

Health workforce survey data

Physician assistant (PA) report

June 29, 2026

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Executive summary

The 2024 PA survey substantially increased the number of respondents and the response rate compared to the 2022 survey. While rural areas have fewer PAs than more urban areas, when controlling for resident populations, the rates of PAs rates in many rural areas are more similar or comparable to those in urban areas. Most responding PAs work full time and plan to continue doing so.

Key findings

- The 2024 survey more than doubled the number of respondents compared to the 2022 survey.
- The number of physician assistants with reported wages from unemployment insurance data has increased every year since 2018.
- Staffing levels appear to be stable, with new hires out numbering turnover from 2018 through 2023 with many hired during the pandemic being retained.
- While the vast majority of respondents plan to continue working the same hours they work now over the next two years, about 5% indicated they plan to reduce their hours or retire.
- Surgical was the most commonly reported primary specialty with primary care and family medicine being the third and fourth respectively.
- Office clinics including single and multiple specialty groups were the most common primary practice settings.
- While rural counties typically have fewer PA providers compared to more metro or urban areas, when controlling for county population, the rates of providers for many rural counties are generally far more comparable to more populated counties.
- The majority of respondents indicated they earned their qualifying degree outside of Utah.
- Most respondents indicated they precept as in mentoring, teaching, or instructing a student or new staff member.



Introduction

The Utah Health Workforce Information Center (HWIC, <https://hwic.utah.gov/>) was established in 2022 through HB176 (<https://le.utah.gov/~2022/bills/static/HB0176.html>) and is a key entity in efforts to collect and analyze healthcare workforce data in Utah. This legislation also created the Governor’s Health Workforce Advisory Council (HWAC), which provides strategic guidance and oversight on policies and initiatives to strengthen the state’s healthcare workforce across all sectors. The Department of Professional Licensing (DOPL), responsible for the licensing of healthcare professionals in Utah, is now required to integrate workforce survey questions into the licensing process. These surveys, previously developed and administered by the Utah Medical Education Council (UMEC), help inform decisions regarding workforce trends and needs. By incorporating these surveys and capturing this data, the HWAC will now have data to inform health workforce initiatives and recommendations for Utah.

Background

A physician assistant/associate (PA) is a licensed clinician practicing medicine. The American Academy of Physician Associates says PA programs typically take 3 academic years and require clinical rotations, certification exams, and other requirements (AAPA, 2024). PAs are not limited by specialty or setting but are trained to “emphasize patient education, preventive care, and chronic care management” and their training “enables them to provide a wide spectrum of patient care” (AAPA, 2024, para. 6).

According to the AAPA, PAs commonly “take medical histories, conduct physical exams, diagnose and treat illness, order and interpret tests, develop treatment plans, prescribe medication, counsel on preventive care, perform procedures, assist in surgery, make rounds in hospitals and nursing homes, and do clinical research” (AAPA, 2024, para. 15). While these duties are similar to nurse practitioners (NPs), there are some significant differences. PAs are educated in general medicine and trained to practice medicine whereas NPs are population-focused such as pediatric or women’s health nurse practitioners, and are trained in the advanced practice of nursing (AAPA, 2024, para. 25-26).

Utah PA workforce in context

Table 1 compares key characteristics of Utah’s PA workforce to national averages. It highlights differences in wages, employment density, education levels, age, and gender distribution. Understanding these comparisons helps identify areas in which Utah’s PA workforce aligns with or differs from broader trends.



Table 1. Comparison of Utah PA Workforce to National Averages

Measure	National average	Utah average
Average PA wage	\$133,260	\$119,856
PAs per 1,000 jobs	0.5	1
Associate's degree holders	1%	1%
Bachelor's degree holder	12%	10%
Master's degree holders	84%	82%
Average PA age	39	43
Gener distribution (female)	72%	51%

Bureau of Labor Statistics, 2024; Zippia, 2025; Data USA, 2023; National Commission on Certification of Physician Assistants, 2024; Department of Workforce Services, 2025

Comparing the average Utah PA wage to the national average results in a difference of about \$13,404 per year meaning Utah PAs on average earn about 10% less.

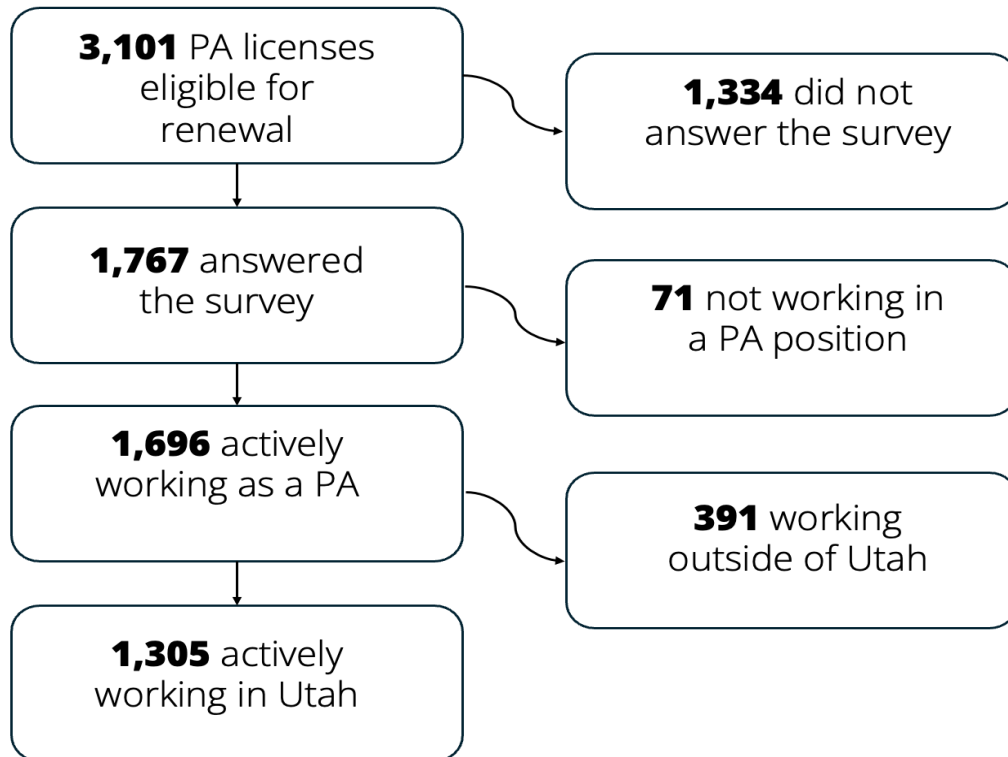
While education, age, and gender are derived from survey results that are not generalizable to the entire Utah PA population, PA workforce survey respondents are slightly older than and do not have the same educational background as the national average.



Methods

DOPL survey

Figure 1. DOPL survey population and respondents



DOPL, Utah, 2024

All practitioners who were eligible for online renewal were offered the survey during their license renewal process, and participation in the survey was voluntary. This type of sampling design is often referred to as convenience samples or non-probability samples. Providers who chose to respond to the survey may not be representative of the entire workforce. Therefore, the statistical analysis included in this report only represents individuals who participated in the survey and does not attempt to make inferences about the entire population. Comprehensive unit and item non-response rates are also provided to guide interpretation of the results (see Appendix A). Additional limitations that provide important context for subsequent report information will be included on an as-needed basis.

DOPL data preparation and analysis

Once the renewal period closes, DOPL sends a secure CSV file with all the responses to HWIC. Quality checks are performed, including how to evaluate duplicate respondent records, questions



with multiple responses, and null-type values. Only data from respondents who replied to a question and provided a valid license number are included in the analysis. Including responses from those with invalid license numbers can introduce bias since the missing data might represent a distinct group that could potentially skew results.

PAs whose license had expired in the previous two years were eligible for online renewal and were invited to participate in the survey. DOPL reported there were 3,101 PAs eligible for renewal, and 1,767 of them provided a valid DOPL license number and responded to at least one survey question.

Other data sources

While the focus of this analysis is on the PA DOPL survey, supplemental data are also used to help contextualize the survey results and provide deeper insights into the PA workforce in Utah. Other data sources that are included in this report include: Unemployment Insurance (UI), National Plan and Provider Enumeration System (NPES), and education data.

UI data includes those with reported wages and shows that there were 2,028 providers in 2023. UI analysis is based on data captured through the Utah Department of Workforce Services' Unemployment Insurance program. Employers pay unemployment taxes based on the wages earned by their employees. A data-sharing agreement is in place that allows the HWIC to request data for individuals found in healthcare workforce professional licenses.

UI data has limitations. Notably, the data contains an industry code and employer name but does not specify geographic area, job title, or scope of work performed by the individual. The data indicates that a provider was employed in a healthcare-related industry as indicated by a code starting with 62 in the North American Industry Classification System (NAICS). In addition, self-employed healthcare workers, such as those in private practice, do not report their wages since they do not pay into the Utah unemployment insurance program.

The NPES serves as the national system designed to assign unique identifiers to health care providers and health plans who apply for the National Provider Identifier (NPI). NPIs are being used across the healthcare industry and government health care programs.

Graduation counts and the number of programs come from the Integrated Postsecondary Education Data System (IPEDS) Graduates data, Urban Institute Education Data Portal (UIEDP) API directory: <https://educationdata.urban.org/documentation/colleges.html#ipeds-awards-by6-digit-cip-code>.

Additional API information is available at: <https://urbaninstitute.github.io/education-datapackage-r/>

Job postings are obtained from Conference Board–Lightcast Help Wanted OnLine data, provided by the Department of Workforce Services (DWS). DWS provides monthly counts of jobs by Standard Occupational Classification (SOC) codes associated with PAs.



Note that all 2020 data should be interpreted with an understanding that the COVID-19 pandemic caused significant disruptions in healthcare staffing, hiring patterns, and workforce demand, which may not reflect typical trends.



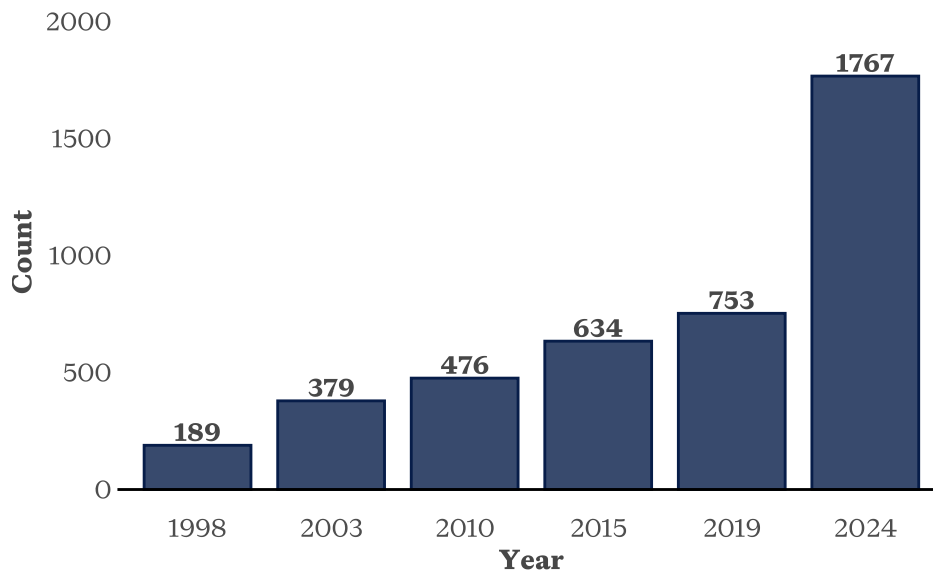
Results

Licensed and active workforce

PA providers who renewed their license during 2023 and those whose license expired in the previous two years were eligible for online renewal and were supposed to be invited to participate in the survey. Based on the population files supplied by DOPL, approximately 57% responded to at least one survey question and provided a valid license number that matched PA licenses from DOPL's database.

The 2024 survey results look to have increased the number of respondents compared to past surveys. This survey showed the most respondents of all PA surveys reported on by HWIC.

Figure 2. PA survey responses
Increase in the number of respondents

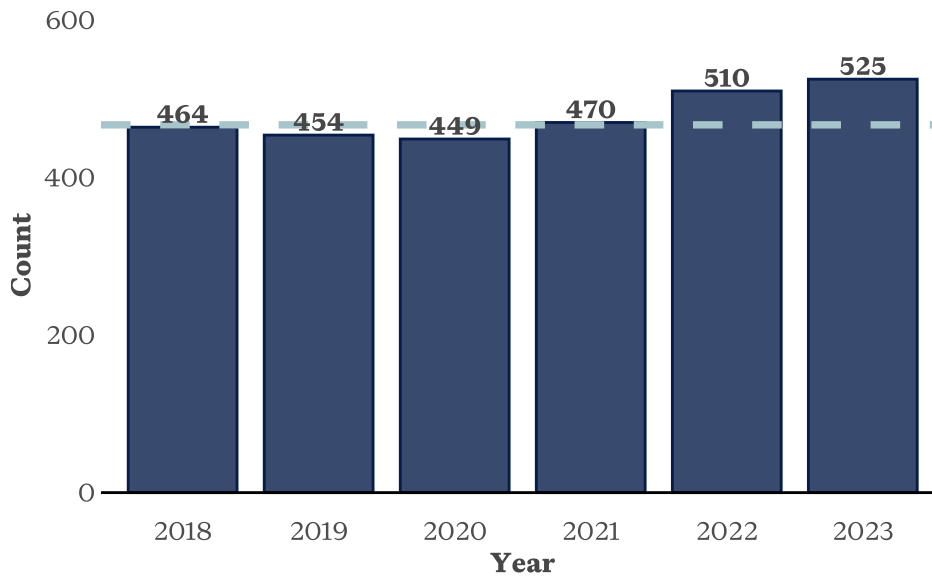


PA workforce survey, Utah, 2024

Figure 2 shows the number of respondents for the PA workforce surveys. The 2024 survey more than doubled the number of responses of the 2022 survey while generally maintaining relatively high item response rates that are detailed in the response rates section of the report's methodology.



