolina Department of Public Health (DPH) Office of Primary Care (PCO) engaged the South Carolina Office for Healthcare Workforce (SCOHW) within the South Carolina Area Health Education Consortium (SC AHEC) to assist in developing a statewide primary care needs assessment. This work included:

1. Analyzing unmet needs, care and access disparities, and health workforce issues affecting the availability of primary care physicians
2. Engaging multiple stakeholder organizations in South Carolina to collect feedback on needs assessment methods and measures and help identify infrastructure challenges and assets affecting access to care in the state
3. Assisting the Primary Care Office in sharing the methodology and results of the needs assessment with the federal Health Resources and Services Administration (HRSA) and with partners and stakeholders across South Carolina

This report summarizes that work and includes:

1. A description of the target populations in South Carolina and their unmet health needs
2. A discussion of relevant barriers in the state that the South Carolina PCO and its stakeholders can work to address
3. A plan that provides for ongoing collaboration with stakeholders to continue monitoring and addressing health needs in the state

Methods and data sources are briefly described in **Appendix 1.**

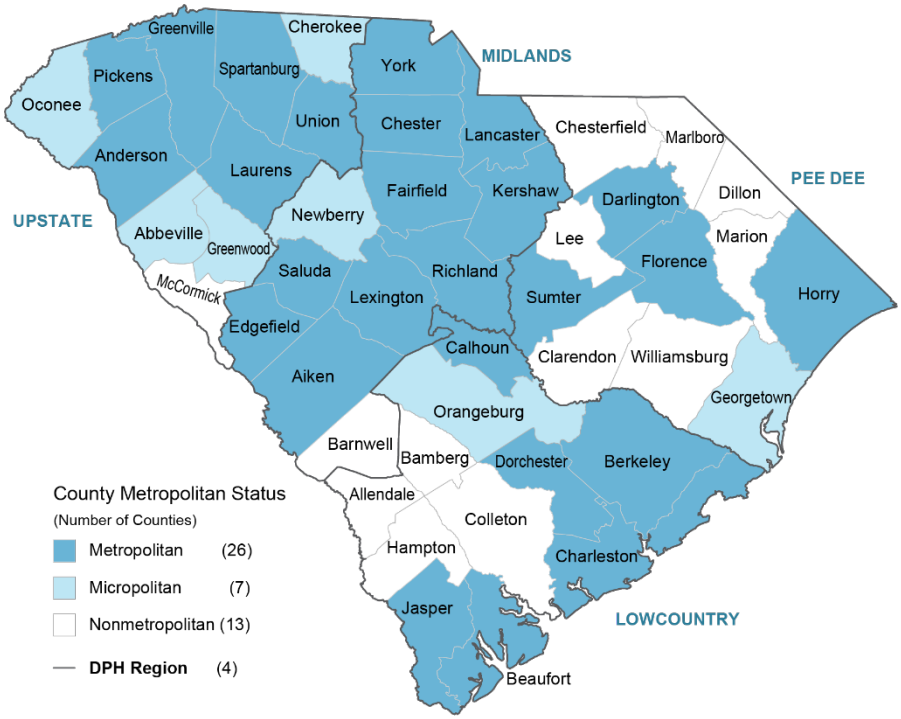
A Description of the Target Populations in South Carolina and Their Unmet Health Needs

South Carolina has over 5.3 million people across 46 counties, an increase of 4.4% since 2019. According to Core Based Statistical Area (CBSA) designations, defined by the U.S. Office of Management and Budget, 7 counties are micropolitan (compared to 8 in 2020) and 13 counties are non-core or nonmetropolitan (compared to 12 in 2020) (**Figure 1**). In 2025, 21 counties were designated as whole-county geographic Primary Care Health Professional Shortage Areas (HPSAs), 22 counties were considered population HPSAs, and 3 counties received no HPSA designation (**Appendix 3**).[4] Since 2021, the number of geographic HPSAs increased from 11 counties to 21, while the number of low-income HPSAs or counties not designated decreased.[5] **Tables 1 through 3** describe the population, morbidity and mortality, and socioeconomic characteristics of the state's population.

[4] South Carolina Department of Public Health, GIS, Office of Information Technology. South Carolina Primary Care Health Professional Shortage Areas (HPSAs). Updated March 2, 2026. Accessed March 30, 2026. https://dph.sc.gov/sites/scdph/files/2026-03/HPSA_Primary%20Care_20260303.pdf

[5] Gaul K, Sarrica-Barefoot B. Primary Care Needs Assessment, South Carolina, 2021. Charleston, SC: South Carolina Office for Healthcare Workforce, South Carolina AHEC. December 2021.

Figure 1. Metropolitan Status and DPH Regions, SC, 2023



Sources: Metropolitan status based on 2020 Census delineations, updated July 2023, U.S. Census Bureau, https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html.

Table 1. Population Characteristics, SC, 2023

	Total State		Nonmetropolitan Counties		Micropolitan Counties		Metropolitan Counties	
	#	%	#	%	#	%	#	%
Total Population, 2023	**5,373,555**	**100.0%**	**310,530**	**5.8%**	**419,205**	**7.8%**	**4,643,820**	**86.4%**
Sex, 2023								
Male	2,611,037	48.6%	152,740	49.2%	201,512	48.1%	2,256,785	48.6%
Female	2,762,518	51.4%	157,790	50.8%	217,693	51.9%	2,387,035	51.4%
Race, 2023								
American Indian and Alaska Native	19,401	0.4%	3,227	1.0%	1,388	0.3%	14,786	0.3%
Asian and Pacific Islander	109,647	2.0%	2,154	0.7%	3,525	0.8%	103,968	2.2%
Black	1,357,856	25.3%	145,760	46.9%	123,866	29.5%	1,088,230	23.4%
Other	107,309	2.1%	5,511	1.8%	6,564	1.6%	95,234	2.1%
White	3,378,794	62.9%	142,464	45.9%	261,434	62.4%	2,974,896	64.1%
Ethnicity, 2023								
Hispanic	400,548	7.5%	11,414	3.7%	22,428	5.4%	366,706	7.9%
Age, 2023								
0 - 19	1,287,660	24.0%	71,248	22.9%	97,092	23.2%	1,119,320	24.1%
20 - 64	3,047,964	56.7%	171,305	55.2%	225,342	53.8%	2,651,317	57.1%
65 or Older	1,037,931	19.3%	67,977	21.9%	96,771	23.1%	873,183	18.8%

Source: Fu B, Chastain-Brown A, Campbell C, Palmer C, Fluharty M, Gaul K. 2026 South Carolina Health Professions Data Book. SC Office for Healthcare Workforce, SC AHEC. January 2026. https://www.scahec.net/scohw/reports/149. Age and race data derived from 2023 population data from SC Revenue and Fiscal Affairs Office, Health and Demographics Division.

Table 2. Standard Morbidity and Mortality Rates, SC, 2020-2024

	Total State	Nonmetropolitan Counties	Micropolitan Counties	Metropolitan Counties
Total Population, 2023	**5,373,555**	**310,530**	**419,205**	**4,643,820**
Vital Statistics and Health Status Indicators				
Resident births, 2023	57,721	3,260	3,993	50,468
Resident deaths, 2023	58,008	4,613	5,709	47,686
Percent of births < 2500 grams (low birth weight), 2023	10.0%	13.9%	10.7%	9.7%
Infant mortality rate – White, 2023	5.0	6.6	6.9	5.5
Infant mortality rate – Black & Other, 2023	10.6	11.8	14.2	8.1
Number of new cases - All cancers, 2020	10,791	993	1,012	8,846
Percent of adults diagnosed with heart disease, 2023	4.3%	5.9%	5.5%	4.9%
Percent of adults diagnosed with hypertension, 2023	37.8%	49.8%	42.7%	38.4%
Percent of adults diagnosed with diabetes, 2023	14.7%	20.1%	16.6%	13.6%
Percent of adults who currently smoke, 2023	15.5%	19.7%	17.6%	14.8%
Percent of adults reporting a sedentary lifestyle, 2023	25.0%	32.9%	31.1%	25.7%
Percent of adults overweight or obese (BMI ≥ 25), 2023	70.5%	75.3%	69.7%	70.3%
Breast cancer death rate – Black women, age-adjusted, 2020-2024	25.0			
Breast cancer death rate – White women, age-adjusted, 2020-2024	19.2			
Prostate cancer death rate – Black men, age-adjusted, 2020-2024	39.3			
Prostate cancer death rate – White men, age-adjusted, 2020-2024	17.6			

Sources: Fu B, Chastain-Brown A, Campbell C, Palmer C, Fluharty M, Gaul K. 2026 South Carolina Health Professions Data Book. SC Office for Healthcare Workforce, SC AHEC. January 2026. https://www.scahec.net/scohw/reports/149
Cancer data from DPH SC Central Cancer Registry. https://dph.sc.gov/professionals/public-health-data/cancer-registry. Accessed May 22, 2026. Data are combined for 2020-2024 to minimize the amount of suppressed data at the county level.

Table 3. Poverty Rates and Socioeconomic Characteristics, SC, 2023

	Total State		Nonmetropolitan Counties		Micropolitan Counties		Metropolitan Counties	
	#	%	#	%	#	%	#	%
Total Population, 2023	**5,373,555**	**100.0%**	**310,530**	**5.8%**	**419,205**	**7.8%**	**4,643,820**	**86.4%**
Socioeconomic Characteristics								
Percent of adults without health insurance, 2023	11.5%		13.4%		12.1%		10.2%	
Percent unemployed, 2023	3.0%		4.1%		3.5%		2.9%	
Percent of households with income < $25,000, 2023	21.1%		33.5%		26.8%		19.2%	
Percent with high school education or less, 2023	41.7%		57.9%		46.3%		39.4%	
Medicaid full benefit members (includes CHIP*), 2023	1,322,114		122,092		124,636		1,075,386	
Per capita income, 2023	$57,332		$43,215		$50,017		$58,937	
Poverty, all ages, 2023	724,634	13.9%	70,886	23.8%	68,556	16.8%	585,192	12.9%

*CHIP is the Children's Health Insurance Program managed by states and funded by both state and federal governments.
Sources: Fu B, Chastain-Brown A, Campbell C, Palmer C, Fluharty M, Gaul K. 2026 South Carolina Health Professions Data Book. SC Office for Healthcare Workforce, SC AHEC. January 2026. https://www.scahec.net/scohw/reports/149
Poverty counts and percentages, without confidence intervals, from SAIPE, U.S. Census Bureau. 2023. https://www.census.gov/data-tools/demo/saipe/#/?s_state=45&s_county=&s_district=&s_geography=us. Accessed August 26, 2025. Percentages are based on total in SAIPE (5,003,261).

Unmet Health Needs

According to the 2025 America's Health Rankings, South Carolina ranks 36th in overall health, the state's highest ranking since 1990. South Carolina also ranked 39th in avoided care due to cost (13.8% of adults), 37th in percent of total population that is uninsured (9.0%), 40th in premature death, and 24th in frequent physical distress (defined as percentage of adults reporting physical health was not good 14 or more of the past 30 days).[1]

A Kaiser Family Foundation analysis found that 78.5% of the need was met in the state's primary care HPSAs in 2025 (by dividing the number of physicians available to serve the population by the number of physicians necessary to eliminate the primary care HPSAs). In comparison, across the U.S., only 48.2% of the need was met.[2]

Hospitalization for ambulatory care sensitive conditions such as diabetes and hypertension can be an indicator of inadequate access to primary care.[6] Preventable hospitalization signals a potential lack of access to preventive care and chronic care management in primary care settings. South Carolina ranks 21st in preventable hospitalizations, with 2,552 discharges for ambulatory care sensitive conditions per 100,000 Medicare beneficiaries age 18 and older.[1]

Health Disparities

Health disparities are prevalent in South Carolina and negatively impact population health outcomes associated with race, ethnicity, geography, and socioeconomic status.

Across the state, one-third of adults have diagnoses of multiple chronic conditions (MCCs). There are disparities found based on race and ethnicity as well as geography. Non-Hispanic Black adults have a higher prevalence of MCCs at 43.7% compared to 38.0% of non-Hispanic White individuals. The prevalence of MCCs is also greater in rural counties of the state compared to urban counties.[7]

Rural populations have a heavier burden of chronic disease than urban counterparts. In South Carolina, the prevalence of diabetes in adults is 18.6% in rural counties compared to 13.2% in urban counties. Similarly, 45.9% of the adult population in rural counties reported a diagnosis of hypertension compared to 37.9% of the population in the state's urban counties.[3]

Access to health care includes not only having a provider available in a geographic region but also being able to afford medical care. In 2024, 15.3% of Black adults and 27.6% of Hispanic adults in South Carolina reported not seeing a doctor in the past 12 months because of cost, compared to 10.9% of White adults.[8]

In South Carolina between 2020 and 2024, Black women had higher death rates for breast cancer (25.0 per 100,000 population) and Black men had higher death rates for prostate cancer

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[6] Gettel CJ, Kitchen C, Rothenberg C, et al. Emergency department visits among rural and urban older adults: Disparities in ambulatory and emergency care sensitive conditions. *BMC Health Serv Res*. 2025;25(975):1-9. https://doi.org/10.1186/s12913-025-13161-2. Accessed February 24, 2026.

[7] South Carolina Department of Public Health. *South Carolina State Health Improvement Plan*. Updated October 9, 2025. Accessed January 23, 2026. https://dph.sc.gov/sites/scdph/files/2025-10/25-117-DPH_SHIP_Report_V12.pdf

[8] Kaiser Family Foundation. State Health Facts website. https://www.kff.org/state-health-policy-data/state-indicator/percent-of-adults-reporting-not-seeing-a-doctor-in-the-past-12-months-because-of-cost-by-raceethnicity. Accessed February 24, 2026.

(39.3 per 100,000 population) compared to White women and men (19.2 and 17.6 per 100,000 population, respectively) (**Table 2**).

