Policy Report

A Strategy for Strengthening Indiana's Physician Workforce

November 2026



Introduction

Indiana's physician shortage remains one of the state's most pressing but least discussed healthcare challenges. The state ranks near the bottom nationally in physician supply, and shortages are expected to grow as physicians from the large Baby Boom generation retire and demand for medical services increases with a growing and aging population.

The consequences of an inadequate supply of primary care and specialist physicians extend well beyond the healthcare system itself. Physician shortages constrain access to care, worsen health outcomes, and adversely impact the competitiveness of Indiana employers and communities.

Meeting Indiana's current and future healthcare needs will require a comprehensive strategy to strengthen the state's physician workforce, identify ways to increase the number of physicians who train and practice in Indiana, and also consider how the state can meet its growing healthcare needs in the context of a limited supply of physicians nationwide.

This paper examines the scale of Indiana's physician shortage, the role of Graduate Medical Education (GME) in addressing it, and ways to retain more physicians who train in the state.

Indiana's Physician Workforce Challenge

Indiana has long ranked among the states with the fewest physicians relative to population size. **Today, our state ranks 42nd in the nation, with 239 active physicians for every 100,000 population, compared with the national average of 304.**[1] This ranking is concerning in itself, but it does not capture the extent of Indiana's physician shortage or how it is likely to change over time.

The federal Health Resources and Service Agency (HRSA) uses a simulation model to estimate physician supply and demand at the state level. HRSA's demand scenario estimates how many physicians are needed to meet the population's health care needs if current utilization patterns continue. HRSA projects physician supply by starting with the current workforce and modeling future entrants, retirements, hours worked, and other departures from practice.

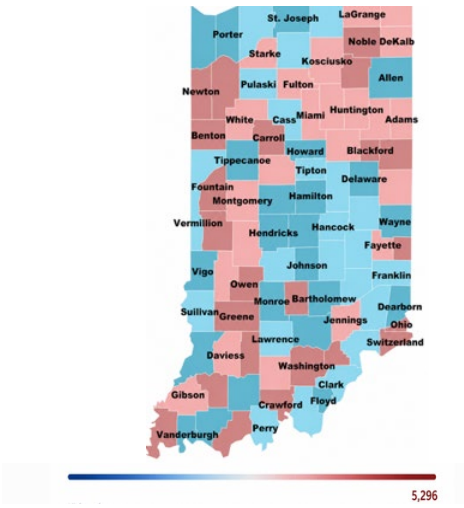
For Indiana, HRSA's 2026 projection is sobering: physician supply totals 17,720 FTEs compared with modeled demand of 24,100, leaving a current gap of 6,380. By 2032, the

[1] Association of American Medical Colleges (AAMC), *Indiana Physician Workforce Profile*, 2025.

modeled gap grows to 7,150 physician FTEs, with projected supply reaching only 18,000 while demand rises to 25,150. [2]

HRSA's estimates should not be interpreted as a prediction that Indiana will be short exactly 7,150 individual doctors in 2032. Workforce models necessarily depend on a variety of assumptions that are subject to change and recalculation. But the magnitude and trajectory of the modeled gap provides strong independent evidence that Indiana's supply of physicians does not meet current demand levels, and this gap is expected to grow into the future.

Figure 1
Geographic Distribution of Indiana Physicians



Indiana's physician shortage is unevenly distributed across the state. As *Figure 1* shows, rural counties generally have fewer physicians relative to population.[3] But access problems are not limited to rural Indiana; they are also prevalent in smaller metropolitan and suburban communities. In fact, some 67 of Indiana's 92 counties are considered to be Primary Care Healthcare Professional Shortage areas by HRSA.[4]

This geographic variation underscores that simply increasing the state's overall number of physicians will not cure Indiana's physician access challenges. To have the greatest impact, additional physicians must practice in the communities and specialty fields where shortages are most severe.