Figure 3. PA employers
Increase in employed PAs over time



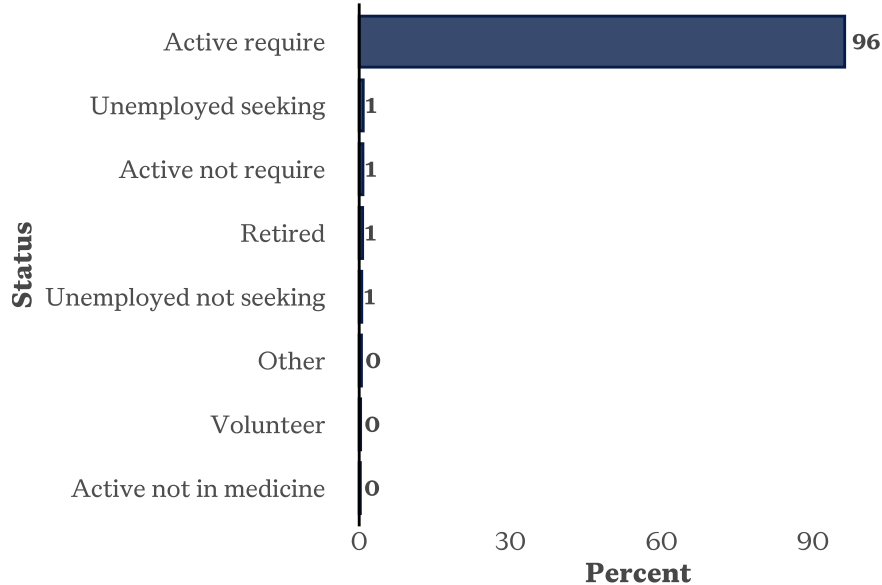
Unemployment insurance data, DWS, 2024

Figure 3 shows the count of PAs in UI data working in healthcare with reported wages. UI data shows that there were 2,229 distinct providers during 2018-2023. The number of PAs has increased every year since 2018 with a count of in 2023.



Figure 4. Employment status

Most are active in a position that requires licensure



PA workforce survey, Utah, 2024

Figure 4 shows the proportion of respondents' reported employment status. Response options were modified for the presentation of the chart. What is displayed as "active require" appeared on the survey as "actively working in a position that requires this license". "Active not require" appeared on the survey as "actively working in a position in the field of nursing that does not require this license". "Unemployed seeking" appeared on the survey as "unemployed and seeking work that requires this license". "Volunteer" appeared on the survey as "volunteer work only". "Unemployed not seeking" appeared on the survey as "unemployed and not seeking work that requires this license". "Active not in medicine" appeared on the survey as "actively working in a position in a field other than medicine". Of those who responded to the question, 96% report actively working in a position that requires their license.

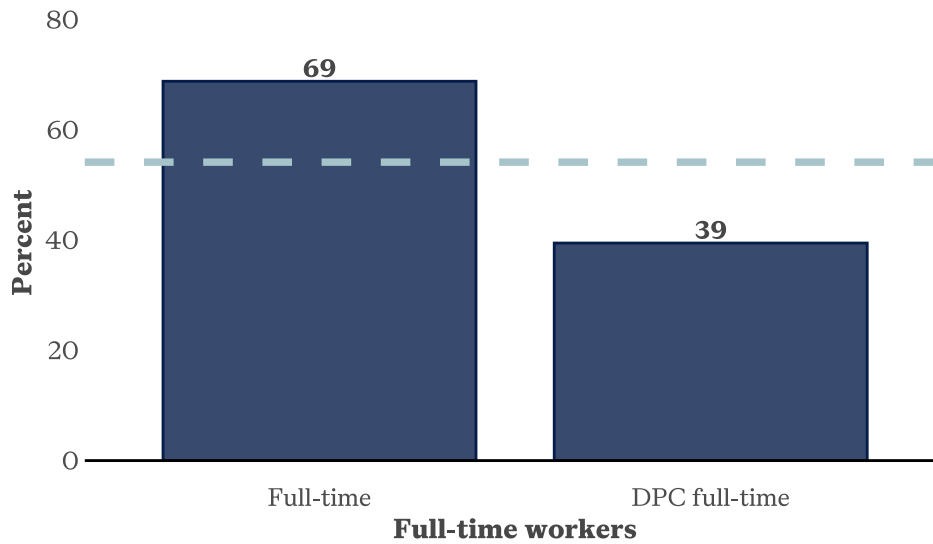
Full-time, direct patient care, and full-time equivalence (FTE)

To better estimate the supply of PAs in the workforce, full-time workers, direct patient care (DPC), and full-time equivalence (FTE) estimates are illustrated below.



Figure 5. Full-time workers and direct patient care

Most work full-time



PA workforce survey, Utah, 2024

Figure 5 shows the percentage of respondents' full-time status. Most respondents indicate they work 37 hours or more per week. To estimate the proportion of respondents working full-time, the median of the response range of primary and secondary practice locations was summed and divided by the total number of respondents who reported working at least one hour in Utah.

Table 2. FTE count by county

County	FTE Count	FTE per 100k
Beaver	0	0
Box Elder	8	13
Cache	38	27
Carbon	2	10
Daggett	0	0
Davis	97	26
Duchesne	10	50
Emery	4	40



County	FTE Count	FTE per 100k
Garfield	0	0
Grand	9	91
Iron	19	29
Juab	0	0
Kane	0	0
Millard	1	7
Morgan	3	23
Piute	0	0
Rich	2	73
Salt Lake	557	46
San Juan	8	53
Sanpete	11	36
Sevier	8	36
Summit	17	39
Tooele	21	26
Uintah	4	11
Utah	194	27
Wasatch	9	24
Washington	75	38
Wayne	1	40
Weber	83	31
Total	1,181	796

PA workforce survey, Utah, 2024; Kem C. Gardner Policy Institute, Utah, 2024

Table 2 estimates the count of FTE respondents by county. The count includes both primary and secondary practice locations. FTE was determined by converting responses into numeric values



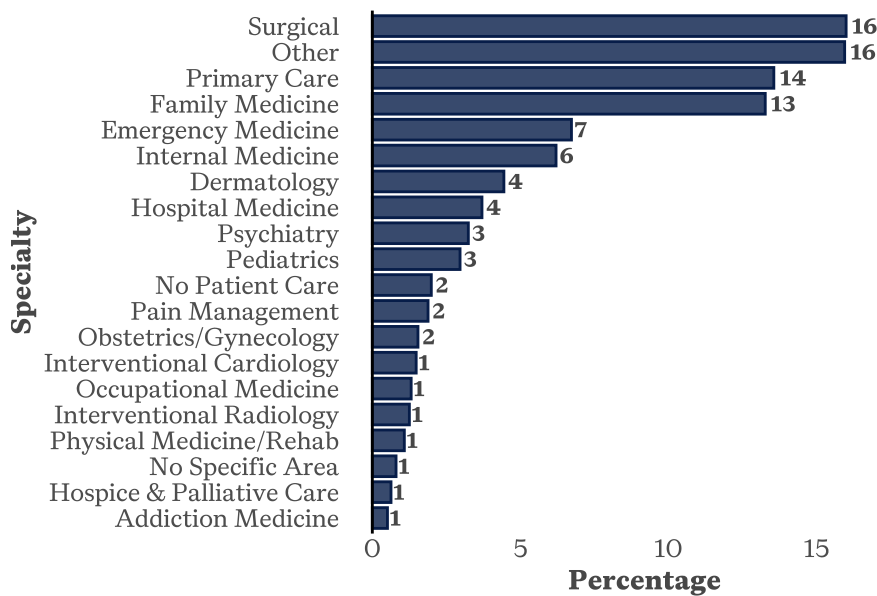
based on the midway point of the response option. Primary and secondary locations were then combined and grouped by county. Hours worked were then summed by each county and divided by 38.5, which is the midway point for the lowest full-time response option.

Specialty

Specialties of providers are analyzed below. While there are many different types of specialties, for this report due to space limitations, only the most common specialties are included in the charts below.

Figure 6. Top primary specialties

Surgical is the most common specialty

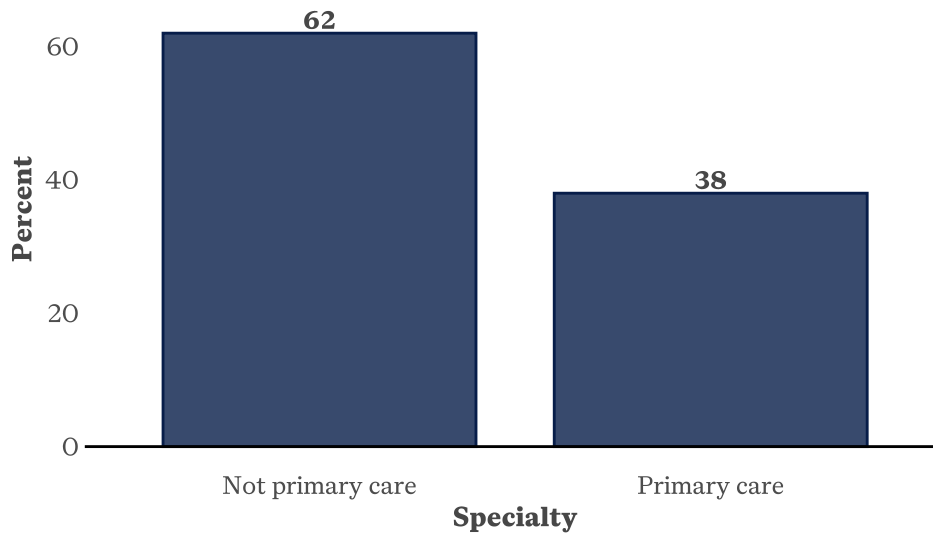


PA workforce survey, Utah, 2024

Figure 6 shows the most common primary specialty. Approximately 16% of providers who responded to the specialty question indicate their primary specialty is Surgical.



Figure 7. Primary care specialties
Most have specialties outside primary care

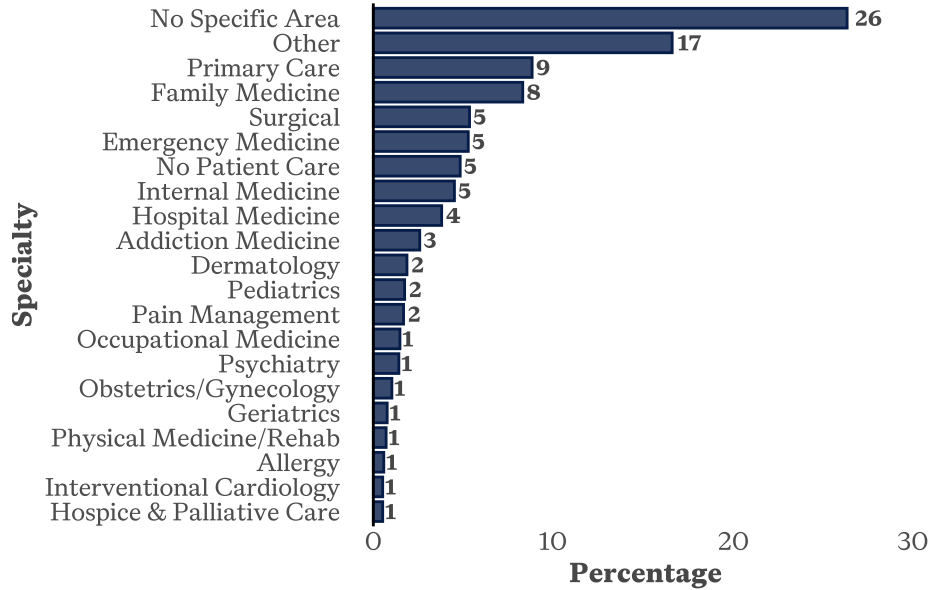


PA workforce survey, Utah, 2024

Most respondents do not have a primary specialty in primary care equivalent specialties (primary care, family medicine, internal medicine, pediatrics, obstetrics/gynecology).