In 2025, South Carolina ranked 46th for low birth weight (10.0% of live births) and 49th in low birth weight racial disparity (ratio of highest rate to White rate) at 2.3. However, the premature death (death before age 75) racial disparity (ratio of highest rate to White rate) in South Carolina was 1.3 (ranked 8th), which is better than the overall U.S. rate of 1.9.[1]

Many factors contribute to the health disparities that are seen in South Carolina, including geographic barriers (e.g., mountain terrain, water features), transportation barriers, availability of primary care providers, cost and lack of health insurance, identifying as a racial/ethnic minority, and inability for patients to take or afford time off of work.[9] Individuals with complex health needs frequently use emergency department services and often also have higher rates of primary care office-based visits, suggesting that primary care may complement, rather than replace, emergency department services for those patients. Limitations in care coordination and system-level inefficiencies contribute to higher overall healthcare utilization and costs.[10] In addition, emergency department visits for ambulatory care sensitive conditions, such as asthma, diabetes, and dehydration, represent preventable utilization that further increases healthcare costs when preventive care and disease management are inadequate.[6] The barriers that patients face often intersect, increasing the challenges and disparities associated with primary care.

Citations to verifiable demographic and health indicators data sources and the rural definition used are found in **Appendix 1.**

The Primary Care Workforce in South Carolina

In 2025, South Carolina ranked 37th in the supply of primary care providers, with 276.1 primary care providers per 100,000 population compared to 291.4 in the U.S.[1] For the purposes of this section, the terms “primary care provider” or “primary care workforce” refers to primary care physicians, all physician assistants, and all nurse practitioners.

Supply, Geographic Distribution, and Demographic Characteristics

Tables 4 through 6 show detailed data on the supply and demographic characteristics of active primary care physicians, physician assistants, and nurse practitioners in South Carolina in 2013 and 2023 (physicians) and 2014 and 2024 (physician assistants and nurse practitioners). **Figures 2 through 4** show the distribution of these providers across the state in 2023 and 2024.

According to South Carolina physician licensure data, there were 5,400 nonfederal physicians with a primary specialty of family medicine or general practice (combined for analytic and reporting purposes), general internal medicine, pediatrics, or obstetrics and gynecology actively

[9] Office of Disease Prevention and Health Promotion. Health Care Access and Quality website. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality. Accessed August 27, 2025.

[10] Giannouchos TV, Pirrallo RG, Wright B. Is frequent emergency department use a complement or substitute for other healthcare services? Evidence from South Carolina Medicaid enrollees. *Health Services Research.* 2025;60(3):1-11. https://doi.org/10.1111/1475-6773.14430. Accessed February 16, 2026.

practicing in South Carolina in 2023. These numbers include residents in training, as they contribute a significant amount of care to the state's population.

In addition to the physician workforce, physician assistants and nurse practitioners also work in primary care throughout the state. With the substantial growth in both professions over the past decade, their contribution to the primary care workforce is significant. According to 2024 licensure data, there were 2,491 physician assistants and 6,196 nurse practitioners actively practicing in the state.[3]

Statewide, the overall provider-to-population ratio was 10.0 active, nonfederal primary care physicians per 10,000 population. Put another way, the population-to-provider ratio was 995 population per active primary care physician (995:1). This ratio improved slightly from 1,011:1 in 2019.

Every county in South Carolina has at least one actively practicing primary care physician, physician assistant, or nurse practitioner (**Figures 2-4**). The primary care workforce is distributed across the state, though there are large geographic areas that do not have a primary care physician. The presence of a primary care provider also does not guarantee access to healthcare.

In 2023-2024, 6.5% of the state's population lived in nonmetropolitan counties, where only 2.8% of active primary care providers practiced. Most of the state's population (86.4%) lived in metropolitan counties, where 90.8% of primary care providers practiced, and 7.8% of the population lived in micropolitan counties, where 6.5% of primary care providers practiced.

More female physicians (8.5%) and female nurse practitioners (13.7%) self-reported as Black than male physicians (4.2%) and male nurse practitioners (8.6%). For physician assistants, the distribution was more even, with 3.7% of males reporting as Black compared to 3.4% of females.

Overall, the age profile of primary care physicians in South Carolina is stable, with a strong supply of younger physicians available to replace older physicians as they leave the workforce. In 2023, 29.6% of primary care physicians were age 55 or older, 43.7% were age 35-54, and 26.7% were younger than 35. However, further analysis indicates age varies by sex and geographic location.

Female physicians were likely to be younger, with a median age of 41 years compared to 50 years for males. Physicians in nonmetropolitan counties are older, with a median age of 55 years, compared to physicians in micropolitan counties (50 years) or metropolitan counties (44 years).

Physicians and physician assistants in nonmetropolitan counties were more likely to be age 55 or older than those in metropolitan counties. In 2023, more than half (54.6%) of physicians in nonmetropolitan counties were age 55 or older, compared with 30.5% in metropolitan counties. In 2024, 23.1% of nonmetropolitan physician assistants were age 55 or older compared to 8.1% in metropolitan counties. The difference was smaller among nurse practitioners. In 2024, 23.0% of nonmetropolitan nurse practitioners were age 55 or older compared to 17.2% in metropolitan counties.

Table 4. Demographic Characteristics of Primary Care Physicians, SC, 2013 and 2023

	2013		2023	
	Count	Percentage	Count	Percentage
Total Primary Care Physicians	**3,788**	**100%**	**5,400**	**100%**
County of Primary Employment				
Metropolitan	3,290	86.9%	4,887	90.5%
Micropolitan	329	8.7%	376	7.0%
Nonmetropolitan	169	4.5%	137	2.5%
Sex				
Male	2,400	63.4%	2,880	53.3%
Female	1,387	36.6%	2,512	46.5%
Unknown	1	0.0%	8	0.1%
Race/Ethnicity				
American Indian	6	0.2%	15	0.3%
Asian	331	8.7%	521	9.6%
Black	379	10.0%	478	8.9%
Hispanic	67	1.8%	115	2.1%
Other	88	2.3%	172	3.2%
White	2,910	76.8%	3,835	71.0%
Unknown	7	0.2%	264	4.9%
Age				
Median Age	48.0		45.0	
Metropolitan	*48.0*		*44.0*	
Micropolitan	*50.0*		*49.5*	
Nonmetropolitan	*51.0*		*55.0*	
Age 55 or Older	1,262	33.3%	1,598	29.6%
25 - 29	40	1.1%	641	11.9%
30 - 34	361	9.5%	800	14.8%
35 - 39	482	12.7%	656	12.1%
40 - 44	596	15.7%	555	10.3%
45 - 49	553	14.6%	533	9.9%
50 - 54	493	13.0%	616	11.4%
55 - 59	490	12.9%	545	10.1%
60 - 64	396	10.5%	409	7.6%
65 - 69	233	6.2%	337	6.2%
70 or Older	143	3.8%	307	5.7%
Unknown	1	0.0%	1	0.0%

Table 5. Demographic Characteristics of Physician Assistants, SC, 2014 and 2024

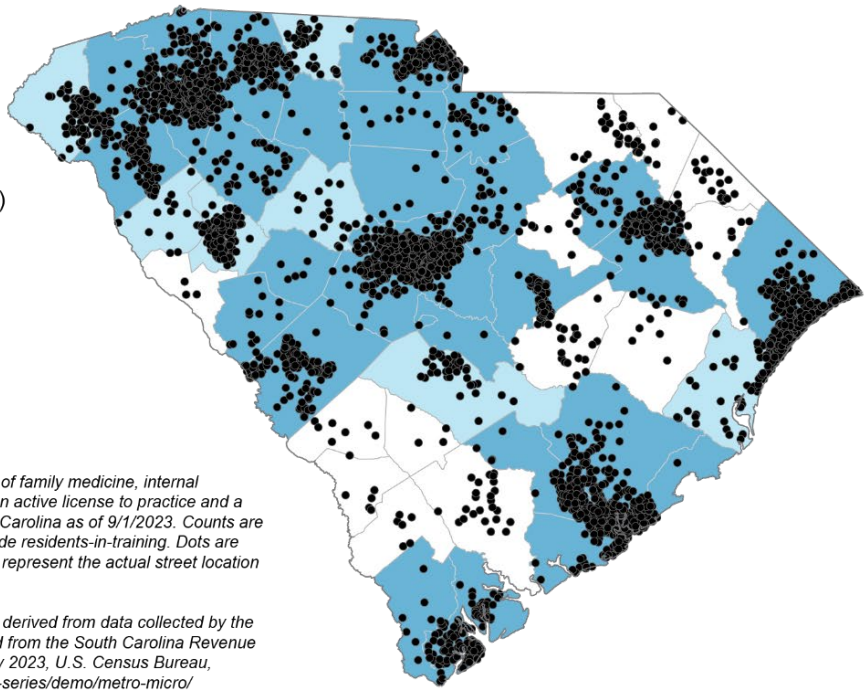
	2014*		2024*	
	Count	Percentage	Count	Percentage
Total Physician Assistants	**953**	**100%**	**2,491**	**100%**
County of Primary Employment				
Metropolitan	846	88.8%	2,311	92.8%
Micropolitan	63	6.6%	128	5.1%
Nonmetropolitan	35	3.7%	52	2.1%
Unknown	9	0.9%	0	0.0%
Sex				
Male	333	34.9%	707	28.4%
Female	616	64.6%	1,770	71.1%
Unknown	4	0.4%	14	0.6%
Race/Ethnicity				
American Indian	2	0.2%	5	0.2%
Asian	22	2.3%	56	2.2%
Black	49	5.1%	88	3.5%
Hispanic	13	1.4%	23	0.9%
Other	14	1.5%	41	1.6%
White	847	88.9%	2,144	86.1%
Unknown	6	0.6%	134	5.4%
Age				
Median Age	36.0		36.0	
Metropolitan	*35.0*		*36.0*	
Micropolitan	*43.0*		*36.5*	
Nonmetropolitan	*47.0*		*38.0*	
Age 55 or Older	104	10.9%	215	8.6%
25 - 29	208	21.8%	549	22.0%
30 - 34	222	23.3%	556	22.3%
35 - 39	155	16.3%	434	17.4%
40 - 44	124	13.0%	327	13.1%
45 - 49	82	8.6%	237	9.5%
50 - 54	52	5.5%	164	6.6%
55 - 59	55	5.8%	106	4.3%
60 - 64	35	3.7%	64	2.6%
65 - 69	13	1.4%	31	1.2%
70 or Older	1	0.1%	14	0.6%
Unknown	6	0.6%	9	0.4%

*PA renewal periods end on December 31 in odd-numbered years, but the data are finalized 2 months later to include late renewals. Therefore, even-numbered years are used as the effective date for data labeling.

Table 6. Demographic Characteristics of Nurse Practitioners, SC, 2014 and 2024

	2014		2024	
	Count	Percentage	Count	Percentage
Total Nurse Practitioners	**2,036**	**100%**	**6,196**	**100%**
County of Primary Employment				
Metropolitan	1,809	88.9%	5,587	90.2%
Micropolitan	153	7.5%	409	6.6%
Nonmetropolitan	74	3.6%	200	3.2%
Sex				
Male	118	5.8%	510	8.2%
Female	1,918	94.2%	5,686	91.8%
Race/Ethnicity				
American Indian	8	0.4%	21	0.3%
Asian	14	0.7%	115	1.9%
Black	180	8.8%	825	13.3%
Hispanic	15	0.7%	64	1.0%
Other	14	0.7%	67	1.1%
White	1,778	87.3%	4,704	75.9%
Unknown	27	1.3%	400	6.5%
Age				
Median Age	46.0		*43.0*	
Metropolitan	*46.0*		*43.0*	
Micropolitan	*49.0*		*44.0*	
Nonmetropolitan	*46.5*		*42.0*	
Age 55 or Older	598	29.4%	1,097	17.7%
25 - 29	124	6.1%	196	3.2%
30 - 34	277	13.6%	841	13.6%
35 - 39	288	14.1%	1,268	20.5%
40 - 44	254	12.5%	1,144	18.5%
45 - 49	240	11.8%	929	15.0%
50 - 54	254	12.5%	721	11.6%
55 - 59	290	14.2%	481	7.8%
60 - 64	198	9.7%	339	5.5%
65 - 69	87	4.3%	181	2.9%
70 or Older	23	1.1%	96	1.5%
Unknown	1	0.0%	0	0.0%

Figure 2.
Distribution of Primary Care Physicians by Primary Practice Location, SC, 2023



1 Dot = 1 Primary Care Physician (5,400)

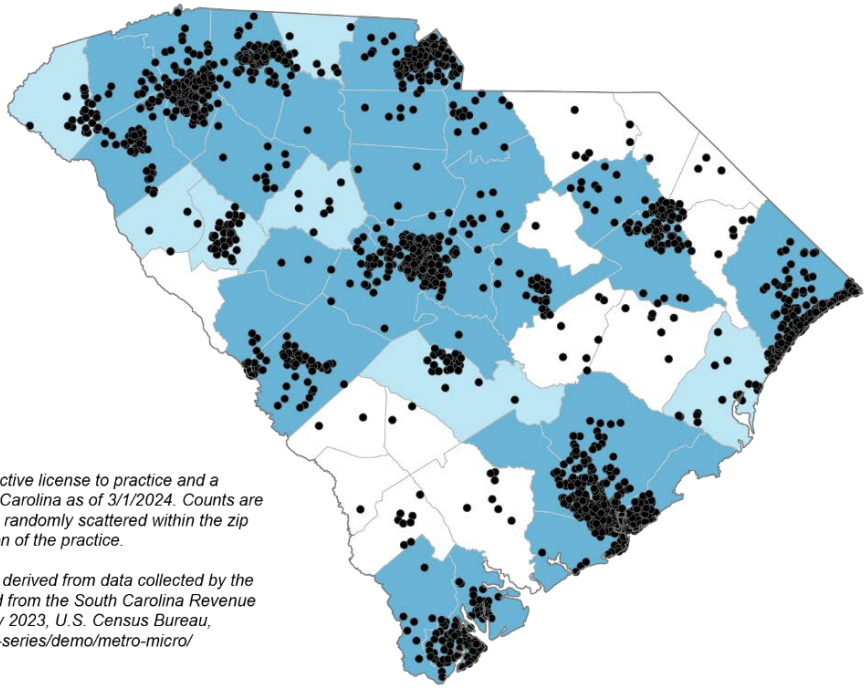
County Metropolitan Status
(Number of Counties)

- Metropolitan (26)
- Micropolitan (8)
- Nonmetropolitan (12)

Note: Data include all physicians with a primary specialty of family medicine, internal medicine, obstetrics/gynecology, or pediatrics that have an active license to practice and a primary practice location in a nonfederal setting in South Carolina as of 9/1/2023. Counts are based on self-reported primary practice location and include residents-in-training. Dots are randomly scattered within the zip code area and may not represent the actual street location of the practice.