Why Graduate Medical Education Matters

Graduate Medical Education (GME) is one of the most important strategies available to Indiana for increasing its physician workforce. All medical school graduates must complete residency training before they can receive their license to practice medicine independently. Furthermore, where physicians complete that training strongly influences where they ultimately practice. [5]

Residency training is where physicians develop professional relationships, establish patient and provider referral networks, become familiar with health systems and health care partners, build personal relationships within and among the community, and often

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Workforce, *Workforce Projections Dashboard*, Indiana, All Physicians, Status Quo scenario; and *Health Workforce Simulation Model: Physician Model Components*, 2025. Accessed August 2026.[3] Bowen Center for Health Workforce Research and Policy, Indiana Physician Workforce Dashboard / county physician distribution data

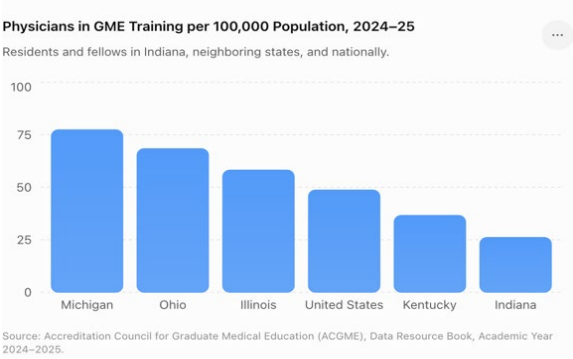
[3] Bowen Center for Health Workforce Research and Policy, Indiana Physician Workforce Dashboard / county physician distribution data

[4] *Health Professional Shortage Areas (HPSA) – Primary Care*, HRSA Health Workforce Shortage Areas, U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Health Workforce, accessed August 2026.

[5] *Report on Residents: Table C6, Physician Retention in State of Residency Training, by State*, Residents Who Completed Training, 2015–2024, Association of American Medical Colleges (AAMC) 2025.

make long-term decisions about where to build their careers. Therefore, the number of physicians Indiana trains through residency has a direct impact on the size of its future physician workforce.

Figure 2



Indiana has substantially less GME capacity than the nation and neighboring states. **In 2024–25, approximately 1,542 residents and 267 fellows were training in Indiana, or 26 per 100,000 population—barely half the national rate of 49**. As *Figure 2* shows, every neighboring state trains more physicians relative to population, ranging from 37 per 100,000 in Kentucky to 77 in Michigan. [6]

Indiana's limited GME programs and capacity restrict its ability to address the physician shortage. Because physicians are more likely to practice near where they complete residency, training fewer residents limits a prominent source of new physicians for the state.

Indiana Retains Physicians Comparatively Well — But Can Do Better

The Bowen Center for Health Workforce Research, which provides Indiana policymakers with extensive data and analysis on the state's healthcare workforce, reports that approximately 53 percent of physicians who complete residency in Indiana remain to practice here. This retention rate is higher than the national average and that of neighboring states.[7]

Indiana's retention rate is encouraging, but nearly half of the physicians trained in the state ultimately practice elsewhere. The challenge will grow as Indiana University and Marian University increase their medical programs. Franciscan Health also recently announced plans for a new osteopathic medical school in Crown Point, with an inaugural class expected in 2030, and eventual total enrollment of 800 students across four years. As medical education expands, additional GME capacity will be critical to converting that growth into a larger physician workforce and retaining more physicians trained by Indiana hospitals and health systems.

[6] *Data Resource Book Academic Year 2024-25,* Accreditation Council for Graduate Medical Education (ACGME) 2026
[7] *Indiana's Physician Pipeline-to-Practice in Context,* Bowen Center for Healthcare Workforce Research and Policy, IU School of Medicine, updated 2026

Indiana Has Made Progress — But Not Enough

Training physicians is expensive. The average direct cost of training a resident is about $200,000 annually.[8] **With some 1,540 residents training in Indiana, that puts the estimated direct cost of residency training statewide at more than $300 million each year.**