Figure 8. Top secondary specialties

Most do not have a secondary specialty



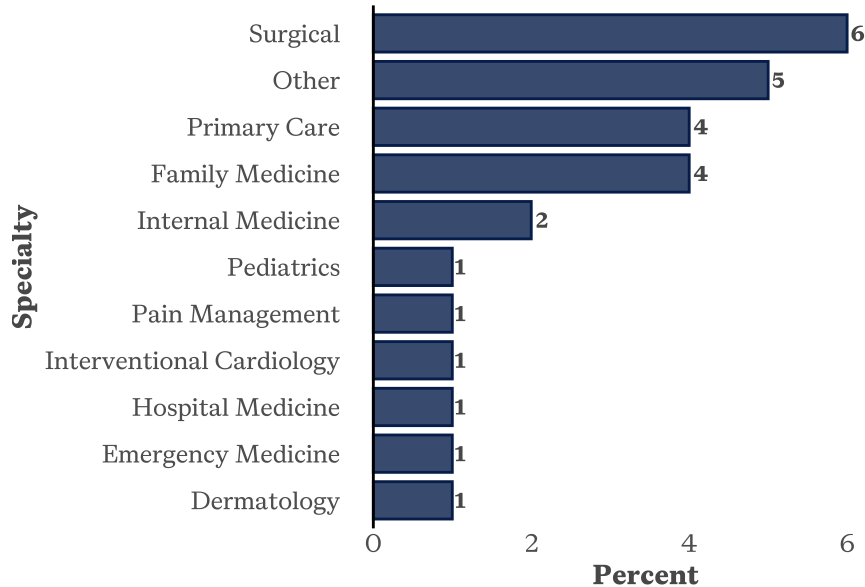
PA workforce survey, Utah, 2024

Figure 8 shows the most common secondary specialty. About 26% of providers who responded to the specialty question indicate they have no specific area for a secondary specialty.



Figure 9. Full-time specialties

Surgical is the most common full-time specialty



PA workforce survey, Utah, 2024

Figure 9 shows the most common full-time status specialties. Surgical is by far the specialty with the greatest proportion of full-time respondents followed by other specialties, family medicine, and primary care.

Practice characteristics

This section includes practitioner survey response information on practices where they provide services, such as the setting type

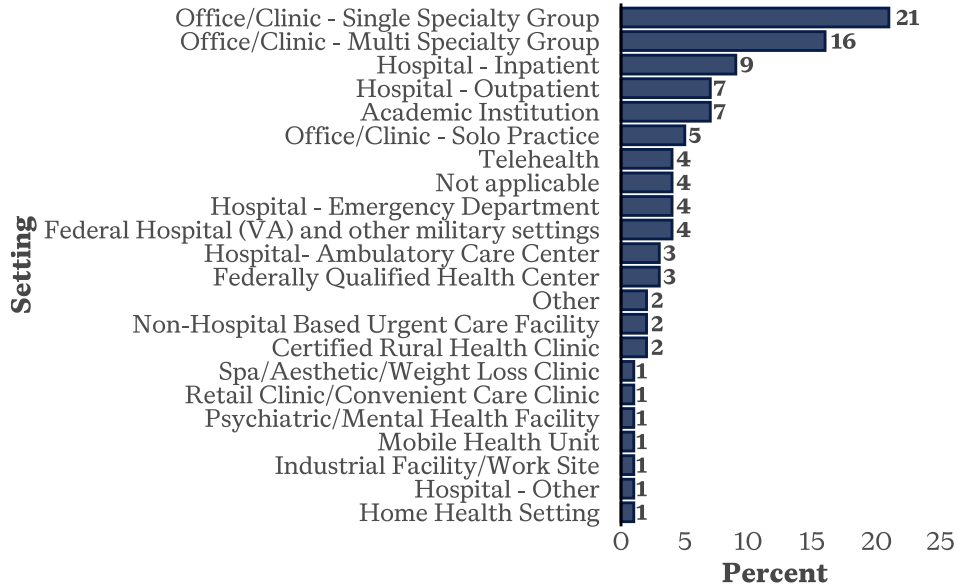
Setting

Settings of providers' practice are analyzed below. While there are many different types of settings, due to space limitations in this report, only the most common specialties are included in the charts below.



Figure 10. Primary practice setting

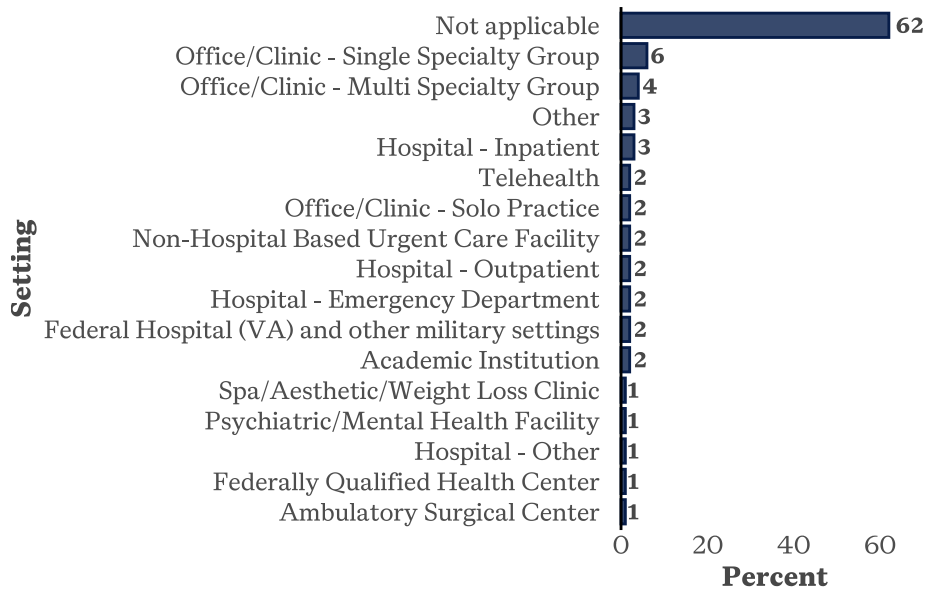
Office/clinic is the most common setting



PA workforce survey, Utah, 2024

Figure 11. Secondary practice setting

Most do not have a secondary setting



PA workforce survey, Utah, 2024



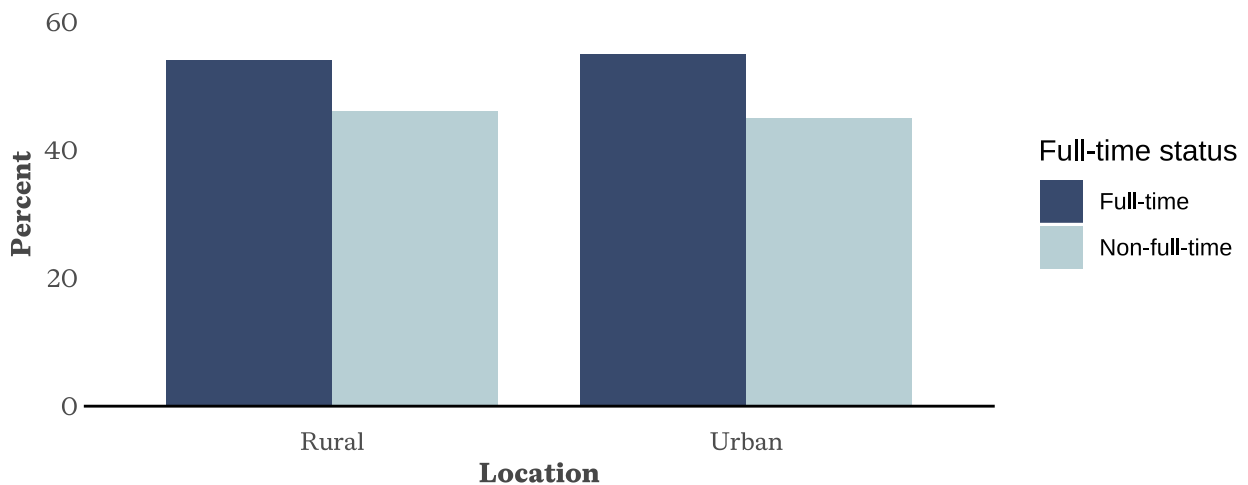
Figure 10 shows the primary setting and Figure 11 shows the secondary setting. Whereas 98% of participants responded to the question regarding their primary practice setting, only 55% responded to the question regarding their secondary practice setting.

Urban versus rural comparisons

Rural care is always a focus to ensure residents in non-urban counties are receiving adequate care as well. Two measures described below were used to compare respondents practicing in urban counties versus those practicing in rural counties, the first being full-time status and the second being two-year employment plans.

Figure 12. PA respondents by full-time status, Urban vs. Rural

Urban and rural counties have similar full-time PA respondent proportions



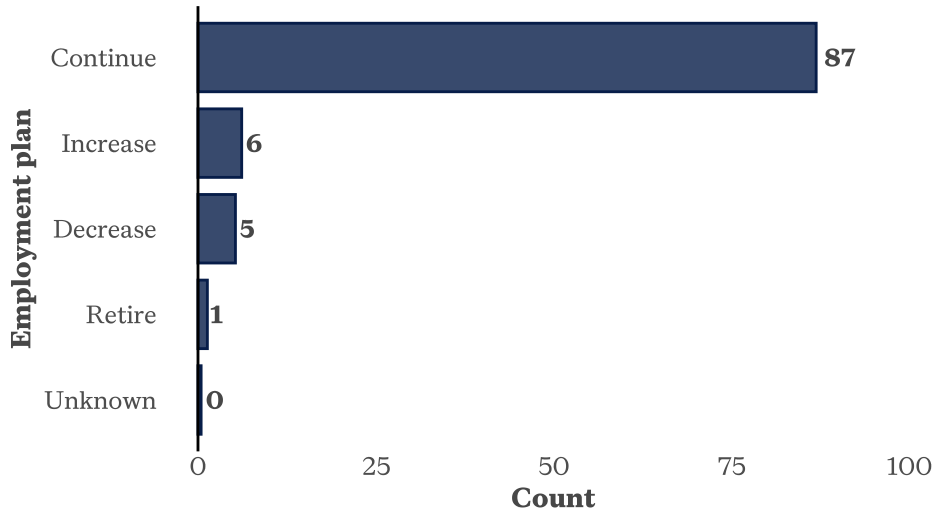
Physician assistant workforce survey, Utah, 2024

Urban and rural areas have similar full-time PAs proportions with urban having 55% of responding PAs whereas rural has 54%.



Figure 13. PA respondents by employment plan, rural counties

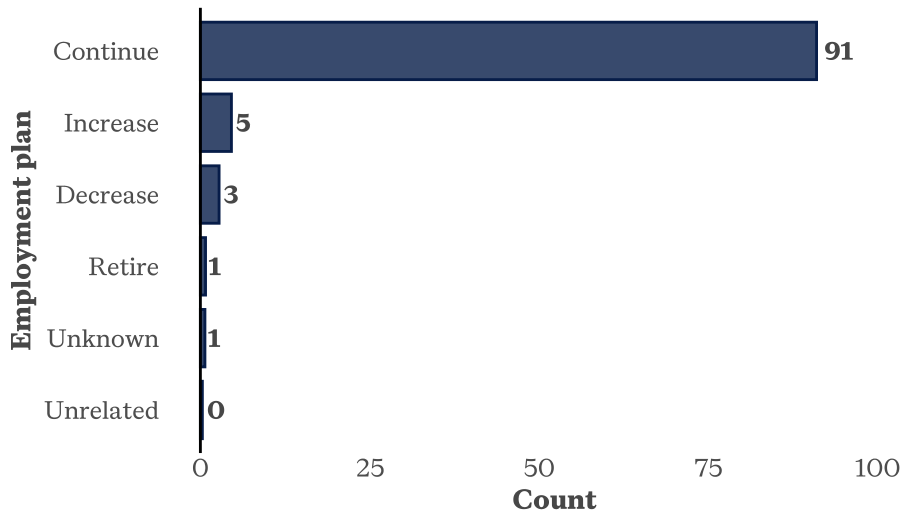
The majority of PA respondents in rural counties plan to continue working as they are



PA workforce survey, Utah, 2024

Figure 14. PA respondents by employment plan, urban counties

The majority of PA respondents in urban counties plan to continue working as they are



PA workforce survey, Utah, 2024

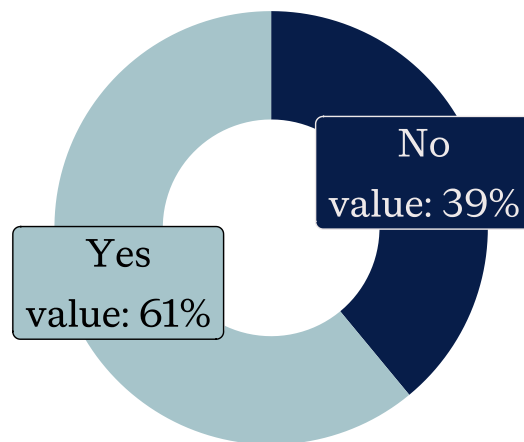


Two-year employment plans appear to be similar as well, with 87% of rural practicing respondents indicating plans to continue as they are compared to 91% of urban practicing respondents indicating they plan to continue as they are.

Telehealth services

The prevalence of telehealth used by PA providers is depicted below, along with a breakdown of hours used.