Sources: SC Office for Healthcare Workforce, SC AHEC, derived from data collected by the South Carolina Board of Medical Examiners and obtained from the South Carolina Revenue and Fiscal Affairs Office; Metropolitan status updated July 2023, U.S. Census Bureau, https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html.

Figure 3.
Distribution of Physician Assistants by Primary Practice Location, SC, 2024



1 Dot = 1 Physician Assistant (2,491)

County Metropolitan Status
(Number of Counties)

- Metropolitan (26)
- Micropolitan (8)
- Nonmetropolitan (12)

Note: Data include all physician assistants that have an active license to practice and a primary practice location in a nonfederal setting in South Carolina as of 3/1/2024. Counts are based on self-reported primary practice location. Dots are randomly scattered within the zip code area and may not represent the actual street location of the practice.

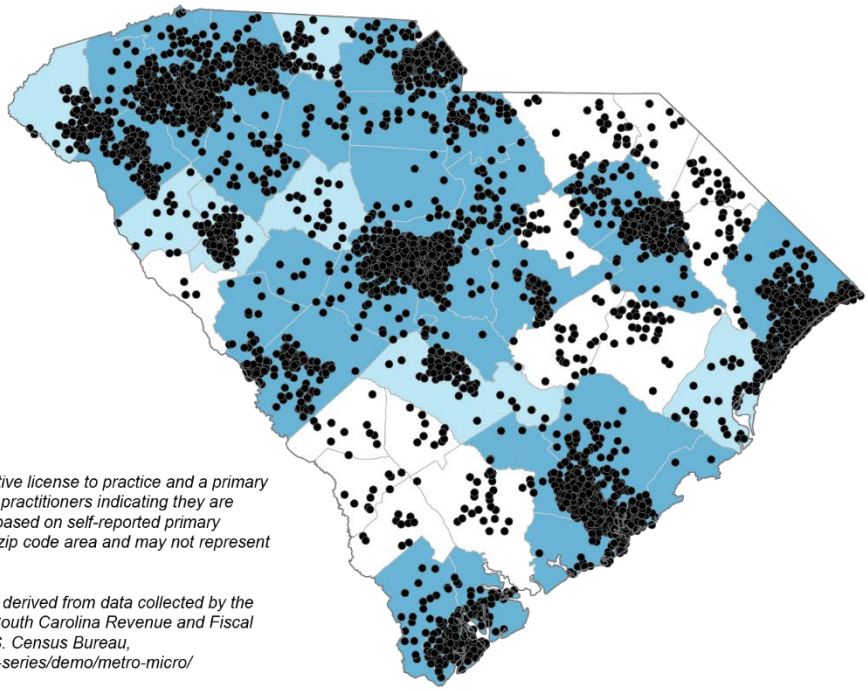
Sources: SC Office for Healthcare Workforce, SC AHEC, derived from data collected by the South Carolina Board of Medical Examiners and obtained from the South Carolina Revenue and Fiscal Affairs Office; Metropolitan status updated July 2023, U.S. Census Bureau, https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html.

Figure 4.
Distribution of Nurse Practitioners by Primary Practice Location, SC, 2024

1 Dot = 1 Nurse Practitioner (6,196)

County Metropolitan Status
(Number of Counties)

- Metropolitan (26)
- Micropolitan (8)
- Nonmetropolitan (12)



Note: Data include all nurse practitioners that have an active license to practice and a primary practice location in South Carolina as of 5/1/2024. Nurse practitioners indicating they are working as RNs are excluded from the map. Counts are based on self-reported primary practice location. Dots are randomly scattered within the zip code area and may not represent the actual street location of the practice.

Sources: SC Office for Healthcare Workforce, SC AHEC, derived from data collected by the South Carolina Board of Nursing and obtained from the South Carolina Revenue and Fiscal Affairs Office; Metropolitan status updated July 2023, U.S. Census Bureau, https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html.

Practice Characteristics

Tables 7 through 9 show detailed data on practice and employment characteristics of active primary care physicians, physician assistants, and nurse practitioners in South Carolina in 2013 and 2023 (physicians) and 2014 and 2024 (PAs and NPs).

Specialty

More primary care physicians reported a primary specialty of family medicine (n=2,119) than general internal medicine (n=1,730), pediatrics (n=906) or obstetrics and gynecology (n=645). Similarly, both physician assistants (n=183) and nurse practitioners (n=4,328) also reported a primary specialty area of family medicine more than the other primary care specialties. In 2024, 57.3% of physician assistants were missing self-reported specialty information in the licensure data, making it difficult to identify specialty distributions and trends.

Form of Employment

Currently, 27.9% of primary care physicians indicate they are self-employed (6.4% solo practice, 21.5% group practice), a decrease from 2013, when 56.5% of primary care physicians were self-employed. This follows a national trend and is likely due to health system consolidation and acquisition of primary care and specialty practices.[11] Likewise, 24.0% of physician assistants

[11] Kane CK. *Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties*. American Medical Association; 2025. Accessed August 13, 2026. https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf.

are self-employed in 2024, a decrease from 2014 when 51.0% reported self-employment.[12] Comparable form of employment information is not collected during license renewal for nurse practitioners.

Primary Practice Setting

Over a third of the state's primary care physicians (38.4%) work in a private office setting, and 22.5% work in a nonfederal general hospital. The remaining 39.1% work in other settings, such as a university or college of medicine, emergency or urgent care clinic, freestanding outpatient clinic, or at rural or community health centers. The number of primary care physicians working in nonfederal general hospitals increased by 91.0% between 2013 and 2023. About 30% of physician assistants and nurse practitioners work in a private office setting, whereas 28.4% of physician assistants and 22.3% of nurse practitioners work in nonfederal general hospitals.

Hours Worked

Primary care physicians and physician assistants in South Carolina currently work an average of 38.2 and 38.8 hours a week, respectively, in patient care. This number is down slightly from 41.6 hours in 2013 for physicians.[13] Nurse practitioners have a slightly lower average of 36.6 hours per week. Rural primary care physicians spend more time in patient care, with an average of 44.7 hours per week in nonmetropolitan counties, compared to 38.1 hours in micropolitan counties and 38.0 hours in metropolitan counties. Overall, female primary care physicians reported working 35.8 hours per week, 4.4 hours less on average than males at 40.2 hours per week.

Citations to primary care workforce data sources are found in **Appendix 1.**

[12] Note: While physician assistants can be self-employed, South Carolina law requires them to practice under physician supervision with approved written scope of practice guidelines.

[13] Note: In addition to patient care, physicians also report hours in administration, teaching, training, research, and other. While these hours are an important part of physicians' productivity and contribution to their field, these hours were not included in this analysis.

Table 7. Practice Characteristics of Primary Care Physicians, SC, 2013 and 2023

	2013		2023		Change	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Primary Care Physicians	**3,788**	**100%**	**5,400**	**100%**	**1,612**	**43%**
Hours per Week in Patient Care						
20 or fewer hours	408	10.8%	674	12.5%	266	65.2%
21 - 40 hours	1,711	45.2%	2,378	44.0%	667	39.0%
41 or more hours	1,517	40.0%	1,171	21.7%	-346	-22.8%
Unknown hours	152	4.0%	1,177	21.8%	1,025	--
Average number of hours per week	41.6		38.2		-3.4	-8.2%
Clinical Specialty						
Family medicine/general practice	1,509	39.8%	2,119	39.2%	610	40.4%
Internal medicine	1,148	30.3%	1,730	32.0%	582	50.7%
Obstetrics/gynecology	439	11.6%	645	11.9%	206	46.9%
Pediatrics	692	18.3%	906	16.8%	214	30.9%
Primary Location Form of Employment						
Self, solo	348	9.2%	346	6.4%	-2	-0.6%
Self, group, same specialty	1,588	41.9%	933	17.3%	-655	-41.2%
Self, group, multi-specialty	203	5.4%	227	4.2%	24	11.8%
Other private employer	1,005	26.5%	1,078	20.0%	73	7.3%
Non-profit health agency*	22	0.6%	575	10.6%	553	2,513.6%
County government	152	4.0%	67	1.2%	-85	-55.9%
State government	271	7.2%	190	3.5%	-81	-29.9%
Federal civilian (incl. USPHS)	133	3.5%	57	1.1%	-76	-57.1%
Residency/intern training	55	1.5%	102	1.9%	47	85.5%
Volunteer	8	0.2%	2	0.0%	-6	-75.0%
Other**	2	0.1%	813	15.1%	811	--
Missing	1	0.0%	1,010	18.7%	1,009	--
Primary Location Practice Setting						
Hospital, nonfederal general	635	16.8%	1,213	22.5%	578	91.0%
Freestanding outpatient clinic	112	3.0%	466	8.6%	354	316.1%
Outpatient mental health clinic	4	0.1%	4	0.1%	0	0.0%
Private office	2,516	66.4%	2,073	38.4%	-443	-17.6%
Rural or community health center	135	3.6%	164	3.0%	29	21.5%
Hospital, nonfederal psychiatric	6	0.2%	6	0.1%	0	0.0%
Hospital, nonfederal rehabilitation	3	0.1%	10	0.2%	7	233.3%
Freestanding ambulatory surgery center	5	0.1%	51	0.9%	46	920.0%
Emergency/urgent care clinic	109	2.9%	117	2.2%	8	7.3%
University/college of medicine	185	4.9%	213	3.9%	28	15.1%
Admin/regulatory health agency	12	0.3%	18	0.3%	6	50.0%
Business establishment	16	0.4%	23	0.4%	7	43.8%
Other**	49	1.3%	345	6.4 %	296	604.1%
Missing	1	0.0%	697	12.9%	696	--

*Non-profit health agency includes employment at not-for-profit hospitals and medical centers.
**Practice settings (e.g., hospice) and form of employment (e.g., employed by practitioner group) that were not available responses in 2013 were combined with the "Other" category for 2023.

Table 8. Practice Characteristics of Physician Assistants, SC, 2014 and 2024

	2014		2024		Change Between 2014-2024	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Physician Assistants	**953**	**100%**	**2,491**	**100%**	**1,538**	**161%**
Hours per Week in Patient Care						
20 or fewer hours	100	10.5%	197	7.9%	97	97.0%
21 - 40 hours	509	53.4%	1,543	61.9%	1,034	203.1%
41 or more hours	204	21.4%	486	19.5%	282	138.2%
Unknown hours	140	14.7%	265	10.6%	125	--
Average number of hours per week	38.3		38.8		0.5	1.3%
Clinical Specialty						
Family medicine/general practice	195	20.5%	183	7.3%	-12	-6.2%
Internal medicine	96	10.1%	86	3.5%	-10	-10.4%
Obstetrics/gynecology	17	1.8%	12	0.5%	-5	-29.4%
Pediatrics	14	1.5%	18	0.7%	4	28.6%
Psychiatry	6	0.6%	10	0.4%	4	66.7%
General surgery	36	3.8%	49	2.0%	13	36.1%
All other specialties	585	61.4%	706	28.3%	121	20.7%
Unknown	4	0.4%	1,427	57.3%	1,423	--
Primary Location Form of Employment						
Self, solo	28	2.9%	49	2.0%	21	75.0%
Self, group, same specialty	383	40.2%	293	11.8%	-90	-23.5%
Self, group, multi-specialty	75	7.9%	255	10.2%	180	240.0%
Other private employer	301	31.6%	806	32.4%	505	167.8%
Non-profit health agency	31	3.3%	336	13.5%	305	983.9%
State government	66	6.9%	79	3.2%	13	19.7%
Federal civilian (incl. USPHS)	18	1.9%	86	3.5%	68	377.8%
Other*	2	0.2%	156	6.3%	154	--
Missing	49	5.1%	431	17.3%	382	--
Primary Location Practice Setting						
Hospital, nonfederal general	246	25.8%	708	28.4%	462	187.8%
Freestanding outpatient clinic	65	6.8%	381	15.3%	316	486.2%
Private office	492	51.6%	728	29.2%	236	48.0%
Rural or community health center	18	1.9%	0	0.0%	-18	-100.0%
Hospital, nonfederal psychiatric	2	0.2%	6	0.2%	4	200.0%
Hospital, nonfederal rehabilitation	0	0.0%	7	0.3%	7	--
Freestanding ambulatory surgery center	1	0.1%	2	0.1%	1	100.0%
Emergency/urgent care clinic	59	6.2%	82	3.3%	23	39.0%
University/college of medicine	45	4.7%	69	2.8%	24	53.3%
Admin/regulatory health agency	0	0.0%	1	0.0%	1	--
Business establishment	0	0.0%	20	0.8%	20	--
Other*	20	2.1%	167	6.7%	147	735.0%
Missing	23	2.4%	320	12.8%	297	--

*Practice settings (e.g., hospice) and form of employment (e.g., employed by practitioner group) that were not available responses in 2014 were combined with the "Other" category for 2024.