Medicare is the largest public source of GME funding, but federal payments cover only a portion of these costs and are limited by caps on the number of residency positions Medicare will support at individual teaching hospitals. [9] As a result, hospitals must finance both costs not covered by Medicare and residency positions above their Medicare caps. An **IBHC analysis estimates Indiana hospitals and health systems collectively contribute on the order of $170 million to $200 million annually toward the direct cost of residency training.**[10]

For large academic health systems, these costs represent a significant but longstanding institutional commitment. However, for smaller and rural hospitals, the financial burden and infrastructure required to establish and operate a residency program can be a major barrier to entering GME at all. This is particularly important because these hospitals increasingly view physician training as a strategy for recruiting and retaining physicians in the communities they serve.

Expanding Indiana's residency capacity will also require a substantial investment in clinical teaching faculty. Residency programs depend on experienced physicians who can supervise residents, teach clinical skills, evaluate performance, and ensure patients receive appropriate care. Many community physicians have little experience with formal medical education, and teaching responsibilities can reduce the time available for patient care. Recruiting physicians to serve as preceptors and preparing them for these responsibilities can therefore be a significant challenge, particularly for smaller hospitals and those in underserved communities.

As Indiana expands GME beyond its established academic medical centers, hospitals will need to develop and support a larger network of qualified clinical educators. This will require faculty development, protected teaching time, and appropriate financial support for physicians who assume educational responsibilities. Without sufficient clinical

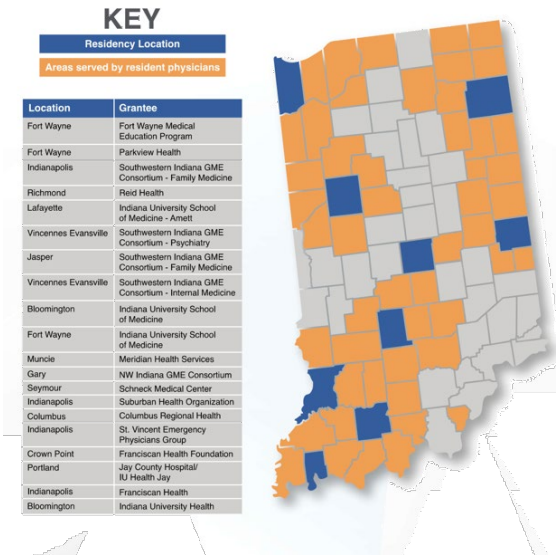
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[8] *Teaching Hospital Characteristics*: *AAMC analysis of FY2023 Hospital Cost Reporting Information System (HCRIS) Data*, Association of American Medical Colleges (AAMC), July 2025 release.

[9] The Balanced Budget Act of 1997 established Medicare-funded residency caps for individual teaching hospitals, generally based on the number of residents they trained in 1996. Although Congress has authorized limited additional positions in recent years, these caps have remained largely unchanged for nearly three decades. By preserving the historical distribution of residency positions, the caps favored states with larger, more established GME systems and disadvantaged states such as Indiana that subsequently sought to expand their physician training capacity.

[10] The IBHC analysis is based on AAMC national estimates of direct graduate medical education costs and Medicare reimbursement, ACGME data on Indiana residency positions, Medicare cost reports from Indiana teaching hospitals, and reported Indiana Medicaid and GME Board funding. The estimated hospital contribution represents the difference between modeled residency training costs and estimated public funding, rather than an accounting of actual hospital expenditures. A technical appendix is available to explain the methodology used in more detail.

teaching capacity, even well-funded efforts to create additional residency positions may struggle to succeed.[11]