Figure 15. % providing telehealth services
Most provide telehealth services

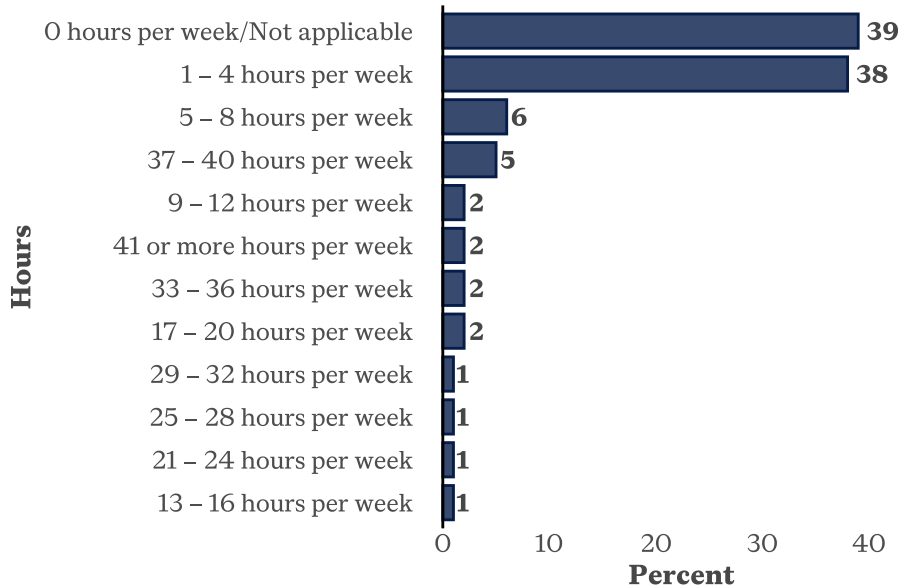


PA workforce survey, Utah, 2024



Figure 16. Telehealth hours

Telehealth hours are common



PA workforce survey, Utah, 2024

Figure 15 shows the hours of telehealth respondents provide while Figure 16 shows the proportion of respondents who provide telehealth services compared to those who do not. The ratio for responding physician assistant providers’ total working hours versus hours spent providing telehealth services was found to be **32:6**. This means that the average physician assistant respondent works an average of around 32 hours a week and provides an average of 6 hours of telehealth a week. Note that these are averages because the responses are in range format (e.g., 21-24 hours worked per week).

Demographics

The following section includes practitioner survey response information on demographic information such as age, race/ethnicity, and sex/gender.

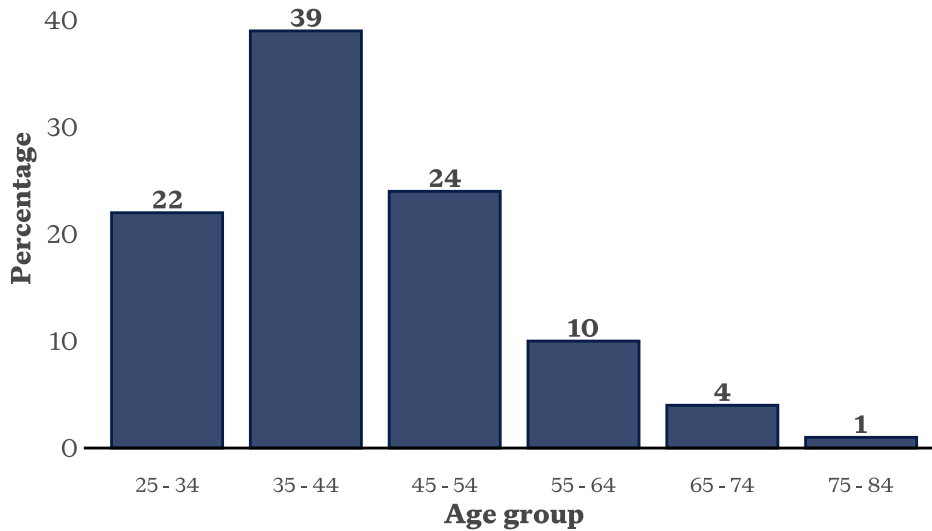
Age

The age of the provider workforce is important to consider in anticipating supply levels as older providers are more likely to retire or decrease working hours.



Figure 17. Age of respondents

Most respondents are between 35 and 44 years old



DOPL, Utah, 2024

Figure 17 shows the proportion of respondents within various age groups. Age data comes from DOPL and not from the survey. Age is calculated from the difference between the survey date and the birth date. Approximately 39% of respondents are between 35 and 44 years old while about 5% are 65 years or older.

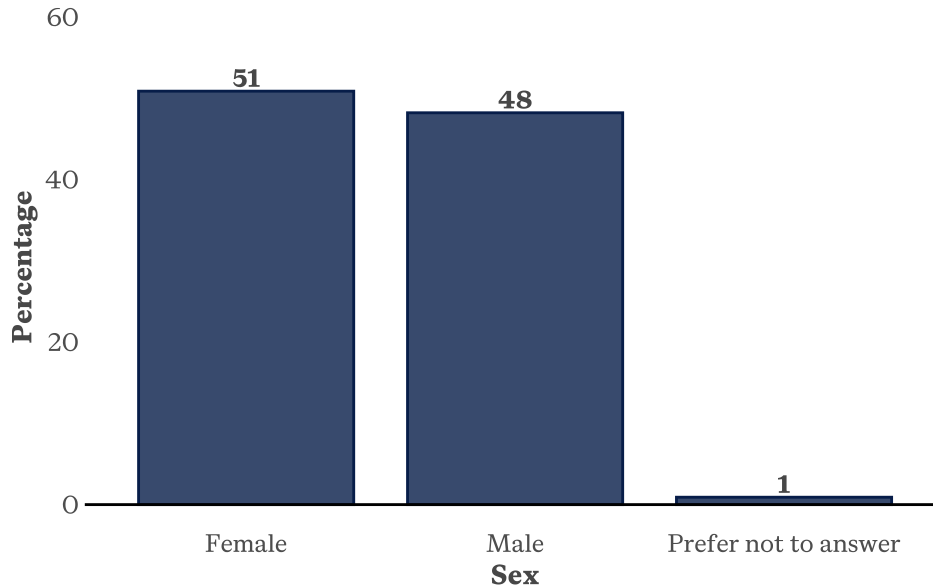
Sex and gender

Sex is an important characteristic to consider due to patient-provider relations because it can impact patient experiences. Sex and gender interact in a variety of ways that can affect patient health outcomes (WHO, 2021).



Figure 18. Sex of respondents

Most PAs are female



PA workforce survey, Utah, 2024

Figure 18 shows the percentage of respondents' sex. Approximately 51% of respondents identify as female, 48% identify as male, and 1% preferred not to answer.

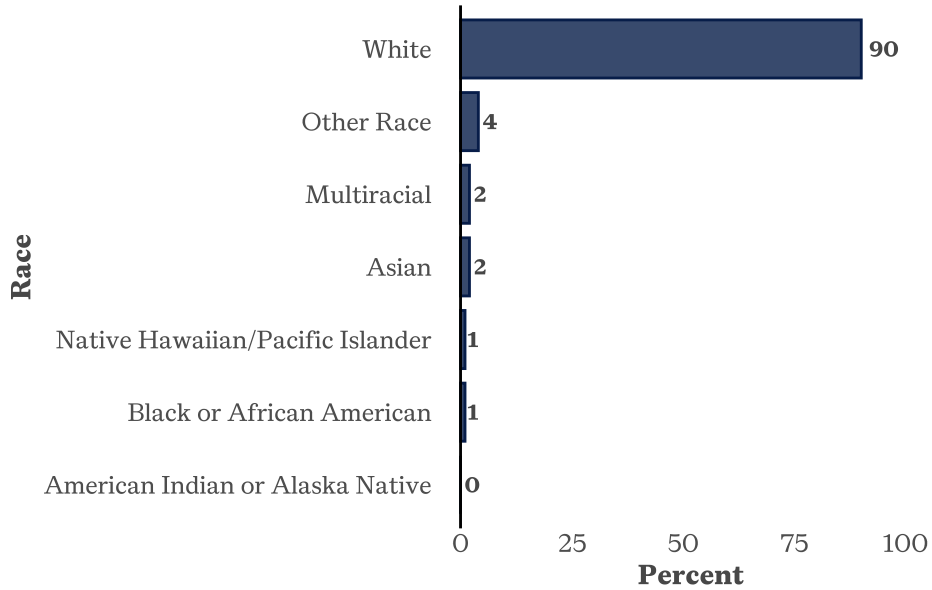
Race and ethnicity

Similar to issues of sex and gender, race and ethnicity are important to consider when analyzing provider workforce demographics (Togioka, et al., 2024).



Figure 19. Race of PA respondents

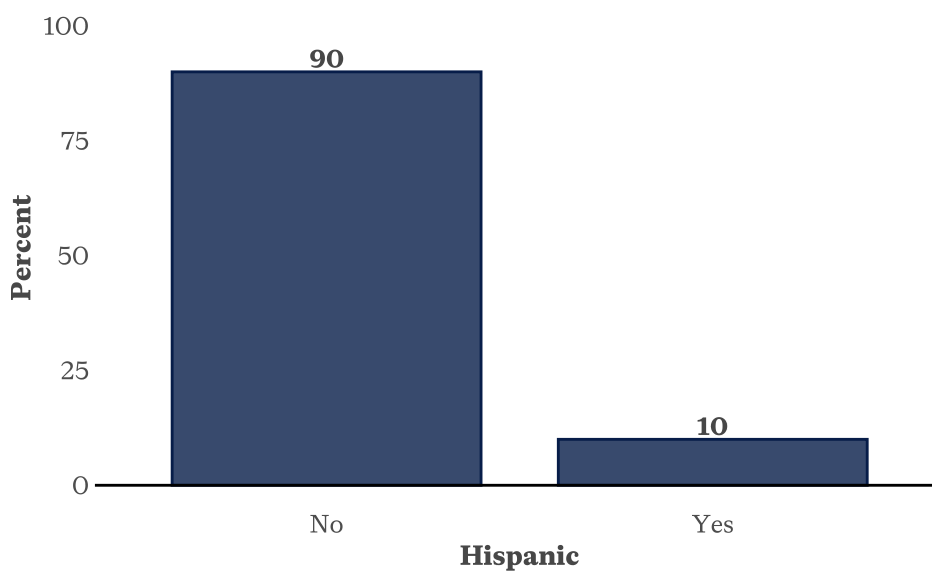
90% of respondents are white



PA workforce survey, Utah, 2024

Figure 20. Ethnicity of respondents

90% of respondents are not Hispanic



PA workforce survey, Utah, 2024



Figure 19 shows respondents' race. Multiracial did not appear as a response option but was created for this report by counting respondents who selected multiple racial options. Approximately 90% of respondents are white. Figure 20 shows the ethnicity of respondents. Approximately 90% of respondents are not Hispanic.

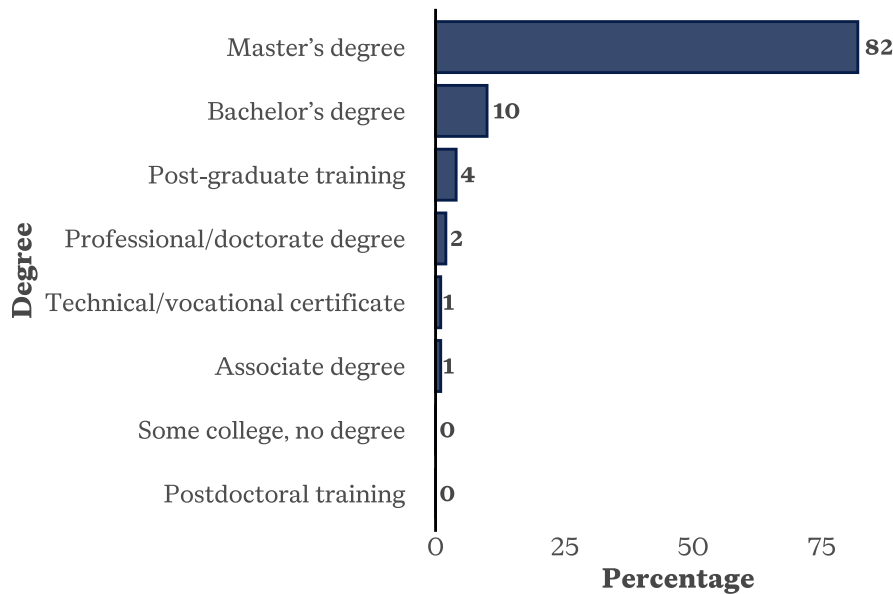
Education

This section includes a review of education, including qualifying education and the highest level of education.

Qualifying education

Aspects of providers' qualifying education, such as degree type and degree location are reviewed below.