Table 9. Practice Characteristics of Nurse Practitioners, SC, 2014 and 2024

	2014		2024		Change Between 2014-2024	
	Count	Percentage	Count	Percentage	Count	Percentage
Total Nurse Practitioners	**2,036**	**100%**	**6,196**	**100%**	**4,160**	**204%**
Hours per Week in Patient Care						
20 or fewer hours	223	11.0%	598	9.7%	375	168.2%
21 - 40 hours	1,637	80.4%	4,971	80.2%	3,334	203.7%
41 or more hours	163	8.0%	498	8.0%	335	205.5%
Unknown hours	13	0.6%	129	2.1%	116	--
Average number of hours per week	35.9		36.6		0.7	1.9%
Clinical Specialty Area*						
Family	1,290	63.4%	4,328	69.9%	3,038	235.5%
Acute care	156	7.7%	497	8.0%	341	218.6%
Adult care	246	12.1%	573	9.2%	327	132.9%
Gerontology	27	1.3%	95	1.5%	68	251.9%
Neonatal care	53	2.6%	84	1.4%	31	58.5%
Pediatric primary care	155	7.6%	242	3.9%	87	56.1%
Psychiatric/mental health	32	1.6%	284	4.6%	252	787.5%
Women's health	74	3.6%	93	1.5%	19	25.7%
Other	3	0.1%	0	0.0%	-3	-100.0%
Primary Location Practice Setting**						
Hospital, inpatient	217	10.7%	882	14.2%	665	306.5%
Hospital, outpatient	184	9.0%	495	8.0%	311	169.0%
Hospital, hospital wide	178	8.7%	7	0.1%	-171	-96.1%
Nursing home/residential care	29	1.4%	269	4.3%	240	828.0%
Freestanding outpatient clinic	312	15.3%	391	6.3%	79	25.3%
Outpatient mental health clinic	10	0.5%	123	2.0%	113	1,130.0%
Private office	769	37.8%	1,855	29.9%	1,086	141.2%
NP provider clinic	n/a	n/a	348	5.6%	--	--
Urgent care clinic	n/a	n/a	291	4.7%	--	--
Alcohol/drug detox center	2	0.1%	30	0.5%	28	1,400.0%
Home care and hospice	29	1.4%	275	4.4%	246	848.3%
Occupational health center	24	1.2%	76	1.2%	52	216.7%
Academic setting	95	4.7%	161	2.6%	66	69.5%
Admin/regulatory health agency	26	1.3%	41	0.7%	15	57.7%
Insured/third party	39	1.9%	66	1.1%	27	69.2%
Other	122	6.0%	844	5.4%	722	591.8%
Missing	0	0.0%	42	0.7%	42	--

*Clinical specialty area is based on nurse practitioner primary national certification. Labels have been simplified (e.g., family nurse practitioner is labeled family) and aggregated first by clinical area (acute care, primary care, psychiatric/mental health), and then to population (gerontology, neonatal care, pediatric primary care, women's health). "Other" in 2014 includes college health NP and oncology NP.
**Due to differences in data collection in 2014 and 2024, some response options for practice setting were aggregated for comparability (e.g., hospital emergency room in 2024 was combined with hospital outpatient to match 2014 responses) or were combined with "Other" in 2024 when no comparable option was available in 2014 (e.g., correctional facility).

Provider Participation and Utilization of Medicaid Services

In state fiscal year 2025 (FY2025), 2,119 primary care physicians within the state and 865 providers in Georgia and North Carolina billed at least one claim to South Carolina Medicaid (**Table 10**). A higher proportion of obstetrician-gynecologists (78%) billed for Medicaid visits than other primary care specialties.

South Carolina provides full Medicaid benefits to children, and limited benefits to adults that meet certain criteria. In 2023, South Carolina had 1,322,114 Medicaid full-benefit members, including those in the Children's Health Insurance Program (CHIP) (**Table 3**). **Table 11** summarizes the number of visits performed by providers who billed for Medicaid services in FY2025.

Table 10. Medicaid Participation Rates by Primary Care Specialty, SC, FY2025

	In-State Providers, FY2025*			Out-of-State Providers, FY2025**
Provider Specialty	**Licensed 2023**	**Billing Medicaid**	**% Billing**	**Billing Medicaid**
Family Practice***	2,119	1,382	65%	217
Internal Medicine	1,730	755	44%	172
Obstetrics & Gynecology	645	502	78%	181
Pediatrics	906	652	72%	295
Total	**5,400**	**3,291**	**61%**	**865**

*Providers within SC. Number licensed derived from 2023 licensure data. Number billing derived from Medicaid claims data (paid claims in medical offices, MCO, and FFS transaction types). Data do not reflect total number of physicians enrolled as Medicaid providers. Providers must file all billing activity related to a claim within one year of the date of service. Data provided may or may not reflect all claim activity.
**Portions of Georgia and North Carolina that are within SC's Medicaid Service Area.
***Family practice includes family medicine and general practice physicians.
Sources: Licensure data from SC Office for Healthcare Workforce at SC AHEC, derived from data collected by the SC Board of Medical Examiners during the license renewal period in 2023, and obtained from the SC Revenue and Fiscal Affairs Office (RFA). Counts include physicians and residents-in-training with an active practice location in a nonfederal setting within SC. Claims data from the SC Department of Public Health, derived from the SC Department of Health and Human Services.

Table 11. Medicaid Patients and Visits Billed by Primary Care Specialty, SC, FY2025

	Visits Billed, In-State Providers*		Visits Billed, Out-of-State Providers**	
Provider Specialty	**#**	**%**	**#**	**%**
Family Practice***	566,684	20%	6,149	11%
Internal Medicine	185,416	7%	4,284	8%
Obstetrics & Gynecology	467,160	17%	12,652	22%
Pediatrics	1,598,925	57%	36,244	64%
Total	**2,818,185**	**100%**	**59,329**	**100%**

*Providers within SC. Data include paid claims only and may or may not reflect all claim activity. Providers must file all billing activity related to a claim within one year of the date of service.
**Portions of Georgia and North Carolina that are within SC's Medicaid Service Area.
***Family practice includes family medicine and general practice physicians.
Source: Claims data from the SC Department of Public Health, derived from the SC Department of Health and Human Services.

Barriers to Primary Health Care

Many barriers to primary health care in South Carolina are exacerbated by the state being predominantly rural. While there is no single agreed-upon definition of rurality in the U.S., there are similar challenges and health outcomes found in rural communities throughout the country, regardless of the rural classifications used. According to a 2026 national report on *Meeting the Health Needs of Rural America*, people living in rural areas have poorer health outcomes and less access to healthcare. Across the country, nearly 1 in 4 rural residents report 2 or more chronic conditions, and rural residents have higher disability rates than urban residents. Regarding affordability, rural residents were more likely to have challenges paying medical bills. Access is also disproportionate across the lifespan in rural compared to urban communities, as rural areas have seen a decline in retail pharmacies, hospital obstetric units, and long-term care services.[14]

Geographically, there are no frontier counties in the state and urban areas are closer together by comparison to western states. Each county has at least one primary care physician and nurse practitioner, and all but one county has at least one physician assistant. Barriers in South Carolina will be heightened more by non-medical drivers of health rather than geographic distances and the number of physicians.

Transportation and Travel Time

An unpublished drive time analysis from the South Carolina Revenue and Fiscal Affairs Office shows there are few areas within South Carolina that are not within a 30-minute drive of an active primary care physician, Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) (**Figure 5**). As of the 2023 census, 9,272 people lived in these areas, which accounts for 0.2% of the state's total population of 5,373,555.

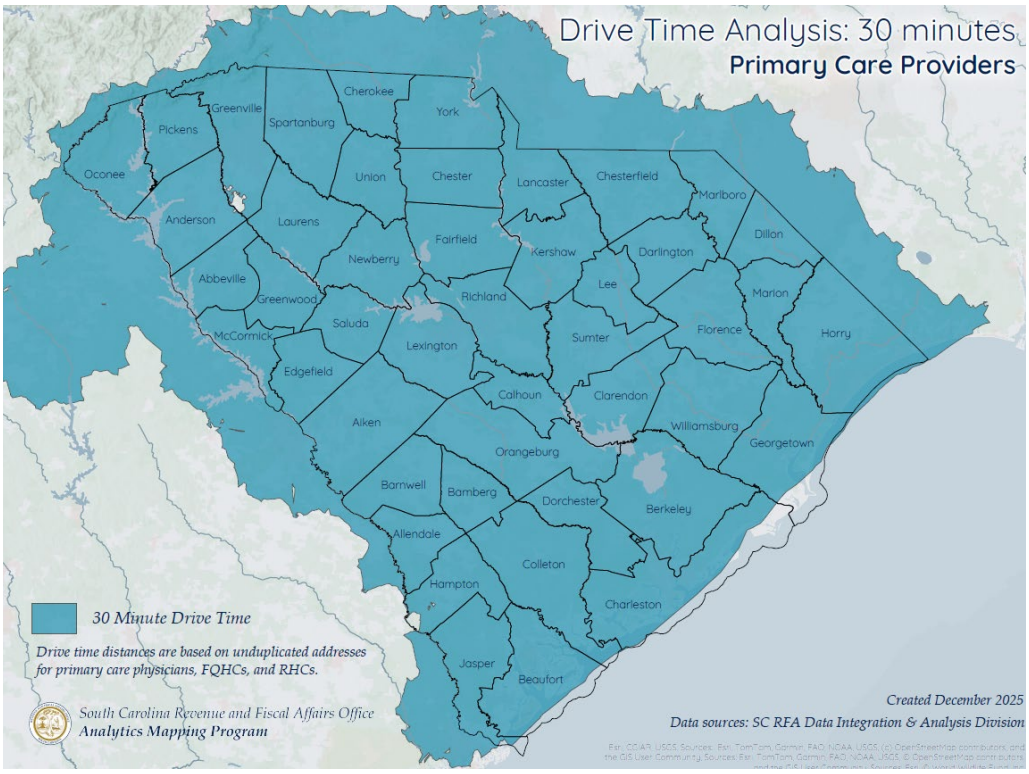
This map does not reflect the realities of access to care. Proximity to a primary care provider does not guarantee that individuals can or will seek care, and they may choose to seek healthcare services near where they work instead of where they live.

Despite the fact that most South Carolinians live within 30 minutes of a primary care provider, not all individuals or families have access to reliable transportation, including public transit systems. Transportation to non-emergency medical visits and other covered services is available at no cost for South Carolina Healthy Connections Medicaid beneficiaries through ModivCare, although there are challenges to this service.[15] All transportation is not guaranteed to be private transport, which could create long wait times at doctor's offices for other patients' appointments as well as potential exposure to pathogens while in those waiting rooms for extended periods of time.

[14] Aspen Health Strategy Group. *Meeting the health needs of rural America.* Aspen Health Strategy Group; 2026. Accessed August 7, 2026. https://www.aspeninstitute.org/wp-content/uploads/2026/02/Meeting-the-Health-Needs-of-Rural-America-FINAL.pdf

[15] South Carolina Department of Health and Human Services. Transportation Beneficiary Information website. https://www.scdhhs.gov/transportation-beneficiary-information. Accessed August 27, 2026.

Figure 5. Area Covered Within 30-Minute Drive Time of a Primary Care Provider, SC, 2023



In addition to transportation, other barriers to access include cost of care, provider or practice panel sizes may not allow them to accept new patients, acceptance of insurance coverage by provider networks, limits to the number of uninsured patients on patient panels, or providers not being available at hours that meet the patient's needs. Patients may also prefer a provider of a similar race or ethnicity, gender, or language, or a specific provider type (i.e., physician, physician assistant, nurse practitioner). Advisory stakeholders in previous needs assessment cycles noted that access becomes further limited if a patient is labeled as non-compliant and dropped from the patient panel. If surrounding practices are owned by the same health system, the patient must look farther away for a new provider.

Description of Challenges Facing the Target Population

Provider Diversity

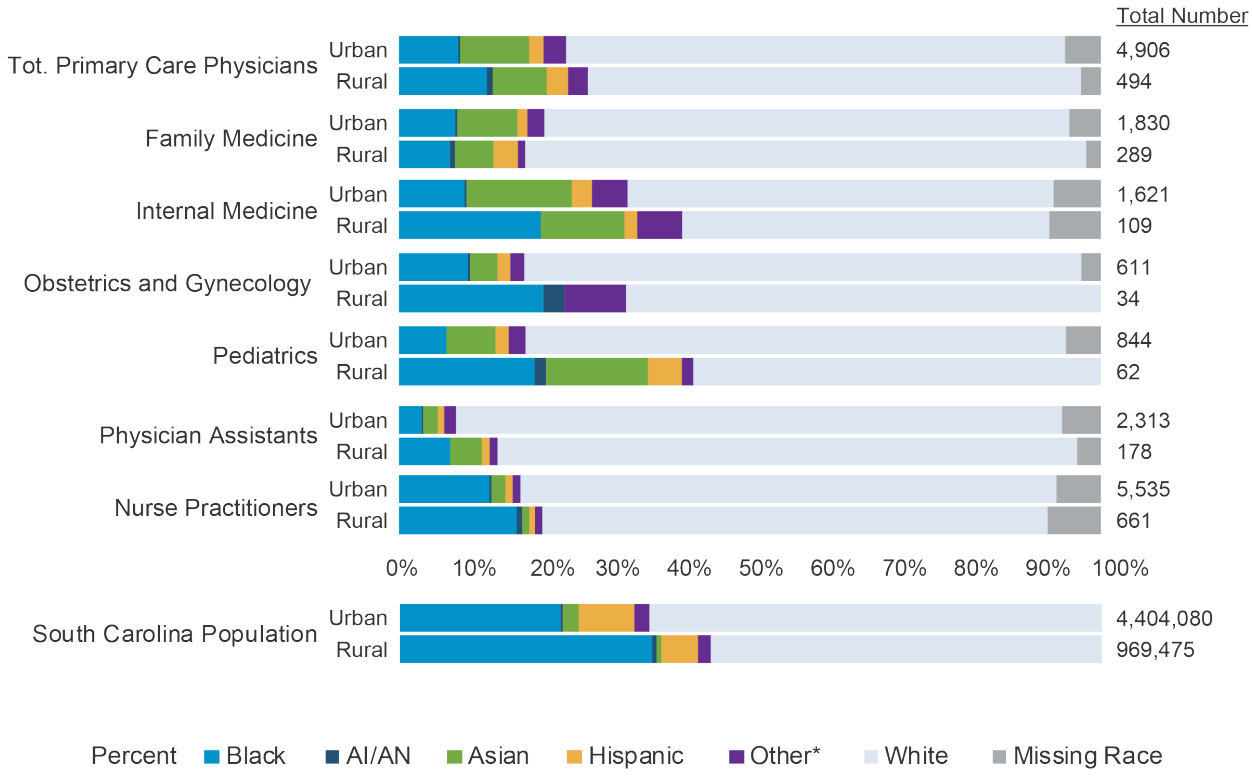
One of the challenges facing South Carolina is the incongruence between the diversity of the primary care workforce and the state's demographics. In 2023, 37.1% of the state's population identified their race or ethnicity as American Indian or Alaska Native, Asian, Black, Hispanic, or other. In comparison, only 24.1% of primary care physicians identify as these races and ethnicities, along with 8.6% of physician assistants and 17.6% of nurse practitioners.