Location	Grantee
Fort Wayne	Fort Wayne Medical Education Program
Fort Wayne	Parkview Health
Indianapolis	Southwestern Indiana GME Consortium - Family Medicine
Richmond	Reid Health
Lafayette	Indiana University School of Medicine - Arnett
Vincennes Evansville	Southwestern Indiana GME Consortium - Psychiatry
Jasper	Southwestern Indiana GME Consortium - Family Medicine
Vincennes Evansville	Southwestern Indiana GME Consortium - Internal Medicine
Bloomington	Indiana University School of Medicine
Fort Wayne	Indiana University School of Medicine
Muncie	Meridian Health Services
Gary	NW Indiana GME Consortium
Seymour	Schneck Medical Center
Indianapolis	Suburban Health Organization
Columbus	Columbus Regional Health
Indianapolis	St. Vincent Emergency Physicians Group
Crown Point	Franciscan Health Foundation
Portland	Jay County Hospital/ IU Health Jay
Indianapolis	Franciscan Health
Bloomington	Indiana University Health

Indiana has increasingly recognized the need to help hospitals overcome these barriers to expanding residency programs. In 2015, the state established the Graduate Medical Education Board to help address the physician shortage by expanding residency training capacity, particularly in underserved areas.

Since 2017, the Board reports making more than $49.5 million in grant awards, supporting approximately 15 new residency programs and 309 resident physicians (see table and map at left).[12] The Board funds feasibility studies and program development and can provide time-limited support of up to $45,000 per resident once programs begin operating.

These investments have helped expand GME beyond Indiana's traditional academic medical centers. Smaller and rural hospitals increasingly view physician training as an important strategy for recruiting and retaining physicians in their communities, and state support can make programs possible that these institutions could not reasonably finance on their own.

But available state funding has not kept pace with demand. The GME Board received approximately $16 million in requests to support residency program expansions this year. This exceeded the Board's annual budget of $7 million, requiring it to choose among qualified applicants leaving several programs without this important funding each year. The funding challenge is expected to grow in the next biennium: the Board's historical biennial appropriation of about $14 million falls well short of the approximately $36 million the GME Board estimates will be needed to support continued program expansion.

For the next several years, Indiana will supplement state GME funding with approximately $5.5 million annually from its federal Rural Health Transformation Program (RHTP) award. That funding will be used to provide technical assistance to rural hospitals and health systems seeking to create or expand residency programs, but it can't be used to fund additional residency positions. Nor can RHTP provide long-term funding stability: it is

[11] The question of how to incentivize more Indiana physicians to become preceptors will be explored in more detail in a forthcoming IBHC white paper.

[12] GME Board presentation to the IBHC. The table and map come from a 2022 report *The Economic Impact of Graduate Medical Education Expansion in Indiana* prepared for the Indiana GME Board by the consulting firm Tripp Umbach. https://www.in.gov/dA/166e36f8f2/FINAL_Economic-Impact-of-Graduate-Medical-Education-in-Indiana.pdf?language_id=1

authorized for only five years, while residency programs require continuing support and small and rural hospitals face increasing financial pressures.

Recommendations -- A More Ambitious Physician Workforce Strategy

The conclusions from this analysis are clear and compelling: Indiana has a substantial physician shortage, demand is projected to grow faster than supply, GME capacity is exceptionally low, and current funding is inadequate to support even immediate requests for additional residency capacity.

Indiana must move beyond an incremental approach of adding a few million dollars at a time to GME funding and instead treat physician training as essential healthcare infrastructure requiring sustained investment. Urgency is required, as HRSA projects shortages in 42 states by the early 2030s, increasing competition among states to attract both residents and practicing physicians.[13]

The state should adopt a multi-year strategy to substantially expand residency capacity, increase the share of Indiana-trained physicians who remain to practice here, and prepare for a healthcare environment in which physicians are likely to remain in short supply.

More specifically, IBHC offers the following recommendations:

1. Invest in GME at a scale commensurate with Indiana's physician workforce needs.

The Indiana GME board estimates that $36 million over the biennium is needed to support all qualified requests to both sustain strategically important programs that require ongoing assistance and establish new residency programs. As a first step in a multi-biennium strategy to substantially expand Indiana's physician-training capacity, the historic biennial appropriation of $14 million should be increased to narrow the funding gap in the 2027–2029 biennial budget.