Figure 21. Qualifying degree of respondents
Master's degree is the most common

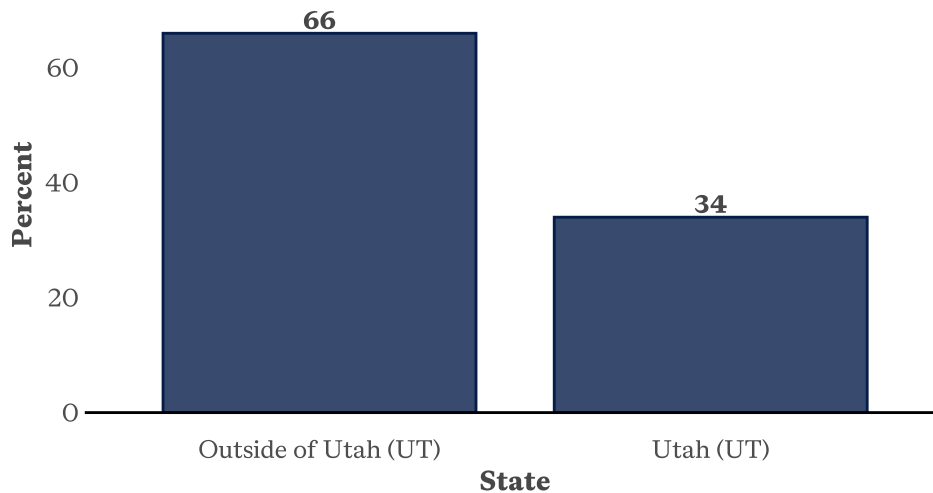


PA workforce survey, Utah, 2024



Figure 22. Qualifying degree inside/outside of Utah

Most earned their degree outside of Utah



PA workforce survey, Utah, 2024

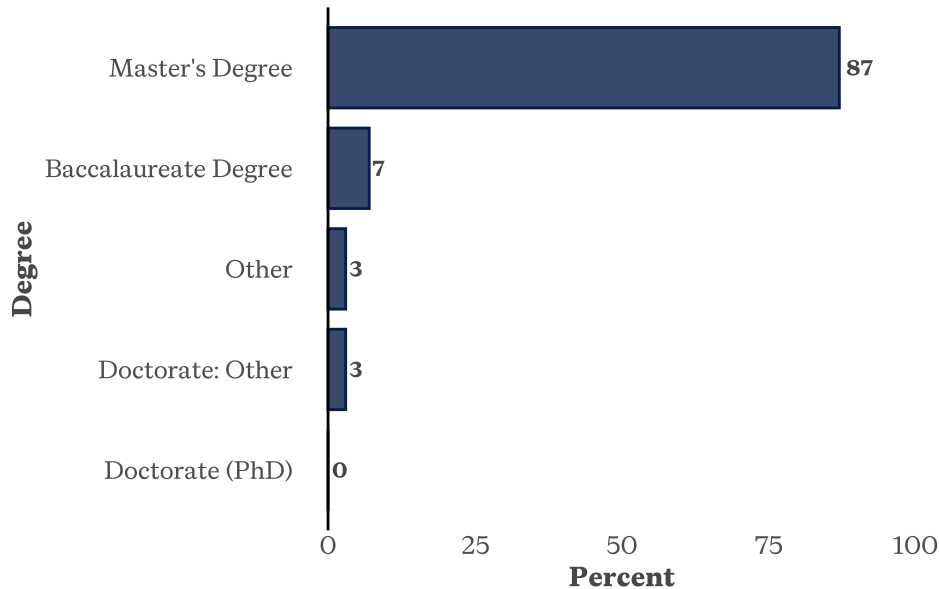
Figure 21 illustrates the percentage of respondents with various types of qualifying education. Figure 22 shows the proportion of respondents who earned their qualifying degree in Utah compared to outside of Utah.

Highest education

Providers' highest level of education is reviewed below.



Figure 23. Highest degree
Master's is the most common



PA workforce survey, Utah, 2024

Figure 23 shows the proportions of responding PAs' highest level of education. Master's degree is by far the most common highest degree for respondents, with approximately 87% with a Baccalaureate degree second with about 7%.

Education debt

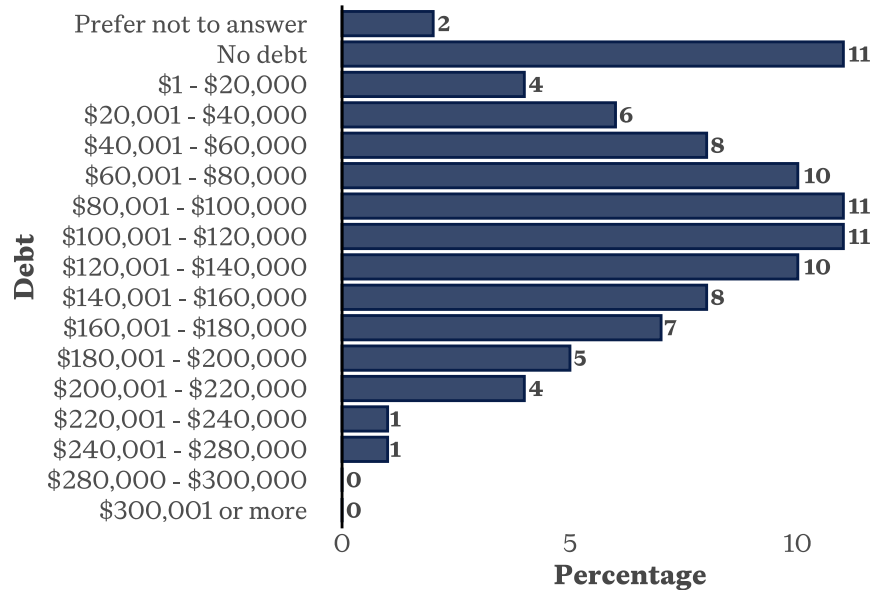
This section includes practitioner survey response information on educational debt.

Responding providers' educational debt is depicted below. It is important to note that responses were regarding total educational debt at the time of graduation as opposed to their current educational debt.



Figure 24. Educational debt

Most respondents are debt free



PA workforce survey, Utah, 2024

Figure 24 shows the proportion of respondents' educational debt. Approximately 11% or respondents indicate they have no educational debt while about 22% of respondents have \$80,000-\$120,000 in educational debt.

Employment characteristics

This section includes practitioner survey response information on their employment, such as specialty, role, telehealth hours, precepting status, and patient types.

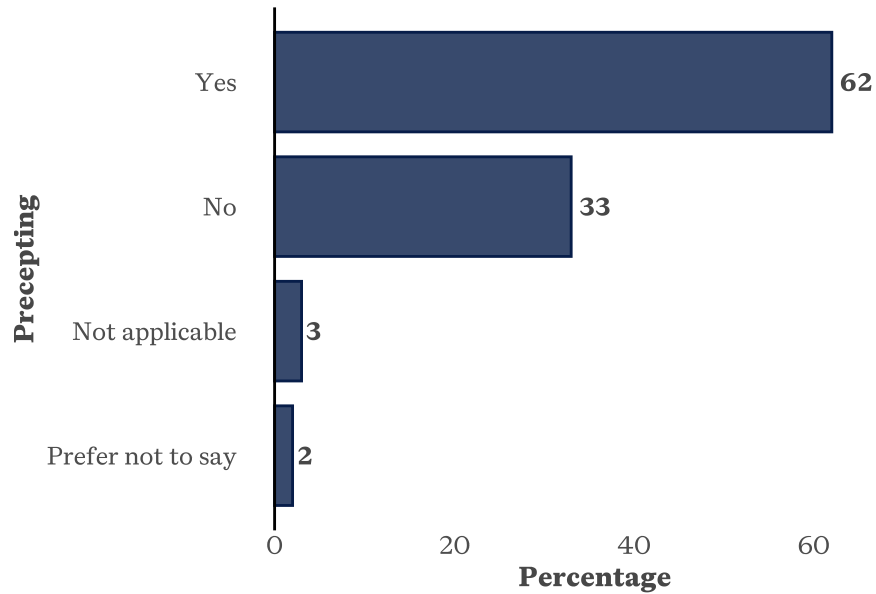
Precepting

The proportion of responding providers who precept is depicted below.



Figure 25. % precepting

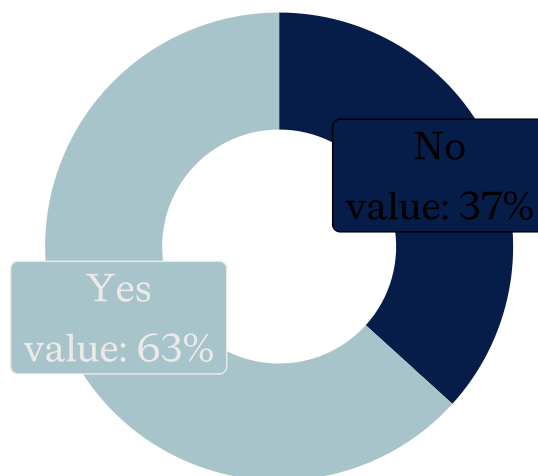
About a third of respondents do not precept



PA workforce survey, Utah, 2024

Figure 26. % precepting

Most respondents precept



PA workforce survey, Utah, 2024

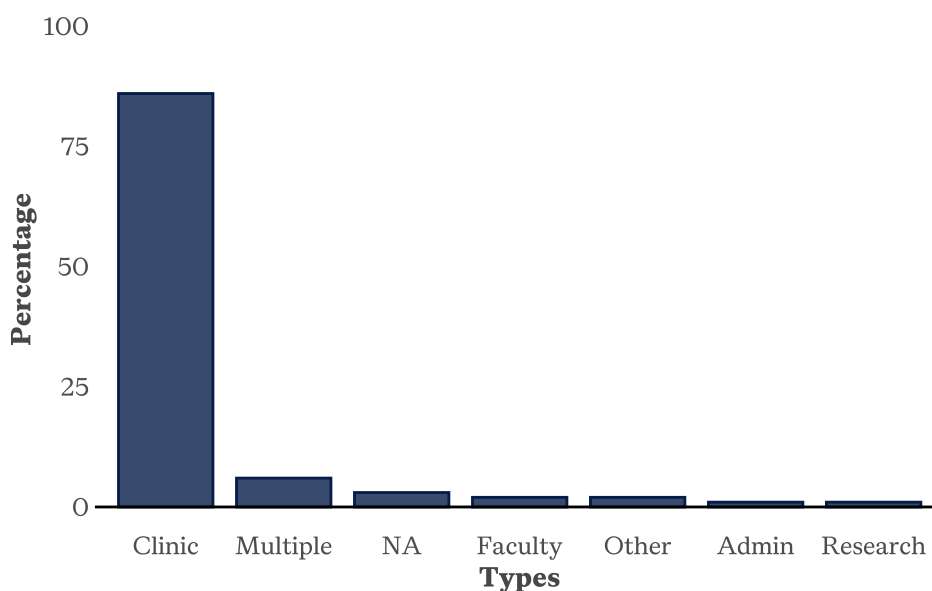


Figure 25 shows the proportion of respondents who precept. PA providers who mentor, teach, or instruct a student or new staff member are considered to precept. Figure 26 is a donut chart that shows the percentage of responding PA providers who precept excluding those who responded with prefer not to say, and grouping those who selected not applicable with those who selected no.

Role and employment type

Responding providers' role and employment type are depicted below.

Figure 27. Primary role types
Clinical is the most common role

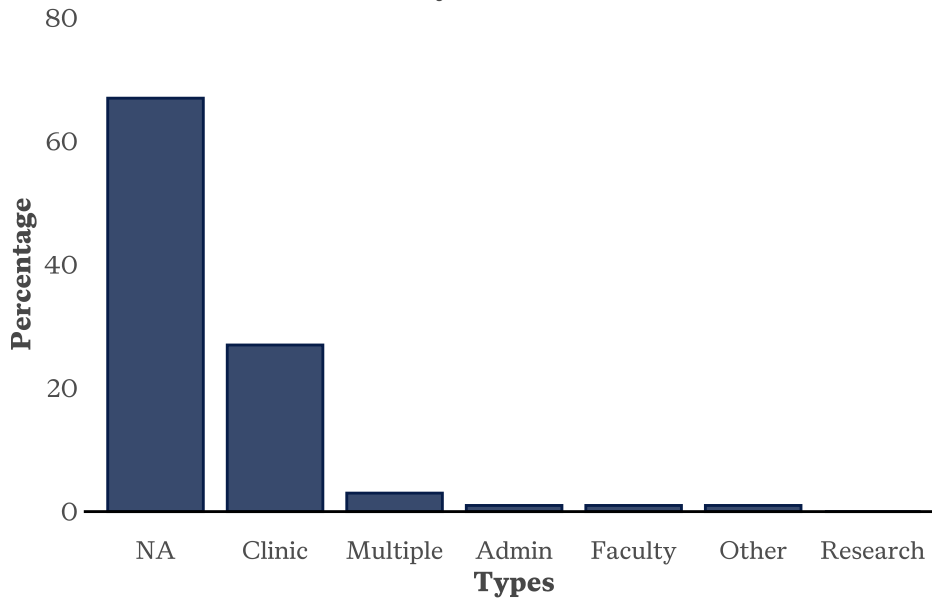


PA workforce survey, Utah, 2024



Figure 28. Secondary role types

Most do not have a secondary role



PA workforce survey, Utah, 2024

Figures 27 and 28 depict the respondents' role. Multiple did not appear as a response option on the survey but was constructed for this report by counting respondents who selected multiple response options.

Income

Income data including employment and wages, comes from matching PA providers from DOPL data to unemployment insurance (UI) data from DWS.