Within the primary care physician specialties, internal medicine was the most diverse at 33.1%. Conversely, obstetrics and gynecology was the least diverse primary care specialty at 18.6%.

One notable difference is that 9.6% of primary care physicians self-reported as Asian, compared to 2.0% of the state's population.

However, when comparing racial and ethnic composition by rural and urban status in South Carolina, the proportion of providers reporting their race as American Indian or Alaska Native, Asian, Black, Hispanic, or other is generally higher in rural counties than in urban counties (**Figure 6**).

Figure 6. Race/Ethnicity of Primary Care Providers by Rural/Urban Status, SC, 2023-2024



Notes: *For SC population, "other" includes "Native Hawaiian and Other Pacific Islander" and "two or more races"; for SC health professions, "other" is listed as a race category. AI/AN = American Indian or Alaska Native. Hispanic origin is considered an ethnicity, not a race; however, Hispanic is collected as a race category on health professional licensure applications. To match this, population data are shown as non-Hispanic by race, with Hispanic including all races that indicated they were of Hispanic origin. Some professions had more complete race information than others; reasons for missing race data are unknown.

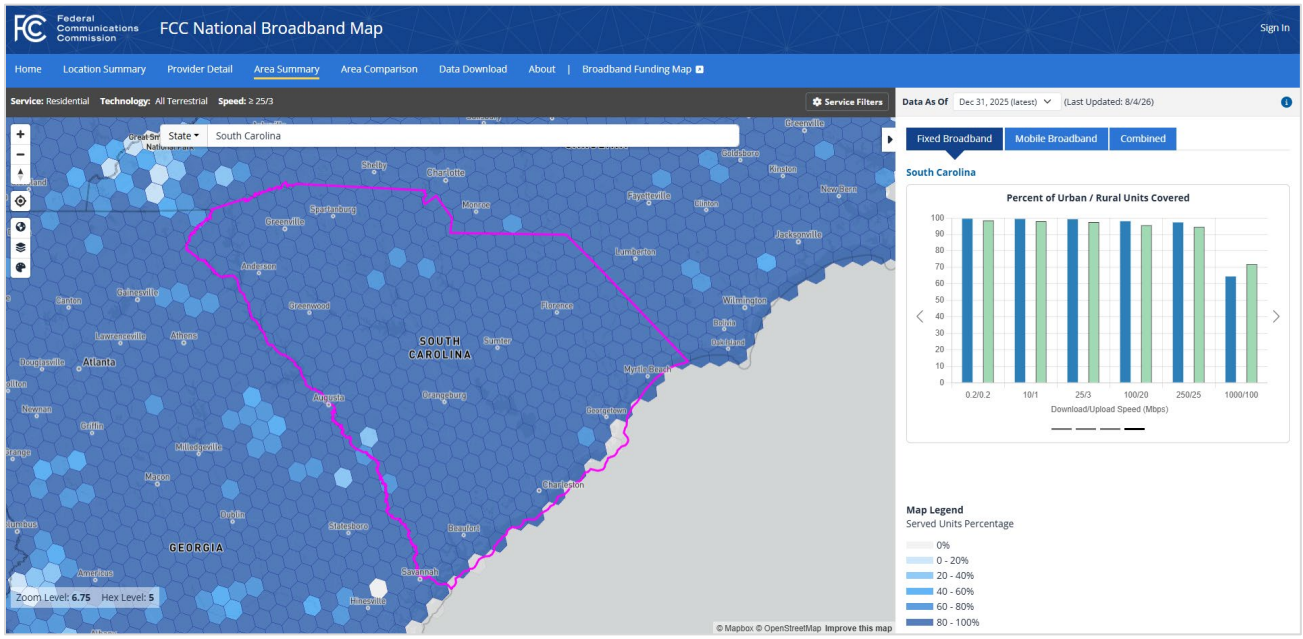
Sources: SC Population: Population data (2023) provided by RFA's Data Integration and Analysis Division, based on the Vintage 2023 Postcensal Estimates from the U.S. Census Bureau. Health professions data: SC Office for Healthcare Workforce, derived from data collected by the SC Department of Labor, Licensing and Regulation and housed by the SC Revenue and Fiscal Affairs Office. All data are self-reported by the licensee at the time of initial application for licensure and include providers actively practicing in a non-federal setting in SC in 2023 (physicians) and 2024 (NPs and PAs). NPs and PAs include all areas of practice, not just primary care. Rural/Urban status: U.S. Census Bureau, Geography Division, https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html. Rural counties are those counties where 50% of more of the population lives outside an urbanized area based on the 2020 Census.

Broadband Access

The ability to connect to reliable high-speed internet impacts access to telehealth services and healthcare information. South Carolina has made significant improvements in recent years with broadband access through several programs and grants managed by the state Broadband Office within the Office of Regulatory Staff.[16] As of December 2025, 98.7% of households had a minimum download speed of 25 megabits per second (Mbps). For households in rural areas, 97.5% had similar internet speed access. **Figure 7** shows a map of state access on the left and a graph with the percent of units with various internet speeds comparing urban and rural areas on the right.[17]

While broadband access has improved across the state, this data does not quantify the number of people without access to adequate technology such as computers, tablets, or cell phones. It also does not account for technology literacy, or individuals' ability to understand, set up, and use Wi-Fi networks and devices. Additionally, this data does not investigate how many people cannot afford internet service.

Figure 7. Broadband Access, SC, December 2025



Source: Federal Communications Commission. FCC national broadband map. https://broadbandmap.fcc.gov/area-summary/fixed?version=dec2025&geoid=45&type=state&zoom=6.75&vlon=-80.792698&vlat=33.711482&br=r&speed=25_3&tech=1_2_3_6_7. Updated December 31, 2025. Accessed August 12, 2026.

[16] Broadband Office. Broadband Office website. https://ors.sc.gov/broadband/office. Accessed August 12, 2026.

[17] Federal Communications Commission. FCC national broadband map. https://broadbandmap.fcc.gov/area-summary/fixed?version=dec2025&geoid=45&type=state&zoom=6.75&vlon=-80.792698&vlat=33.711482&br=r&speed=25_3&tech=1_2_3_6_7. Updated December 31, 2025. Accessed August 12, 2026.

Description of Challenges Healthcare Providers Face

Diversity and Cultural Responsiveness

It is important to recognize that diversity includes more than race and ethnicity. It also applies to characteristics such as sex and age, as well as beliefs and background, such as growing up in poverty, in a rural area, or as a resident of South Carolina. Evidence shows that this kind of diversity supports better communication and trust between patients and providers, better patient outcomes and satisfaction rates, and improved access to care.[18,19] South Carolina's population is diverse and continues to grow. Providers are challenged to relate to patients from different backgrounds and lived experiences. Cultural competency training and exposure to a variety of healthcare settings and patient populations can help providers build the skills they need to provide culturally responsive care.

Difficulty Attracting Providers and Retaining Them in Rural Areas

In 2023, 2.5% of the state's actively practicing primary care physicians were practicing in nonmetropolitan counties, where 5.8% of the state's population live (**Tables 1 and 4**). While every county in South Carolina has at least one active primary care physician, this does not mean that individuals can easily access these physicians. Transportation and travel time, cost, availability of appointments, and acceptance of health insurance remain as barriers to accessing healthcare.

The AMN Healthcare 2023 Survey of Final-Year Medical Residents found that only 2% said they would most like to practice in a community of 10,000 people or less, 2% in a community between 10,001-25,000, and 6% in a community of 25,001-50,000. Respondents were most concerned about educational debt, earning a good income, availability of free time, and burnout. The most important factors when considering practice opportunities were lifestyle, adequate personal time, good financial package, and geographic location.[20]

Physicians and other providers may be reluctant to move to or stay in rural settings due to factors affecting professional satisfaction and family needs. Examples include volume of workload, professional isolation, quality and availability of childcare and primary/secondary education, difficulty taking time off, work opportunities for their spouse, and adequate housing.[21]

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[18] Institute of Medicine. *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. National Academies Press; 2004. https://www.nap.edu/catalog/10885. Accessed September 28, 2026.

[19] Shen MJ, Peterson EB, Costas-Muniz R, et al. The effects of race and racial concordance on patient-physician communication: A systematic review of the literature. *Journal of Racial and Ethnic Health Disparities*. 2018;5(1):117-140. doi:10.1007/s40615-017-0350-4. Accessed September 28, 2026

[20] AMN Healthcare. *2023 Survey of final-year medical residents: Many job choices, many reservations*. AMN Healthcare;2023. Accessed August 27, 2026. https://www.amnhealthcare.com/siteassets/amn-insights/surveys/survey-of-final-year-medical-residents-2023.pdf

[21] Rural Health Information Hub. Recruitment and retention for rural health facilities website. https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention#barriers. Accessed August 27, 2026.

Precepting Students

Research has shown that the more exposure students have to training in rural areas, the more likely they are to practice in rural areas.[22] One study shows that more physicians in rural than urban areas teach premedical students, medical students and advanced practice professional students, but that more physicians in urban than rural areas teach residents and fellows.[23] Another study reported that teaching helped providers feel they were giving back to the profession and increased their job satisfaction.[24] Challenges to rural providers who teach may include that precepting students can be a significant time commitment and can impact productivity, decisions about precepting in rural practices that merge with larger health systems may be made at the corporate level, and practice owners may be disinclined to support teaching if it results in loss of provider productivity or loss of revenue.[23,25]

Current Political and Fiscal Climate in the State

South Carolina currently operates with a nearly $45 billion state budget, as of the fiscal year starting July 1, 2026. This includes a state budget surplus of over $2 billion from the previous year.[26]

During the most recent legislative session, Session 126 in 2025-2026, several bills were introduced that could potentially impact primary care in South Carolina. Bills affecting scope of practice were introduced by the Senate for physician assistants, advanced practice registered nurses (APRNs), and pharmacists.[27,28,29] Additionally, a bill on expanding physician access for international physicians was introduced by the Senate.[30] All 4 bills were referred but did not make it out of committee. Similar bills could be re-introduced in future sessions.

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[22] Russell DJ, Wilkinson E, Petterson S, Chen C, Bazemore A. Family medicine residencies: How rural training exposure in GME is associated with subsequent rural practice. *Journal of Graduate Medical Education*. 2022;14(4):441-450. doi: https://doi.org/10.4300/JGME-D-21-01143.1. Accessed August 19, 2026.

[23] Andrilla CHA, Peterson LE, Patterson DG, et al. Trends in rural and urban family physician teaching of health professions students and residents. *Fam Med.* 2026;58(8):555-563. doi: 10.22454/FamMed.2026.266557. Accessed September 28, 2026.

[24] Alexandraki I, Kern A, Beck Dallaghan GL, Baker R, Seegmiller J. Motivators and barriers for rural community preceptors in teaching: A qualitative study. *Medical Education*. 2024;58(6):737-749. doi:10.1111/medu.15286. Accessed September 28, 2026.

[25] Oster NV, Evans DV, Patterson DG, Andrilla CHA, Graves JM. *Expanding and sustaining rural clinical education: Perspectives from health professions education leaders.* WWAMI Rural Health Research Center, University of Washington; June 2026. https://familymedicine.uw.edu/rhrc/wpcontent/uploads/sites/4/2026/06/RHRC_PBJUN2026_RCE_Oster.pdf. Accessed September 26, 2026.

[26] South Carolina Office of the Governor. *Executive budget state of South Carolina: Fiscal year 2026-27*. South Carolina Office of the Governor; 2026. Accessed August 14, 2026. https://governor.sc.gov/sites/governor/files/Documents/Executive-Budget/FY27%20Executive%20Budget%20Book%20-%20FINAL%200112026.pdf.

[27] South Carolina Legislature. S 0044 general bill: Physician assistants. https://www.scstatehouse.gov/billsearch.php?billnumbers=44&session126&summary=B. Accessed August 17, 2026.

[28] South Carolina Legislature. S 0045 general bill: Advanced practice registered nurse practice authority. https://www.scstatehouse.gov/billsearch.php?billnumbers=45&session126&summary=B. Accessed August 17, 2026.

[29] South Carolina Legislature. S 0378 general bill: Pharmacists. https://www.scstatehouse.gov/billsearch.php?billnumbers=378&session126&summary=B. Accessed August 17, 2026.

[30] South Carolina Legislature. S 0376 general bill: Expanding physician access act of 2025. https://www.scstatehouse.gov/billsearch.php?billnumbers=376&session126&summary=B. Accessed August 17, 2026.