Future GME appropriations should be strategically increased to align with the expanding number of learners graduating from Indiana's medical schools, ensuring that residency opportunities keep pace with physician workforce needs and reducing Indiana's continued export of physician talent to other states.

2. Target GME expansion to Indiana's greatest workforce needs.

As Indiana substantially expands GME, new investments should be guided by where additional physicians are most needed. Statewide physician shortages mask significant differences among communities and specialties, and limited GME resources should be

[13] HRSA *Workforce Projections Dashboard* U.S.

targeted where additional training capacity can have the greatest impact. This includes primary care; specialties in which Indiana faces significant or emerging shortages; and rural and underserved communities.

3. Align GME investments with workforce needs and measure results.

Indiana's Graduate Medical Education Board should commission the Bowen Center for Health Workforce Research and Policy or a similarly qualified organization to assess current and projected physician shortages by specialty and geographic area. The assessment should account for demographic trends, physician retirements, and expected graduation and retention rates, and recommend where and in which specialties additional residency positions are most needed. Updated periodically, these findings should guide state investment in new and expanded residency programs.

Indiana should also track whether publicly supported GME programs produce physicians who remain in the state and practice in the communities and specialties where shortages are greatest. These outcomes should inform future funding decisions. Wisconsin, for example, incorporates physician retention in rural and underserved communities into eligibility criteria for some of its GME payments.

4. Make resident retention a deliberate complement to GME expansion.

Indiana should build on its comparatively strong 53 percent residency retention rate by pursuing strategies to keep more new post-graduate physicians. One opportunity is to strengthen the state's physician loan repayment program, which currently is limited to only $40,000 in assistance for four years of service in designated shortage areas. That is substantially less than the potential benefits available to new physicians in neighboring states. [14] Indiana should also recruit more residents with Indiana ties, provide support international medical graduates who want to remain in the state (including working to expand the number of J-1 visas allocated to the state), and target incentives to physicians practicing in underserved communities, including stipends for physicians in rural communities who are likely to earn less than peers in larger hospitals and practices.

5. Evaluate complementary strategies to strengthen access to care.

Even with substantially greater GME investment and improved physician retention, Indiana should remain attentive to national physician workforce trends and competition from other states seeking to attract and retain healthcare professionals. State policymakers, employers, health systems, and clinicians should develop complementary strategies to expand access and make better use of the physician workforce, including team-based care; appropriate use of advanced practice clinicians; AI and other technologies that can increase physician productivity, expand access to care, and reduce administrative burdens; and clinical advances that reduce the need for physician-intensive care.

[14] *Indiana's Physician Pipeline to Practice in Context*, Bowen Center

Conclusion

Indiana cannot eliminate its physician shortage quickly, and even an ambitious expansion of GME will take years to produce results. But the state must take meaningful steps now to increase its future physician supply.

The state has shown that targeted public investment can encourage hospitals and health systems to create new residency programs and positions, and demand for additional GME support shows that opportunities exist for further expansion. The challenge now is to match those opportunities with a level of sustained investment matching with the state's physician workforce needs.

That investment must be accompanied by an equally deliberate effort to retain more of the physicians Indiana trains. And because physician shortages are projected across much of the country, Indiana must also prepare for the possibility that physicians will remain a scarce resource even if the state succeeds in expanding GME and improving retention.

A comprehensive workforce strategy must therefore address not only how Indiana trains and keeps more physicians, but also how to meet the healthcare needs of a growing and aging population when physician supply remains constrained.

Indiana has begun building the infrastructure needed to strengthen its physician workforce. The task now is to build on that progress at a scale and with an urgency commensurate with the magnitude of the challenge.

About the Indiana Business Health Collaborative

The Indiana Business Health Collaborative (IBHC) is an innovative statewide partnership between Hoosier employers and health care industry stakeholders who are committed to working together to lower the cost of care in Indiana without jeopardizing quality or access to the critical services that Hoosiers rely on. Through the IBHC, members help accelerate market solutions that will reduce costs, maintain a healthy workforce, and strengthen Indiana's economic competitiveness.

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