Table 3. Income data including PA and employer counts with average wage

Year	PA count	Employer count	Total wages	Average wage
2018	1,460	464	\$ 138,069,593	\$ 94,568
2019	1,495	454	\$ 150,865,615	\$ 100,913
2020	1,548	449	\$ 165,351,327	\$ 106,816
2021	1,709	470	\$ 184,858,264	\$ 108,168
2022	1,879	510	\$ 217,853,454	\$ 115,941
2023	2,028	525	\$ 243,068,745	\$ 119,856

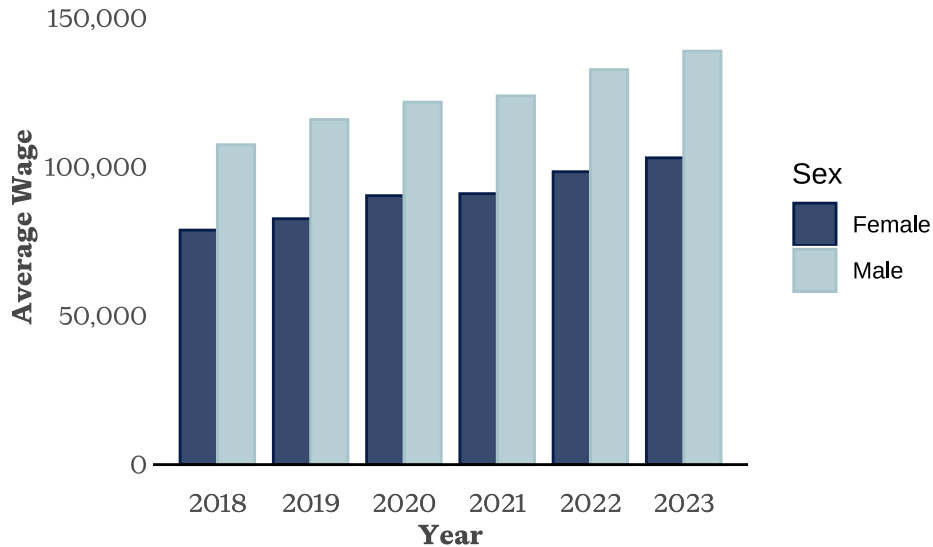
Unemployment insurance data, 2024

The PA count is of distinct physician assistant providers while employer count is of distinct employers of physician assistant providers. Total wages are the sum of physician assistant provider wages, while average wage is the mean physician assistant provider wage. The average physician assistant wage from UI data increased approximately 27% from 2018 to 2023. To avoid counting those who are not actively practicing as a PA, only those with a NAICS code related to healthcare were included.

There is a long history of a national sex/gender pay gap (Majumder et al., 2025; Fry et al., 2025; Coillberg, 2025; Criado-Perez, 2019), and that gap is wider in Utah (Kervin, 2022; Alberty, 2023; Majumder et al., 2025). While the causes for lower female pay can be multifaceted, females commonly “provide essential care to family members, including children and adults who need help” and consequently “often face significant financial consequences when they reduce their employment to provide unpaid family care” (Johnson et al., 2023, para. 1 & 5). It is estimated that the costs related to females “providing unpaid care averages [sic] \$295,000 over a lifetime, based on the 2021 U.S. dollar value, adjusted for inflation” (Johnson et al., 2023, para. 6).



Figure 29. Average wage by sex
Female average wage is 78% of average male wage

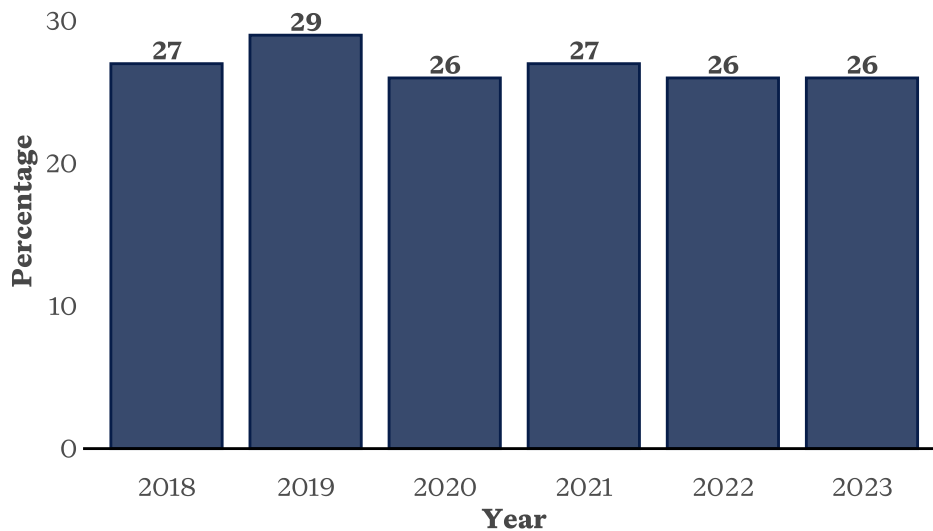


Unemployment insurance data, DWS, 2024

Possible family care in tandem with injuries may explain a fraction of the wage penalties females encounter in the workplace but there are many others. While DWS reports that in 2022, female healthcare workers generally made 51% of male wages (Department of Workforce Services, 2022), the gap is narrower for PAs. From unemployment insurance data, the sex wage gap for PAs is not only substantial but has remained relatively stable from 2018 through 2023. The female-to-male wage gap in 2018 was 73%, meaning the average female wage was 73% of the average male wage. In 2023, the gap had dropped one percent to where the average female wage was 74% of the average male wage, \$103,057 for females compared to \$138,896 for males, a difference of about \$35,839.



Figure 30. % between female and male wages
Preexisting 36% wage gap



Unemployment insurance data, 2024

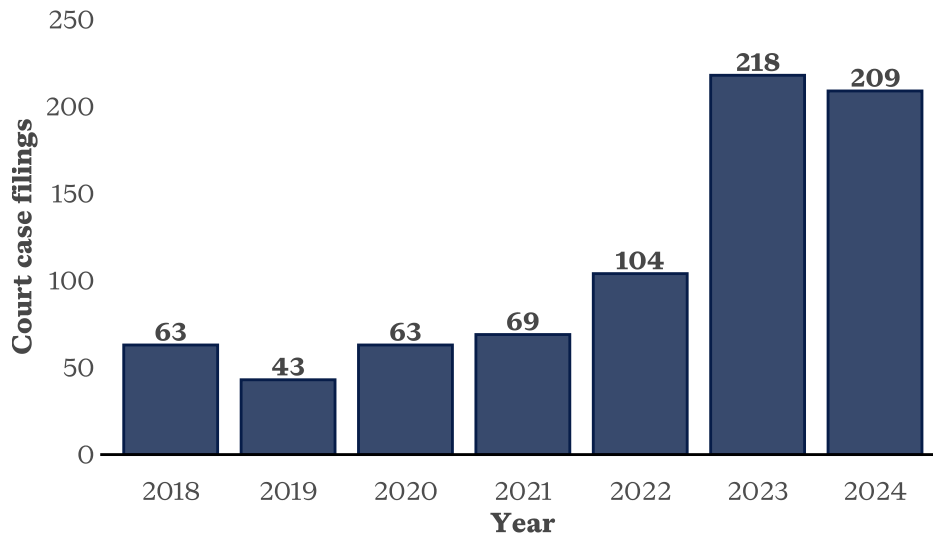
From 2018 through 2023, both female and male average PA wages have increased, and the rate of increase has been seemingly consistent. The average female wage increased approximately 31% whereas the average male wage increased approximately 29%. The preexisting 36% difference between female and male average wages helps explain how the female and male wage gap continues for PAs.

In addition to the issues of lower wages compared to their male counterparts and unpaid labor, female healthcare workers face a considerably more dangerous work environment. Female nurses are “subjected to more acts of violence than police officers or prison guards” and “required time off work due to violence four times more often than other types of injury” (Criado-Perez, 2019, para. 33). While the higher rates of violence are alarming, perhaps even more concerning is that such instances are routinely and dramatically underreported as only 12% of workers report violence because of how common and frequently it occurs (Criado-Perez, 2019, para. 38). While there are many different reasons for violence against females, research suggests “wait times as a trigger for violent behavior directed towards staff” (Criado-Perez, 2019, para. 40).



Figure 31. Violence against healthcare workers

Cases filed has increased



Utah state courts, 2025

Utah court case filings involving a charge of violence against a healthcare worker have dramatically increased. From 2018 to 2021 there were only between 43 and 69 cases filed per year. In 2022 the count of case filings jumped to 104, and in 2023 it more than doubled with 218. While the rise might not be completely due to more instances of violence but more willingness to file, the workplace for many healthcare staff is dangerous. Using unemployment insurance data to estimate the healthcare worker count for Utah in 2023 (88,383) and Utah court case filings involving charges of violence against healthcare staff, the rate of violence per 100,000 was 247 for healthcare workers in Utah. The Commission on Criminal and Juvenile Justice (CCJJ) estimates the rate of violence per 100,000 Utah residents for 2023 was 232 (CCJJ, 2024). This means healthcare workers are about 6.5% more likely to be subjected to violence. Future research and analysis should look at the proportion of violence directed at female and male healthcare workers. It is also important that the rate of violence against healthcare workers is based on court case filings which likely substantially underestimate the rate as most violence goes unreported.

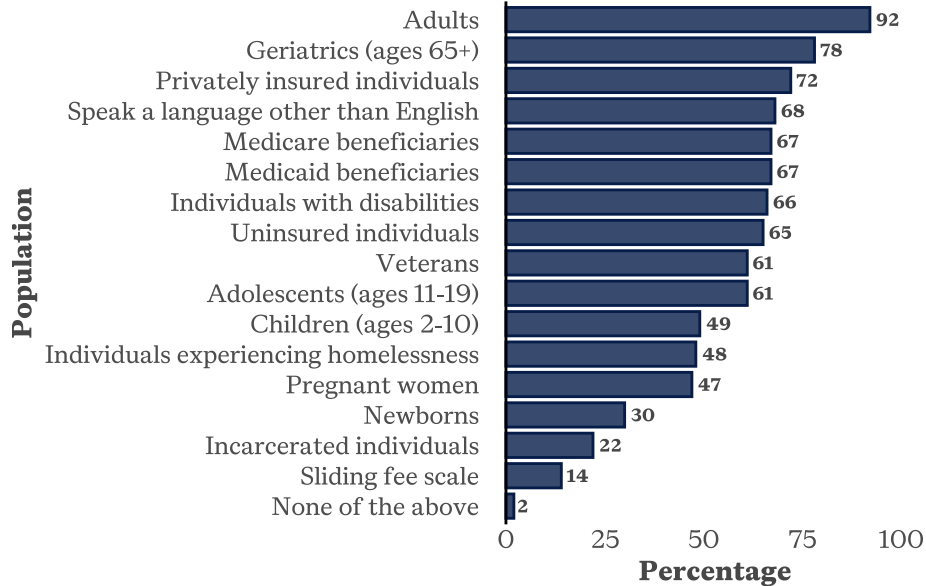
Patient characteristics

The patient population chart above was derived from a multiple selection (i.e., select all that apply) question.



Figure 32. Patient populations

Adults are the most common patient population



PA workforce survey, Utah, 2024

Figure 32 shows the percentage of respondents who see various patient population groups. Children, those experiencing homelessness, pregnant women, newborns, those requiring a sliding fee scale, and the incarcerated are patient populations least likely to receive treatment from a responding PA.

Future employment

This section includes practitioner survey response information on employment intentions, including employment plans for the next two years, anticipated changes in hours worked (change in full-time status), and projections.

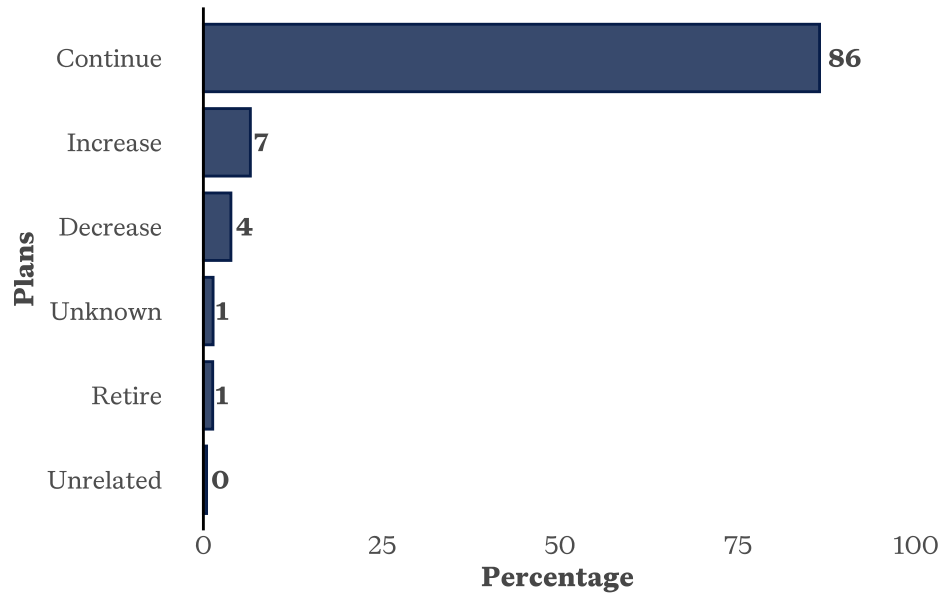
Two-year employment intentions

The following charts look at responses regarding future employment plans over the next two years, specifically if providers plan to change the hours they work per week.