Two bills passed during the 2025-2026 legislative session could potentially have an impact on primary care in South Carolina. The first one gives the Board of Medical Examiners the ability to waive specific examination requirements for certain physicians.[31] Examples could include experienced physicians coming to South Carolina from another state or physicians returning to the workforce. This bill removes one barrier to entry into the workforce for physicians in South Carolina, which includes physicians wishing to practice in rural areas of the state.

The second bill enacted into law gives physical therapists the ability to certify temporary disabilities for people applying for temporary disability placards with the Department of Motor Vehicles (DMV).[32] By providing needed accommodations for those with mobility impairments, they may be better able to access transportation, provide for their daily living needs, and attend healthcare appointments.

State and Federal Programs that Might Affect the State's Ability to Achieve its Goals

There are several state and federal programs that may have an impact on the state's ability to achieve its goals. Some are potential barriers, whereas others are opportunities for improvement.

Current Programmatic Barriers

Current HPSA methodology does not account for nurse practitioners or physician assistants as part of the primary care shortage designation.

The number of nurse practitioners and physician assistants in the workforce has grown rapidly over the last 20 years and is projected to continue growing. The U.S. Bureau of Labor Statistics projects a 41% growth of nurse practitioners in the U.S. between 2025 and 2035, an increase of 137,800 new jobs.[33] Physician assistants are also projected to grow, with a projected 20% growth between 2025 and 2035, an increase of 35,700 job openings across the nation.[34]

In South Carolina, there was a 161% growth in PAs (**Table 8**), and a 204% increase in practicing nurse practitioners (**Table 9**) from 2014-2024. According to 2032 employment projections from the South Carolina Department of Employment and Workforce (DEW), nurse practitioners are projected to be the fastest-growing healthcare occupation in the state, with an additional 60.7% growth expected between 2022 and 2032.[35]

Many nurse practitioners and physician assistants work in South Carolina counties with a primary care HPSA designation and provide primary care services to those communities. By not

[31] South Carolina Legislature. S 3254 general bill: Physician licensure. https://www.scstatehouse.gov/billsearch.php?billnumbers=3254&session=126&summary=B. Accessed August 17, 2026.

[32] South Carolina Legislature. S 3842 general bill: Medical authorization of handicap placards. https://www.scstatehouse.gov/billsearch.php?billnumbers=3842&session=126&summary=B. Accessed August 17, 2026.

[33] U.S. Bureau of Labor Statistics. *Occupational Outlook Handbook: Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* U.S. Bureau of Labor Statistics, U.S. Department of Labor; 2026. Accessed September 4, 2026. https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm#tab-6.

[34] U.S. Bureau of Labor Statistics. *Occupational Outlook Handbook: Physician Assistants*. U.S. Bureau of Labor Statistics, U.S. Department of Labor; 2026. Accessed September 4, 2026. https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-6.

[35] Campbell C, Gaul K. *The South Carolina nurse practitioner workforce, 2022.* South Carolina Office for Healthcare Workforce, South Carolina AHEC. May 2025. https://www.scahec.net/scohw/reports/145. Accessed August 19, 2026.

including them in HPSA designations, this may not accurately reflect access and need and could cause an imbalance in the distribution of resources.[36,37]

While there may be nurse practitioners and physician assistants available to provide safe and effective care, the lack of physicians in rural and underserved areas can impact patients' ability to choose the type of provider they prefer for their primary care needs.

Better reimbursement models are needed to support team-based primary care.

Many students in healthcare fields receive training during their education to work as part of an interprofessional team to improve health outcomes. However, in practice, fee-for-service remains the dominant reimbursement model, which may discourage team-based care, as it only pays for the primary provider of services.

A bill was introduced in the South Carolina Senate in the 2025-2026 legislative session to enact the "Team Based Healthcare Act." It was referred to, but did not make it out of committee. This bill would have required the licensing boards, the South Carolina Department of Health and Human Services (DHHS), and South Carolina DPH to determine the team structure as well as incentives for providers to be a part of this care team.[38] While the bill raised additional questions about scope of practice for physician assistants, advanced practice registered nurses and anesthesiologist assistants, it does highlight the reality that creating team-based healthcare will require cooperation and planning across multiple agencies and professions to be effective.

Clinical training sites are less common in rural areas of the state.

As previously mentioned, research has shown that greater exposure to rural health settings during graduate medical education is associated with a greater likelihood of working in a rural area after graduation.[22] However, that same study indicated that less than 10% of family medicine residency graduates had any training in rural settings.

In 2026, there were 20 family medicine residency programs in the state,[39] with more programs in development. RuralGME lists 5 programs where the majority of training is located in rural areas as defined by the Federal Office of Rural Health Policy (FORHP).[40] One study found that family medicine physicians are likely to stay in the same state where they completed residency training. However, South Carolina was an outlier; despite having a high number of family medicine residents per capita, the state had a high percentage of unfilled family medicine residency

[36] Wittkower LD, Bradley KWV, Plemmons A. Including nurse practitioners in the calculation of primary care health professional shortage areas. *Medical Care Research and Review*. 2026;0(0):1-10. doi:10.1177/10775587261442035. Accessed August 19, 2026.

[37] Bruza-Augatis M, Coplan B, Puckett K. Providing care in underresourced areas: Contribution of the physician assistant/associate workforce. *BMC Health Serv Res*. 2024;24(844):1-11. doi:10.1186/s12913-024-11190-x. Access August 19, 2026.

[38] South Carolina Legislature. S 0669 general bill: Team based health care act. https://www.scstatehouse.gov/billsearch.php?billnumbers=669&session126&summary=B. Accessed August 19, 2026.

[39] South Carolina AHEC. Graduate Medical Education website. https://www.scahec.net/gme.html. Accessed September 28, 2026.

[40] RuralGME. Rural Residency Programs and Rural Rotations Sites website. https://www.ruralgme.org/rural-programs. Accessed September 28, 2026.

positions, a lower ratio of primary care physicians per population, and low family physician retention after residency than most other states.[41]

Health system consolidation has increased significantly in South Carolina in recent years, which leads more often to student training sites being housed within their own health system programs and locations. With the major health systems based in urban areas of the state, this can limit the availability of student rotations in rural sites and FQHCs.

Closure of labor and delivery units in the state decreases access to maternal and infant healthcare.

According to the 2026 maternity care access report by the March of Dimes, 7 out of the 46 counties in South Carolina are classified as "maternity care deserts" and 8 counties are considered "low access." Maternity care deserts are defined as counties that do not have labor and delivery services or obstetrician-gynecologists. In South Carolina, there are approximately 1,000 births annually to residents of maternity care deserts.[42]

The South Carolina Institute of Medicine and Public Health (IMPH) created a statewide taskforce to develop recommendations for improving maternal and infant health, specifically to increase access to care in rural South Carolina. In their 2025 report, they noted that 13 labor and delivery units have closed in South Carolina since 2012. The maternal and infant health report included 12 recommendations to improve health outcomes centered around care delivery, workforce, nonmedical drivers of health, and training and education.[43]

Federal policies and budget will have significant impact on South Carolina hospitals and access to care.

The One Big Beautiful Bill Act (OBBBA), or H.R.1, now Public Law 119-21,[44] has outlined significant changes to the federal budget, with major impacts for rural areas. Since South Carolina did not adopt Medicaid expansion, the state may not feel as extreme effects as other states. However, South Carolina hospitals will still experience impacts due to statutory caps and phased reductions on Medicaid State Directed Payments (SDPs). According to the South Carolina Hospital Association, hospitals will see a collective annual decrease in payments of approximately $258 million each year beginning in 2028. Overall, this will equate to a $1.8 billion annual decrease in Medicaid payments across the state once the law has been fully implemented. This reduction of payment could force the closure of rural hospitals, impacting access to care and putting an even larger burden on rural primary care and emergency medical services (EMS). This

[41] Topmiller M, Peterson LE, Bazemore AW, Carrozza M, Grandmont J, Jabbarpour Y. Majority of family physicians still choose to practice in the state where they were trained. *Health Affairs*. 2026;45(3):246-250. doi:10.1377/hlthaff.2025.01003. Accessed September 28, 2026.

[42] March of Dimes. *Maternity care access in South Carolina*. August 2026. https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-SouthCarolina.pdf. Accessed August 19, 2026.

[43] Farrell T, Hubbard A, Hunt B, Taylor H, Wilks A. *Improving maternal and infant health: Increasing access to care in rural South Carolina.* South Carolina Institute of Medicine and Public Health. April 2025. https://imph.org/wp-content/uploads/Maternal-and-Infant-Health-Report-2025.pdf. Accessed August 19, 2026.

[44] U.S. Government Publishing Office. Public Law 119-21: An act to provide for reconciliation pursuant to title II of H. Con. Res. 14. https://www.govinfo.gov/app/details/PLAW-119publ21/summary. Accessed August 20, 2026.

could also cause an increase in maternity deserts in the state, and hospital job losses could lead to economic instability and negatively impact recruitment of new industries.[45]

Federal policies may impact the number of students pursuing professional degrees in healthcare.

Public Law 119-21 also included changes to federal student loans beginning July 1, 2026. Under the Reimagining and Improving Student Education (RISE) Final Rule,[46] students in professional programs (e.g., medicine) can borrow up to $50,000 per academic year or up to $200,000 in student loans over a lifetime. These caps exclude undergraduate loans, which are now capped at $57,500. While education programs for advanced practice registered nurses and physician assistants were initially considered graduate programs with lower lifetime loan caps, a U.S. District Court temporarily stayed the professional degree definitions. Under the temporary stay, students in graduate nursing and physician assistant programs are defined as professional students for the duration of the stay.[47] The new limits on student borrowing could potentially have a long-term impact on people choosing to enter a healthcare field or which career or specialty they choose.

Current Programmatic Advantages

While there are some significant barriers, there are also several community-based, state, and federal initiatives that may help the state achieve its goals.

Programs in South Carolina are preparing future health professionals for primary care practice in rural and medically underserved areas.

South Carolina AHEC supports South Carolina's primary care workforce pipeline through programs that provide students with exposure to primary care careers and training experiences in primary care settings. The Health Careers Program (HCP) introduces students to primary care professions and educational pathways, while the Health Professions Student (HPS) Program provides learning opportunities focused on primary care practice through the Institute for Primary Care, Interprofessional Team Case Conferences, and support for primary care clinical rotations in rural and medically underserved communities.[48,49] In FY2025, the HCP delivered 11,802 total contact hours of programming to 1,243 high school and college students. During the same year, the HPS Program supported 1,134 training site placements with 355 preceptors at 179 community-based training sites and provided 1,225 weeks of student housing

[45] South Carolina Hospital Association. *South Carolina hospitals and the One Big Beautiful Bill*. 2026. https://scha.org/wp-content/uploads/2026/01/OBBB_1pager.pdf. Accessed August 19, 2026.

[46] U.S. Department of Education. Reimagining and improving student education: Federal Student Loan Program final regulations. 34 C.F.R. § 685;2026. https://www.federalregister.gov/documents/2026/05/01/2026-08556/reimagining-and-improving-student-education-federal-student-loan-program-final-regulations. Accessed September 26, 2026.

[47] Federal Student Aid. (GENERAL-26-42) Update to list of professional degree programs due to court order. FederalStudentAid website. https://fsapartners.ed.gov/knowledge-center/library/electronic-announcements/2026-06-29/update-list-professional-degree-programs-due-court-order-updated-july-10-2026. Updated July 10, 2026. Accessed September 26, 2026.

[48] South Carolina AHEC. Health Careers Program website. https://www.scahec.net/healthcareers.html. Accessed September 28, 2026.

[49] South Carolina AHEC. Health Professions Student Program website. https://www.scahec.net/healthstudents.html. Accessed September 28, 2026.

for nearly 200 students during clinical rotations.[50] Together, these programs provide exposure to primary care careers, primary care practice settings, and interprofessional models of care that support the development of South Carolina's future primary care workforce.

The HRSA-funded South Carolina AHEC Scholars Program is part of a national initiative to prepare future health professionals to become leaders in interprofessional practice and serve those who need it most. The 2-year program accepts students from various disciplines and training programs across the state, including medicine, nurse practitioner, and physician assistant programs. The program includes didactic and experiential training opportunities with a specific focus on primary care and service to rural and underserved populations.[51] An internal analysis of post-completion data suggests that 53% of health professional graduates who completed the program remain in practice in South Carolina. Among physician completers, nearly 70% are practicing in primary care settings, while more than 62% of nurse practitioner completers are practicing in primary care (written communication with advisory members, September 2026).

The Center for Rural and Primary Healthcare (CRPH) supports 2 on-campus rural interest groups: the Rural Interest Group (RIG) at the University of South Carolina (USC) for undergraduate, graduate, and professional students, as well as the Rural Health Interest Group (RHIG) at the USC School of Medicine. Both groups host guest speakers about rural healthcare, evidence-based programs, and broader economic and policy topics.[52]

SCPHCA administers a Health Professions Education and Training (HPET) initiative to recruit, train, and retain healthcare workers, including primary care providers in FQHCs, and to support community-based training. This multi-year partnership with SCORH helps FQHCs build relationships and strengthen opportunities to offer hands-on clinical education and training experiences (written communication with advisory members, September 2026).

South Carolina has prioritized increasing the number of family medicine residency programs in the state.

As of 2026, South Carolina currently has 20 family medicine residency programs, an increase from 8 programs in 2016 and 16 programs in 2021. Data from the Association of American Medical Colleges (AAMC) indicates that 44.1% of physicians who completed GME in South Carolina were actively practicing in the state in 2024, significantly increasing to 75.2% retention if physicians completed both medical school and residency in the state.[53] At this point, the growth in GME slots in the state has not shown comparable growth in physicians practicing in South Carolina.[54] Feedback from the advisory group and confirmed in the literature also suggested that some of the new or existing programs may not be sustainable, with family

[50] South Carolina AHEC. *South Carolina Area Health Education Consortium 2025 Annual Report*. https://www.scahec.net/docs/archive/2025-sc-ahec-annual-report.pdf. Accessed September 28, 2026.