Figure 33. Two-year employment plans

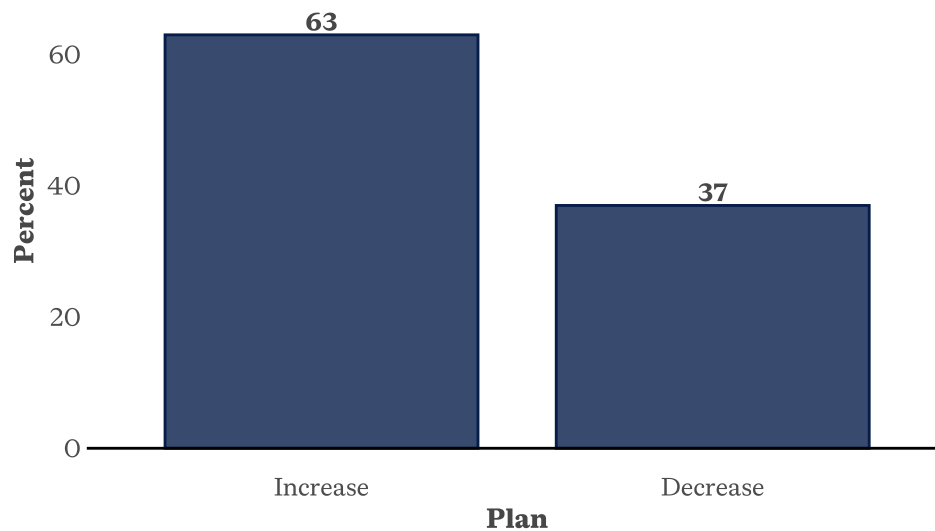
Most plan to continue as they are



PA workforce survey, Utah, 2024

Figure 34. Increase vs decrease hours

Of those who plan to change, most plan to increase hours

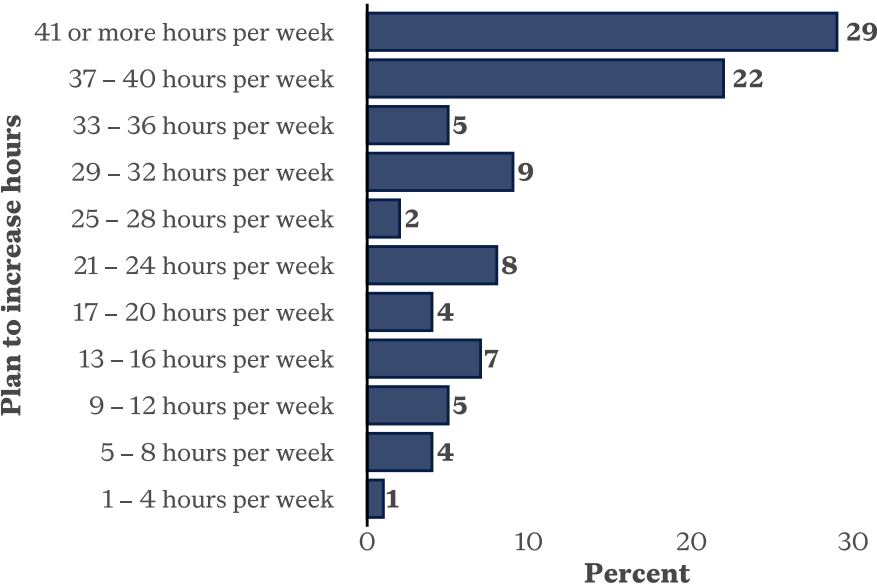


PA workforce survey, Utah, 2024



Figure 33 shows respondents’ two-year employment plans. Figure 34 compares those who plan to increase their hours with those who plan to decrease their hours. Figures 35 and 36 look at just those respondents who plan to increase or decrease their work hours per week and how many hours they plan to work per week following their change.

Figure 35. Plan to increase hours
41 ore more hours is the most common response

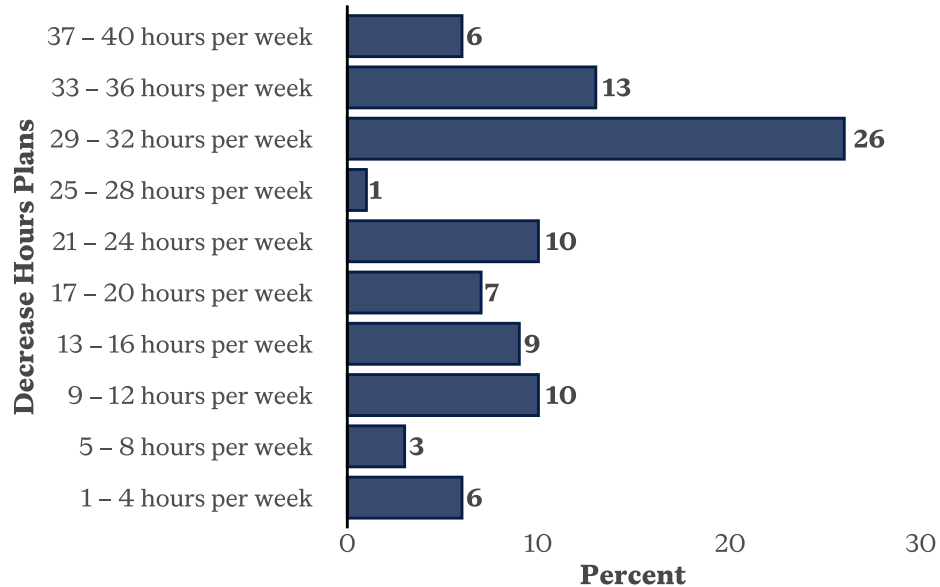


PA workforce survey, Utah, 2024



Figure 36. Plan to decrease hours

29-32 is the most common response



PA workforce survey, Utah, 2024

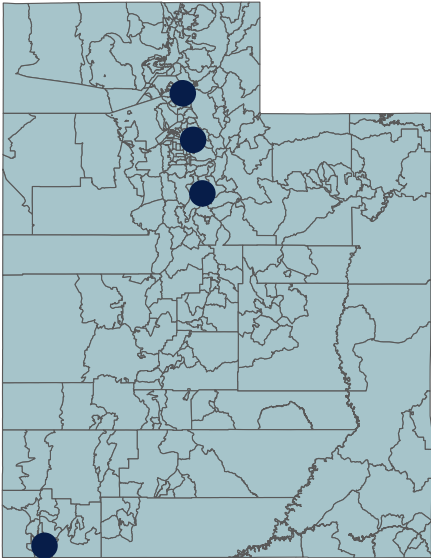
It should be noted that the small response rate related to the question regarding a change in hours is a consequence of the relatively low number of respondents indicating they plan to increase or decrease hours. Approximately 78% of respondents indicate they plan to continue working the same hours as they do currently.



Programs

PA-related educational programs located in the state of Utah are mapped below along with counts.

Figure 37. PA programs geography
4 counties have PA programs



Urban Institute Education Data Portal, 2024

Table 4. PA educational programs

County	Program count
Salt Lake County	1
Utah County	1
Washington County	1
Weber County	1

Urban institute education data portal, 2024

Only physician assistant and physician assistant studies programs were included while all other healthcare programs were excluded.

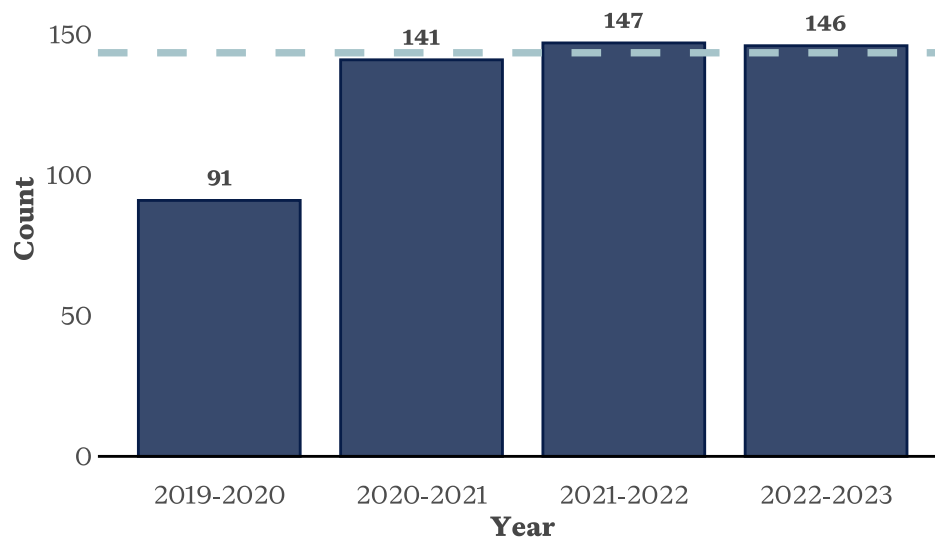


Graduates

Counts of Utah's PA-related program graduates are provided below by academic year.

Figure 38. PA graduates

The number of PA graduates has plateaued



Urban institute education data portal, 2024

The chart above displays PA graduates derived from the medicine classification of instructional programs or CIP code (51.1201) completions by academic year. Data comes from Integrated Postsecondary Education Data System (IPEDS), via Education Data Portal v. 0.22.0, Urban Institute, under ODC Attribution License. 2023 provisional data files from the IPEDS Data Center were accessed in November 2024.

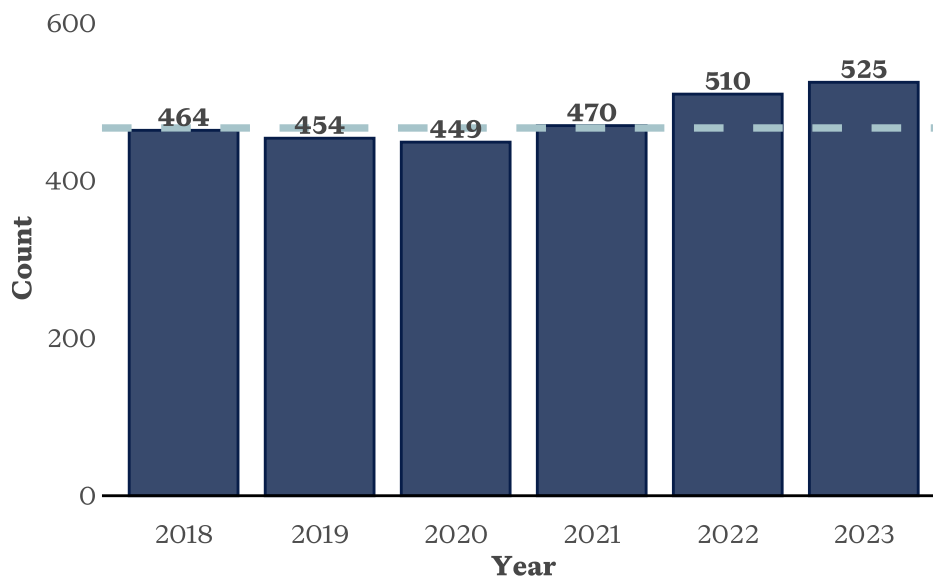


Workforce indicators

This section includes workforce indicators and job postings data.

Employer counts of PA providers derived from unemployment insurance data are depicted below.

Figure 39. PA employers
The number of distinct employers has increased



Unemployment insurance data, DWS, 2024

PA employer counts with a NAICS code related to healthcare from unemployment insurance data suggest a 2023 increase of 3% from 2022, and an increase of 13% from 2018. The count of distinct employers has increased every year since 2020.

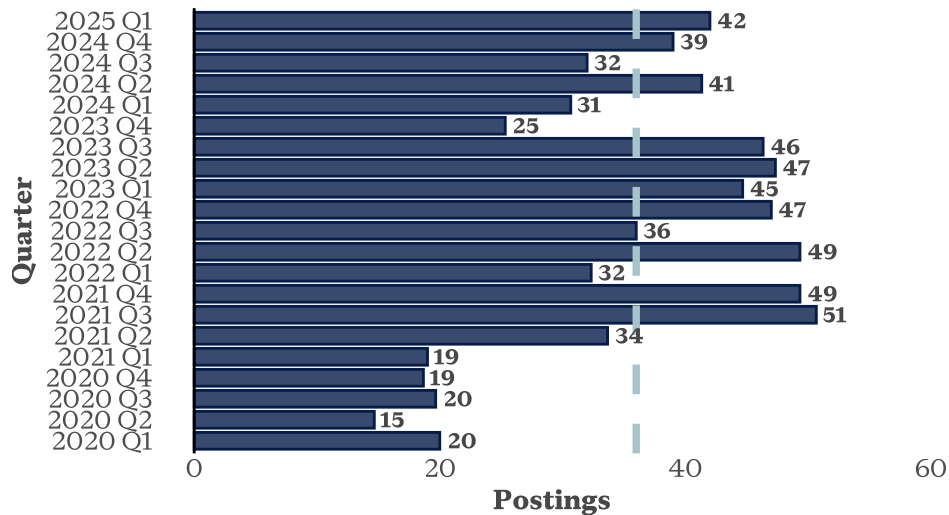
Job postings

The quarterly average number of PA job postings from Conference Board–Lightcast Help Wanted OnLine data, provided by DWS, along with the advertised salary, is depicted below.