[51] South Carolina AHEC. AHEC Scholars Program website. https://www.scahec.net/ahecscholars.html. Accessed August 20, 2026.

[52] Center for Rural and Primary Healthcare. Rural Health Interest Group website. https://www.scruralhealth.org/rural-health-interest-group. Accessed August 20, 2026.

[53] Association of American Medical Colleges. *U.S. Physician Workforce Data Dashboard*. Association of American Medical Colleges. 2025. Accessed August 20, 2026. https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard.

[54] Gaul K, Chastain-Brown A, Lefebvre A. *Trends of available PGY-1 residency positions and practicing physicians in South Carolina, 2004-2023.* South Carolina Office for Healthcare Workforce, South Carolina AHEC. September 2024. https://www.scohw.org/reports/143. Accessed August 20, 2026.

medicine already struggling to fill available first-year residency positions.[55] As residency programs are cohort-based and take multiple years to complete, more analysis will be needed in the future to determine whether the increase in GME positions has a positive effect on the physician workforce in the state.

South Carolina AHEC provides financial and programming support to the state's family medicine residency programs. Activities include providing faculty development funds for professional development in teaching, collaborating for family medicine recruitment, and supporting the block of promotional booths for the state's family medicine residency programs at the annual American Academy of Family Physicians (AAFP) FUTURE Conference in Kansas City, Missouri.[56]

Beginning in July 2024, the University of South Carolina School of Medicine Greenville launched the Primary Care Accelerated Track (PCAT), an innovative program for students with the goal of becoming a primary care physician. The 3-year accelerated MD program leads directly into a 3-year Prisma Health Family Medicine residency. The medical school provides a scholarship for students to attend tuition-free with a 4-year commitment to primary care with Prisma Health upon completing residency.[57]

Several programs in South Carolina focus on recruitment and retention of primary care providers.

South Carolina AHEC administers the state's Rural Provider Incentive Program. This program provides financial incentives to full- and part-time primary care, general surgery, and psychiatry physicians, nurse practitioners, certified nurse midwives, and physician assistants who practice outpatient care in underserved areas in the state. Funds are paid out annually after employer verification. Providers have flexibility to use the funds as needed, which could include paying back student loans, investing in a local practice, or purchasing a home. The program has currently funded over 675 primary care providers in rural communities.[58] In FY2025, 87% of providers participating in the Rural Provider Incentive Program were retained in their rural practice location for the entire fiscal year.[59]

SCORH provides recruitment services to help healthcare employers in rural areas of the state find the best providers for their communities. They also provide technical assistance to FQHCs, look-alike community health centers (CHCs), RHCs, and Critical Access Hospitals (CAHs) to promote employment opportunities and connect them to state and national resources for practice support.[60] SCORH also serves as the state's network coordinator for the National Rural Recruitment and

[55] Stickler M, Shaver WM, Franks AM. Family medicine residency match is not a "field of dreams". *J Am Board Fam Med.* 2026;38(6):980-982. doi:10.3122/jabfm.2025.250131R1. Accessed September 4, 2026.

[56] South Carolina AHEC. Graduate Medical Education website. https://www.scahec.net/gme.html. Accessed August 20, 2026.

[57] University of South Carolina School of Medicine Greenville. Primary Care Accelerated Track website. https://sc.edu/study/colleges_schools/medicine_greenville/medical_education/pcat/. Accessed August 20, 2026.

[58] South Carolina AHEC. Rural Provider Incentive Program website. https://www.scahec.net/recruitment.html. Accessed August 20, 2026.

[59] Medical University of South Carolina. 2025 annual accountability report. https://www.scstatehouse.gov/reports/aar2025/H510%20and%20H530.pdf. September 2025. Accessed September 26, 2026.

[60] South Carolina Office of Rural Health. Workforce Recruitment + Retention website. https://scorh.net/workforce-recruitment-retention/. Accessed August 20, 2026.

Retention Network (3RNET), a national clearinghouse for rural health care jobs.[61] While SCORH is the primary member of 3RNET, they collaborate closely with the DPH PCO and South Carolina AHEC regarding 3RNET's Provider Retention & Information System Management (PRISM),[62] National Health Service Corps (NHSC), and state incentive surveys. Additionally, SCORH is a core partner in initiatives such as Project Hometown SC, a two-year project to strengthen community identity, support local workforce, and improve retention of the community's population in Cheraw, Hartsville, and Walterboro.[63]

In addition to recruitment efforts, SCORH is also involved with other initiatives to support rural providers. It houses the Center for Practice Transformation, which supports rural providers in identifying opportunities to improve care and maximize reimbursement in their practices through the use of quality improvement methods and new care models. SCORH, along with CRPH, has awarded Rural Enhancement Grants for rural health providers to purchase technology and educational materials to advance their practices.[64]

The DPH PCO houses the Conrad 30 Waiver program to sponsor up to 30 J-1 visa holders per year who are physicians with employment in a designated HPSA.[65] Additionally, the DPH PCO assists with NHSC site designation applications and connecting providers with designated sites.[66] Programs and initiatives are focusing on health care quality and access for underserved areas in South Carolina.

HRSA currently recognizes 24 organizations that provide services over 248 health center service delivery sites (**Figure 8**). SCPHCA is the membership organization that represents the community health centers in the state. They support clinical and health care improvement and provide technical assistance and training to the state's health centers.[67]

SCDHHS accepted applications for the Rural & Medically Underserved Area Grant, which awarded one-time infrastructure funds to create or improve facilities for rural and medically underserved areas. In February 2024, SCDHHS issued $48.2 million total in awards to 26 different applicants across the state.[68]

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[61] 3RNET. 3RNET website. https://www.3rnet.org/. Accessed August 20, 2026.

[62] 3RNET. Provider Retention & Information System Management (PRISM) website. https://www.3rnet.org/PRISM. Accessed September 26, 2026.

[63] Project Hometown SC. Project Hometown SC website. https://projecthometownsc.org/. Accessed September 28, 2026.

[64] Center for Rural and Primary Healthcare. Rural Practitioner and Practice Enhancement Grants website. https://www.scruralhealth.org/rural-practitioner-and-practice-enhancement-grants. Accessed August 20, 2026.

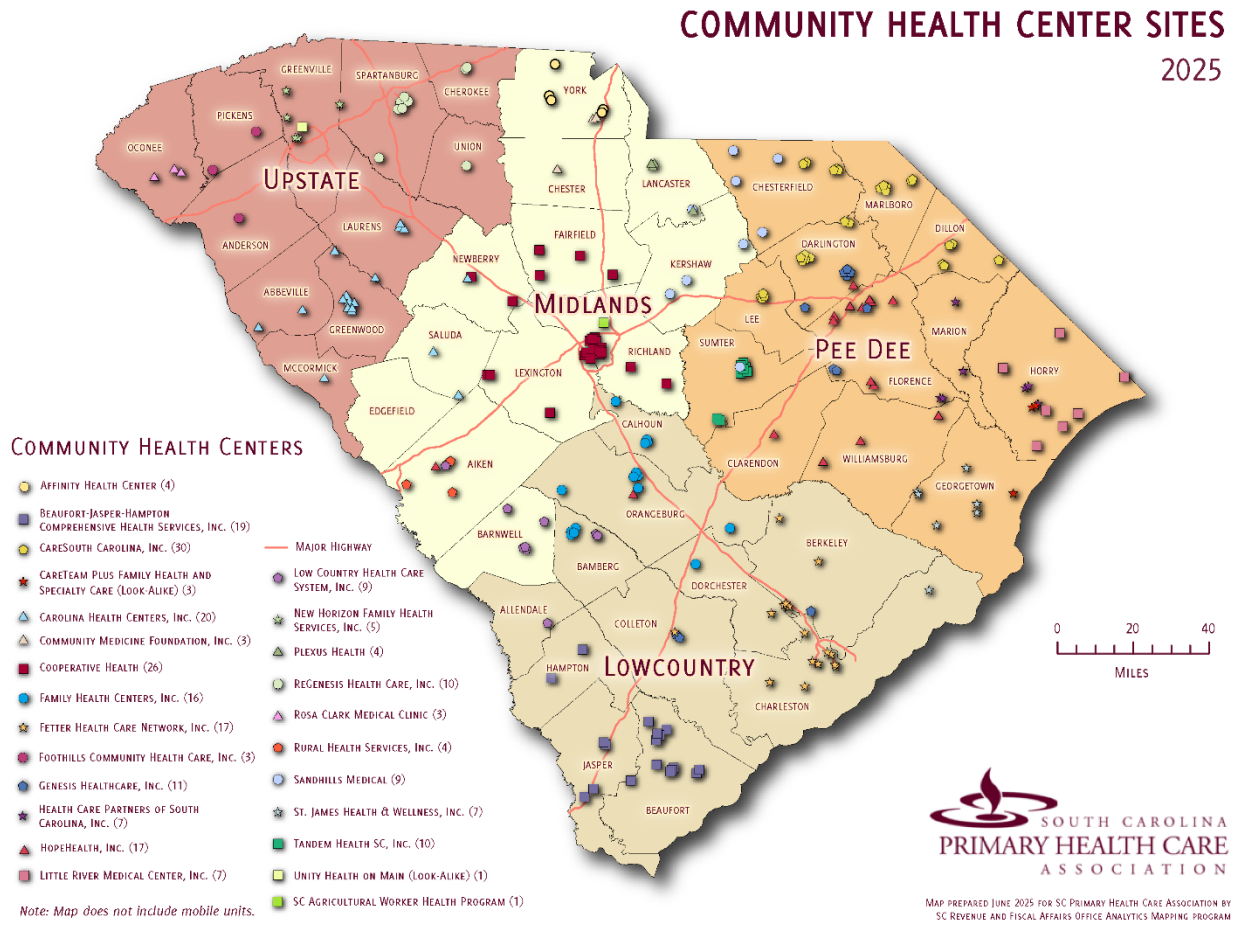
[65] South Carolina Department of Public Health. PCO: J-1 Waiver website. https://dph.sc.gov/professionals/south-carolina-primary-care-office/pco-j-1-waiver. Accessed August 20, 2026.

[66] South Carolina Department of Public Health. PCO: Physician Incentive, Student Loan Repayment, and Scholarship Programs website. https://dph.sc.gov/professionals/south-carolina-primary-care-office/pco-physician-incentive-student-loan-repayment-and. Accessed August 20, 2026.

[67] South Carolina Primary Health Care Association. South Carolina Primary Health Care Association website. https://www.scphca.org/. Accessed August 20, 2026.

[68] South Carolina Department of Health and Human Services. Grant Opportunities website. https://www.scdhhs.gov/resources/grants. Accessed August 20, 2026.

Figure 8. Location of Community Health Centers in SC, 2025



Source: Personal communication with SCPHCA, September 2026.

The most recent program for the state is the Rural Health Transformation Program (RHTP), a federal initiative led by the Centers for Medicare and Medicaid Services (CMS) and administered by SCDHHS. South Carolina received just over $200 million from CMS for SCDHHS to distribute through grant funding. Grant applications were accepted through June 2026 for the first four state initiatives, with a fifth initiative coming as a future funding opportunity. Of the 712 grant applications received, SCDHHS awarded 228 grants totaling $167,299,900.[69] Awardees include large health systems, such as the Medical University Hospital Authority, Prisma Health, and McLeod Health, as well as smaller hospitals such as Allendale County Hospital and Hampton Regional Medical Center. Additional awardees include smaller practices such as Family Medicine Associates, LLC in Kingstree and Bamberg Family Practice; FQHCs; universities; community organizations like Foothills Area YMCA; and the South Carolina Department of

[69] South Carolina Office of the Governor. South Carolina announces recipients of Rural Health Transformation Program funding. September 15, 2026. https://governor.sc.gov/news/2026-09/south-carolina-announces-recipients-rural-health-transformation-program-funding. Accessed September 25, 2026.

Behavioral Health and Developmental Disabilities (BHDD).[70] At this time, the statewide impact of this funding remains to be seen.[70] While the RHTP could provide significant short-term help to support rural health in South Carolina, there is concern about long-term sustainability in conjunction with federal budget cuts through implementation of Public Law 119-21.

Plan for Ongoing Collaboration with Stakeholders in South Carolina

In February 2025, SCOHW convened an advisory committee to identify existing information and data resources and to guide the development of this primary care needs assessment. This advisory committee included representation from the SC DPH, SCORH, SCPHCA, SC Thrive, and SC AHEC (**Appendix 2**).

Members of the committee provided guidance on issues impacting access to primary care services, data sources to support the needs assessment, and examples of programs that aim to help improve access to services. The committee members served as subject matter experts throughout the development of this report. The committee was engaged again in September 2026 to review barriers and opportunities as well as provide feedback on strategic, long-term approaches to reduce health provider shortages and shortage designations.

The members of this committee collaborate routinely on matters pertaining to primary care and other healthcare needs of the state. Additionally, each advisory member organization is participating on workgroups that are implementing the 2025-2030 State Health Improvement Plan (SHIP; see next section). The PCO will be meeting in-person and virtually with members of the advisory group and other stakeholders during regular SHIP workgroup meetings. Timelines for implementation are not yet available.

Strategic, Long-Term Plan to Reduce Shortage Designations

In October 2025, Live Healthy South Carolina and the South Carolina DPH released the 2025-2030 South Carolina State Health Improvement Plan (SHIP). This plan was created collaboratively with state government agencies, healthcare providers, and other key community stakeholders. The SHIP focuses on nine key priority areas for the state, with one of them being improvement of access to high-quality care. This key priority area has a clear relationship with reducing health provider shortages and shortage designations within the state. The strategies and action items listed below come directly from the SHIP.[7]

Strategy 1: Reduce structural and economic barriers within the healthcare system.

a. Invest in and expand innovative treatment sites and services.
b. Expand and support the utilization of navigators and support persons.
c. Reduce out-of-pocket costs and improve reimbursement rates.

[70] South Carolina Department of Health and Human Services. *South Carolina Rural Health Transformation Program: Year 1 awards*. https://www.scdhhs.gov/sites/dhhs/files/SC%20RHTP%20Year%201%20Award%20List%20to%20CMS.pdf. September 15, 2026. Accessed September 25, 2026.

Strategy 2: Strengthen access to and navigation of the healthcare system.

a. Enhance care coordination and infrastructure.
b. Maximize full utilization of healthcare professionals within the scope of their education and licensure.
c. Establish and strengthen conventional and non-traditional partnerships to boost healthcare education and service delivery.
d. Strengthen quality improvement strategies and initiatives within EDs.

Strategy 3: Advance healthcare policies to close coverage gaps across populations.

a. Expand access to care through private, public, and insurance marketplaces.
b. Expand prevention services across all insurance platforms.
c. Incentivize employers to provide insurance options and subsidize lower premiums.

Strategy 4: Adopt and expand programs that improve geographical access to care.

a. Develop payment models for community health workers, community paramedicine, doulas, and peer support specialists.
b. Invest in rural health centers, federally qualified health centers (FQHCs), and free clinics.
c. Explore innovative healthcare models with enhanced reimbursement for rural and underserved areas.
d. Recruit and retain residents of underserved, rural areas through workforce development and training.

Appendices

Appendix 1. Methods and Data Sources

SCOHW undertook a cross-sectional analysis of secondary, county-level data sources, including census, licensure, and other data as appropriate, to describe the target population and the available primary care workforce in South Carolina. Data were analyzed at the state and county levels. Additional information was gathered to provide context, including novel programs in the state to increase access to primary care services and improve health outcomes.

The structure and phrasing used in this document are similar to, and in places duplicates of, the oral health and mental health needs assessments prepared for this same purpose. Data, figures, and text were updated as needed to reflect the appropriate shortage designation category.

Demographic and Health Indicators Data Sources

1. Fu B, Chastain-Brown A, Campbell C, Palmer C, Fluharty M, Gaul K. 2026 South Carolina Health Professions Data Book. South Carolina Office for Healthcare Workforce, South Carolina AHEC. January 2026. https://www.scahec.net/scohw/reports/149
    - Variables used: population, resident births, resident deaths, total pregnancies number and rate, low birthweight % (<2500 grams), teen pregnancies number and rate, infant mortality rate, % of adults diagnosed with heart disease, % of adults diagnosed with hypertension, % of adults diagnosed with diabetes, % of adults who currently smoke, % of adults reporting a sedentary lifestyle, % of adults overweight or obese (BMI ≥ 25), % of adults without health insurance, % unemployed, % of households with income < $25,000, % with high school education or less, # of Medicaid Full Benefit Members (includes CHIP), and per capita income.
2. Poverty counts and percentages, without confidence intervals: Small Area Income and Poverty Estimates (SAIPE), U.S. Census Bureau. 2023. https://www.census.gov/data-tools/demo/saipe/#/?map_geoSelector=aa_c. Accessed August 26, 2025.
3. Cancer data from DPH South Carolina Central Cancer Registry. https://dph.sc.gov/professionals/public-health-data/cancer-registry. Accessed May 22, 2026. Data are combined for 2020-2024 to minimize the amount of suppressed data at the county level.
4. America's Health Rankings. *2025 Annual Report: State Summaries*. America's Health Rankings, United Health Foundation. Accessed February 23, 2026. https://assets.americashealthrankings.org/ahr_2025annualreport-statesummaries_all.pdf

Provider Workforce Data Sources

Primary Care Physician Workforce Data

1. Source for 2013 data: Unpublished analyses on physician demographic and practice characteristics derived from self-reported data collected biennially by the South Carolina Board of Medical Examiners and obtained from the South Carolina Revenue and Fiscal Affairs Office. Data include physicians with a primary specialty of family medicine, general practice (combined

with family medicine for purposes of analysis), internal medicine, obstetrics/gynecology, or pediatrics who have an active license to practice and a primary practice location in a nonfederal setting in South Carolina as of June 30, 2013. Analyses will not match the 2013 physician data published in the 2014 South Carolina Health Professions Data Book, available at https://www.scahec.net/scohw/reports, because those counts include some federal physicians.

2. Source for 2023 data: Fu B, Chastain-Brown A, Campbell C, Palmer C, Fluharty M, Gaul K. 2026 South Carolina Health Professions Data Book. South Carolina Office for Healthcare Workforce, South Carolina AHEC. January 2026. https://www.scahec.net/scohw/reports/149. Data include physicians with a primary specialty of family medicine, general practice (combined with family medicine for purposes of analysis), internal medicine, obstetrics/gynecology, or pediatrics that have an active license to practice and a primary practice location in a nonfederal setting in South Carolina as of September 1, 2023. Additional unpublished analyses on physician demographic and practice characteristics were derived from self-reported data collected by the South Carolina Board of Medical Examiners and obtained from the South Carolina Revenue and Fiscal Affairs Office.
3. At the time of publication, the 2023 physician data were the most current licensure data available.

Physician Assistant (PA) Workforce Data

1. Source for 2014 data: Unpublished analyses on physician assistant demographic and practice characteristics derived from self-reported data collected biennially by the South Carolina Board of Medical Examiners and obtained from the South Carolina Revenue and Fiscal Affairs Office. Data include PAs with an active license to practice and a primary practice location in a nonfederal setting in South Carolina as of December 31, 2013. Analyses will not match the 2014 physician assistant data published in the 2014 South Carolina Health Professions Data Books, available at https://www.scahec.net/scohw/reports, because those counts include some federal providers.
2. Source for 2024 data: Fu B, Chastain-Brown A, Campbell C, Palmer C, Fluharty M, Gaul K. 2026 South Carolina Health Professions Data Book. South Carolina Office for Healthcare Workforce, South Carolina AHEC. January 2026. https://www.scahec.net/scohw/reports/149. Data include PAs with an active license to practice and a primary practice location in a nonfederal setting in South Carolina as of March 1, 2024. Additional unpublished analyses on PA demographic and practice characteristics were derived from self-reported data collected by the South Carolina Board of Medical Examiners and obtained from the South Carolina Revenue and Fiscal Affairs Office.
3. Data note: PA renewal periods end on December 31 in odd-numbered years, but the data are finalized 2 months later (“post-lapse”) to include late renewals. Therefore, even-numbered years are used as the effective date for data labeling.
4. At the time of publication, the 2024 physician assistant data were the most current licensure data available.

Nurse Practitioner (NP) Workforce Data

1. Source for 2014 data: Unpublished analyses on nurse practitioner demographic and practice characteristics derived from self-reported data collected biennially by the South Carolina Board of Nursing and obtained from the South Carolina Revenue and Fiscal Affairs Office. Data include NPs with an active license to practice and a primary practice location in a nonfederal setting in South Carolina as of April 30, 2012.
2. Source for 2024 data: Fu B, Chastain-Brown A, Campbell C, Palmer C, Fluharty M, Gaul K. 2026 South Carolina Health Professions Data Book. South Carolina Office for Healthcare Workforce, South Carolina AHEC. January 2026. https://www.scahec.net/scohw/reports/149. Data include NPs with an active license to practice and a primary practice location in South Carolina as of May 1, 2024. Due to changes in data collection, it is no longer possible to distinguish NPs working in federal settings. Additional unpublished analyses on NP demographic and practice characteristics were derived from self-reported data collected by the South Carolina Board of Nursing and obtained from the South Carolina Revenue and Fiscal Affairs Office.
3. At the time of publication, the 2024 nurse practitioner data were the most current licensure data available.

Rural Definition

1. Metropolitan Statistical Areas (MSAs) - Metropolitan and micropolitan statistical areas are geographic entities defined by the U.S. Office of Management and Budget (OMB) for use by federal statistical agencies in collecting, tabulating, and publishing federal statistics. A metropolitan area contains a core urban area of 50,000 or more population. A micropolitan area contains an urban core of at least 10,000, but less than 50,000 population. Each metropolitan or micropolitan area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration with the urban core (as measured by commuting to work). Any county that is not designated a metropolitan or micropolitan area is designated as a nonmetropolitan area.
2. Source: U.S. Census Bureau. About Metropolitan and Micropolitan Statistical Areas website. https://www.census.gov/programs-surveys/metro-micro/about.html. Updated February 27, 2026. Accessed August 27, 2026.

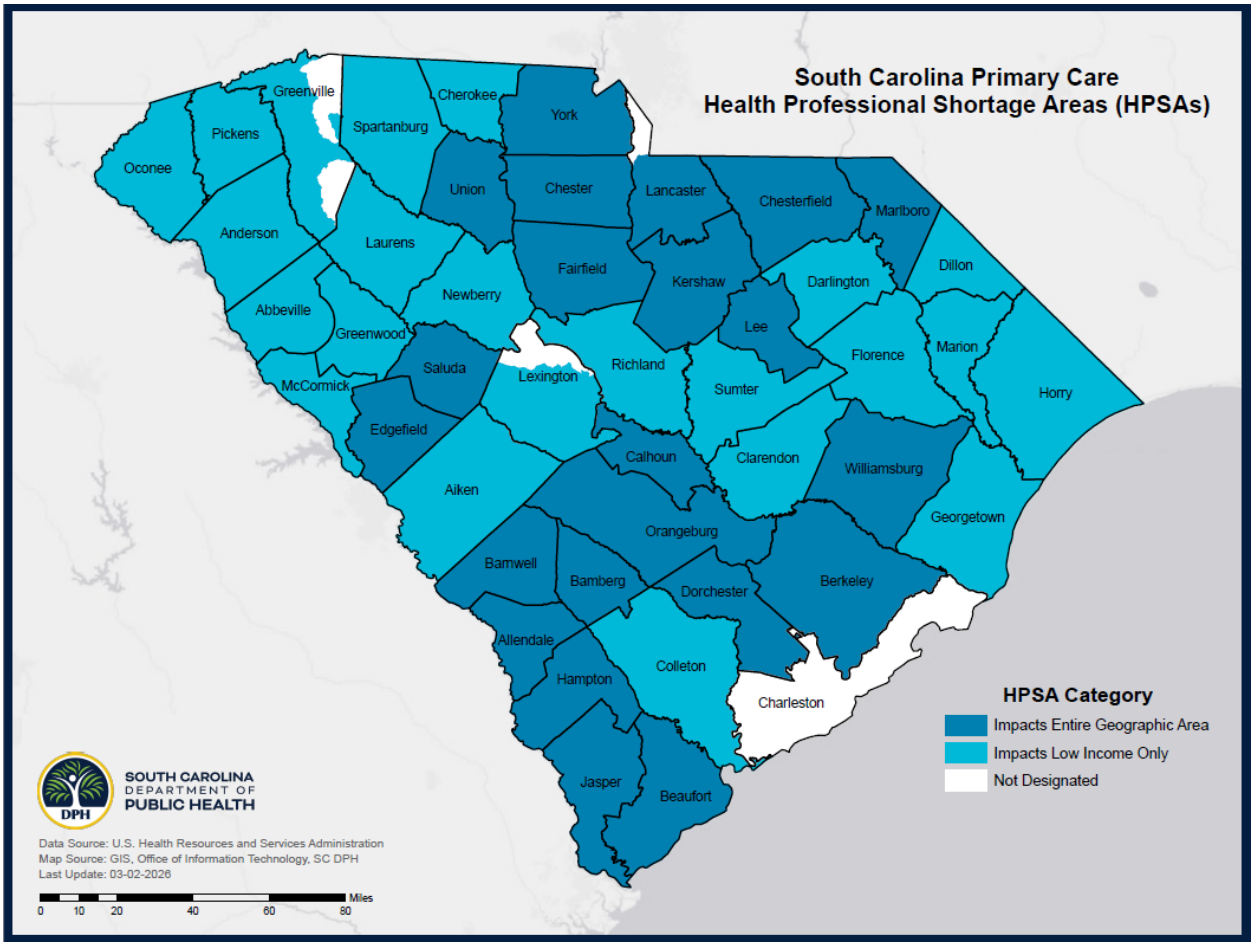
Appendix 2. Primary Care Advisory Committee

In February 2025, the SCOHW convened an advisory committee to identify existing information and data resources and to guide the development of the primary care needs assessment. This advisory committee included:

- Graham Adams, Chief Executive Officer, SC Office of Rural Health
- Ashlyn Chastain-Brown, Program Coordinator, SC Office for Healthcare Workforce, SC AHEC
- Kristin Cochran, Director, Recruitment & Retention Programs, SC AHEC
- Katie Gaul, Director, SC Office for Healthcare Workforce, SC AHEC
- Ann Lefebvre, Executive Director, SC AHEC
- Stephanie McGuire, Chief Learning & Development Officer, SC Thrive
- Kendra Neely, Director of Primary Care Office, SC Department of Public Health
- Christine Palmer, Senior Research Associate, SC Office for Healthcare Workforce, SC AHEC
- Vicki Young, Chief Executive Officer, SC Primary Health Care Association

Committee members provided guidance on issues affecting access to primary care services, data sources to support the needs assessment, and examples of programs that aim to improve access to services and health outcomes. The committee members served as subject matter experts throughout the development of this report. The committee convened again in September 2026 to review barriers and opportunities and provide feedback on strategic, long-term approaches to reduce health provider shortages and shortage designations.

Appendix 3. Primary Care Health Professional Shortage Areas, SC, 2026



Source: South Carolina Department of Public Health, GIS, Office of Information Technology. South Carolina Primary Care Health Professional Shortage Areas (HPSAs). Updated March 2, 2026. Accessed March 30, 2026. https://dph.sc.gov/sites/scdph/files/2026-03/HPSA_Primary%20Care_20260303.pdf