Figure 40. Average count of monthly job postings

The average number of postings has dropped from 2021-2022 levels

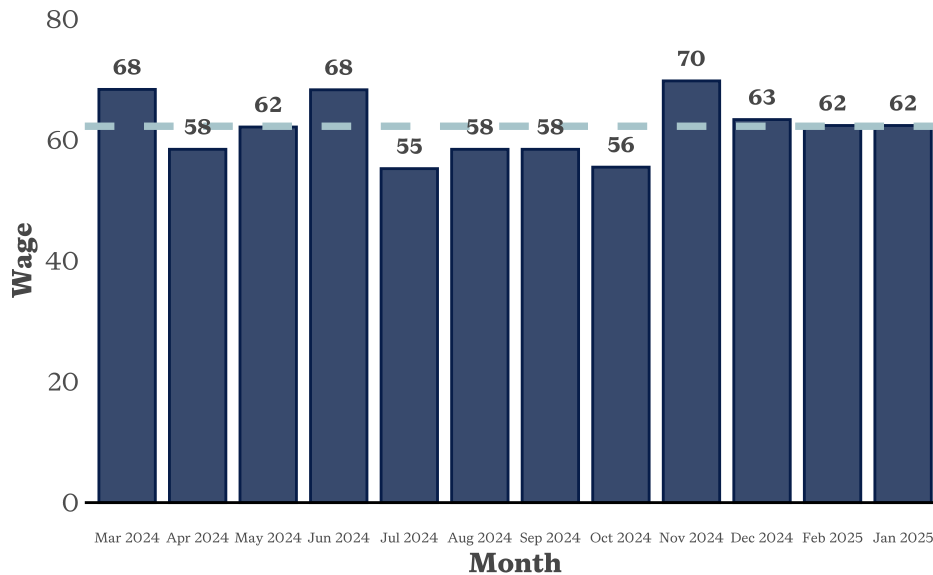


Conference Board–Lightcast Help Wanted OnLine data, provided by DWS, 2024

Figure 40 shows the average number of job postings. Data comes from DWS help-wanted online job postings. Job postings are received as monthly counts of unique listings. For this report, those counts are used to calculate quarterly averages. Advertised wages are averages of wages specified in monthly job postings. Averages or means are based on monthly distinct counts of job postings. Monthly counts are of all distinct job postings and not just the new monthly postings. Displaying values of means rather than the sum of counts was decided because there was a perceived higher risk of inflating counts through summing due to the possibility of including duplicates, which is avoided by taking the mean. While the same job may be listed in different months, the mean would avoid compounding its representation, while the sum would not.



Figure 41. Advertised wage of job postings
Advertised wage has plateaued



Conference Board–Lightcast Help Wanted OnLine data, provided by DWS, 2024

Figure 41 displays the monthly average hourly wage for help-wanted online job postings. Not all job postings advertise the salary. Comparing the count of unique job postings to the count of job postings with an advertised salary during 2024, about 41% do advertise a salary. It cannot be determined from the data if the advertised salary is an accurate representation of pay or wages. It might be accurate for some professions or jobs but might not be for others.

Table 5. Forecasting job postings

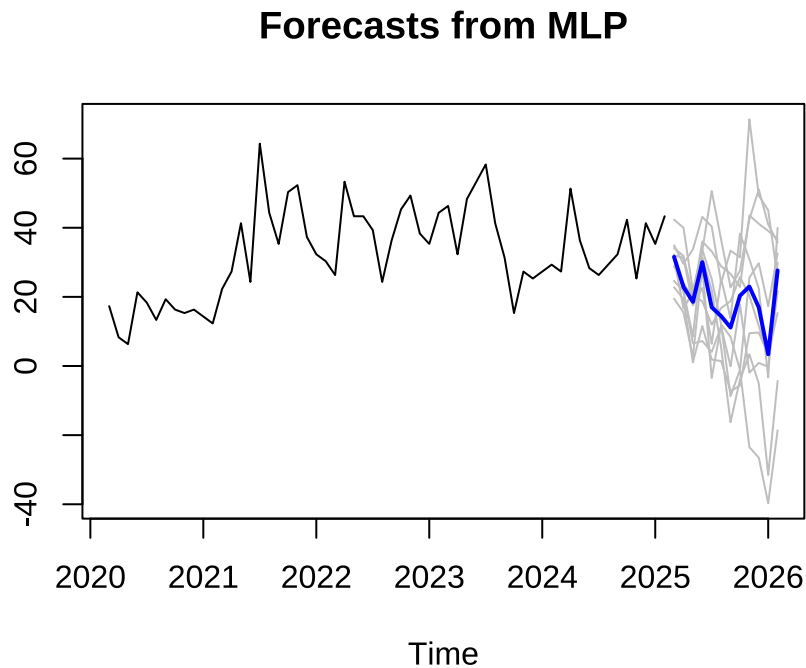
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
3	28	32	23	19	3	17	14	11	20	23	17

Conference Board–Lightcast Help Wanted OnLine data, provided by DWS, 2024

Table 5 displays the projected outlook of PA job listings.



Figure 42. Forecasting PA job postings. Projects mild fluctuations job postings but a return to previous levels



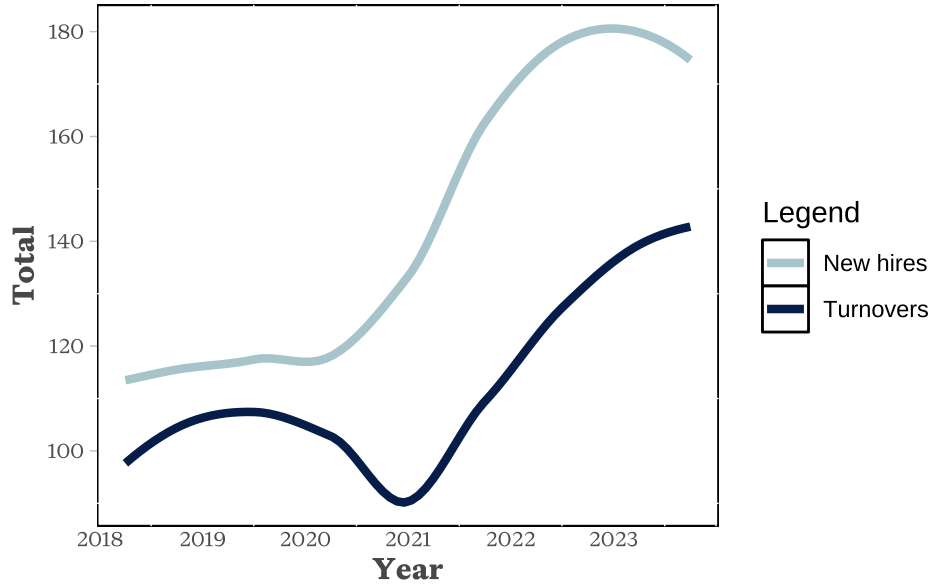
Conference Board–Lightcast Help Wanted OnLine data, provided by DWS, 2024

Figure 42 is a forecast model or an MLP projection that is based on the DWS data on unique job postings. Projections are done using a multilayer perceptron (MLP), which is a low-level neural network. This architecture is the baseline for many common AI applications today. Grey lines show the various simulations run by the neural network, while the blue line is the averaged prediction over the next year which gives us the most likely scenario. Simulated predictions like these are healthy estimates of future projections, but they should not be taken as the concrete truth as unpredictable factors are in play (COVID-19 being a great example).



Figure 43. PA turnovers and new hires

New hires continue to outpace turnovers despite recent slowdown



Data may not capture self-employed provider job change counts.

Unemployment insurance data, Department of Workforce Services, 2024

Figure 43 shows staffing levels appear to be stable, with new hires out numbering turnover for the vast majority of quarters from 2018 though 2023. Additionally, many of the PAs hired during the pandemic seem to have remained in the workforce.

Unemployment insurance data workforce activity

Counts of PA providers who were hired and those who terminated employment for Utah employers are provided in the table below.

Table 6. PA employment added/loss

Year	Added	Loss	Net
2018	367	300	67
2019	469	430	39
2020	493	393	100
2021	606	380	226
2022	684	523	161



Year	Added	Loss	Net
2023	693	570	123

Unemployment insurance data, DWS, 2024

Unemployment insurance data is used to determine the general yearly trend of job growth or loss. The added column is the count of new hires, while the loss column are counts of providers leaving employment. The net column is simply the sum of the added and loss aggregates. A major limitation of unemployment insurance data is that since it does not include all providers who work in a self-employed practice. To avoid including those who are not actively working as a PA, only those with a NAICS code related to healthcare are included.

Regardless of the limitations, the data shows a massive increase in the number of PAs in 2021. In 2021, employers hired 226 PAs which is more than all the PAs hired the previous 3 years. The number of PAs added slowed significantly in the following year but has remained higher than the numbers from 2018-2020.

A possible driving force for employers to hire PAs might be their relatively lower costs compared to physicians (MDs and DOs). During 2023, PAs on average earned an average yearly wage of \$119,856, whereas the average physician earned an average yearly wage of \$294,332 (Unemployment insurance data, DWS, 2024). It should be noted that APRNs also have a relatively lower cost than physicians and have more similar wages to PAs, with an average yearly wage of \$103,964 (Unemployment insurance data, DWS, 2024). However, whereas PAs are required to work under the supervision of physicians, APRNs do not have such a requirement.

Table 7. PA NAICS grouping counts

NAICS group	2018	2019	2020	2021	2022	2023
Ambulatory Health Care Services	696	716	729	811	885	970
Hospitals	412	436	462	512	553	575
Nursing and Residential Care Facilities	17	12	12	9	13	13
Social Assistance	9	5	3	12	16	14

Unemployment insurance data, DWS, 2024

Table 7 displays the counts of providers by NAICS groupings which is the North American Industry Classification System used by federal agencies to analyze business data. Data from 2023 shows an increase from 2019-2021 but a drop from 2022. Ambulatory Health Care Services and Hospitals are the largest source of jobs, comprising more than 98% of the sector's 2023 employment.



It is important to note that while the analysis counts distinct PA providers by year and NAICS group, there is some double counting when a PA provider changes employment with different NAICS codes. For example, a worker may have started a year employed in a hospital setting but later in the year moved to an ambulatory care setting. That worker in the Table 7 would be counted once in each setting during the year in question.



Discussion

Utah's provider supply faces a unique paradox. While the state hosts one of the nation's top-ranked training programs (University of Utah Health 2025), it consistently ranks among the lowest in the country for provider-to-population ratios (America's Health Rankings 2025). Utah's PA workforce has expanded by approximately 33% since 2018, this growth has been eclipsed by the state's rapid population surge, leaving the medical workforce chronically under-supplied relative to escalating demand.

Despite ranking 47th in the nation for primary care supply (America's Health Rankings, 2025; University of Utah Health, 2025), Utah is home to one of the country's top PA training programs. The University of Utah's program, ranked third nationally, produces high-caliber clinicians; however, this success does not translate into local workforce gains, as many graduates leave the state or enter specialty fields, worsening shortages in rural and underserved areas.

Separate from educational considerations, there are two major workforce issues affecting Utah's supply of PAs, salaries and hours. Utah PAs earn significantly less than their national peers, with an average salary of \$119,856 (Unemployment insurance data, 2024) compared to the national average of \$133,260 (Bureau of Labor Statistics, 2024). This wage gap, coupled with the state's rising cost of living, creates a significant sustainability challenge for Utah's PA workforce.

Workforce supply is further strained by a significant disparity in the amount of work hours. While only 13% of PAs nationwide work part-time (Career Explorer, 2026), Utah's HWIC survey data reveals a much higher rate of 32% working fewer than 36 hours per week. This trend suggests that Utah's headcount of PAs does not translate to the same volume of patient care found in other states. This capacity gap is further exacerbated by the fact that only 57% of full-time respondents are engaged in direct patient care, suggesting a significant portion of the workforce is diverted into administrative, educational, or non-clinical roles.

While the current PA workforce remains largely stable, maintaining adequate capacity will depend on supporting new graduates, supporting full-time work among early-career PAs, and managing gradual reductions in hours among mid-career professionals. The PA workforce in Utah has increased since 2018 along with the net growth in job postings and paid employment in recent years. The number of new PA graduates has also plateaued along with both job postings and advertised wages. Comparing Utah PAs from 2025 NPPES data to the 2024 National Commission on Certification of Physician Assistants Statistical Profile of Board Certified PAs, Utah's 50 PAs per 100,000 population is less than the US rate of 56 per 100,000 population.



Limitations

While these findings offer valuable insights, they should be interpreted in light of several limitations. The data are drawn from a voluntary survey administered during license renewal, with an average response rate of about 50%, which may not fully represent the entire PA workforce. Because the survey is neither a complete census nor a statistically valid random sample, results cannot be generalized to all PAs and must be interpreted with caution.

Additionally, license counts from the DOPL include all individuals holding an active license, but do not confirm whether the licensee is currently practicing, practicing in Utah, or working in a PA role. All employment and demographic information are self-reported, which introduces the potential for misclassification, recall bias, and error. Finally, the data represent a single point in time and do not reflect changes in the workforce that may occur after data collection.

The Conference Board–Lightcast Help Wanted OnLine job postings data, provided by DWS does not easily equate into net job growth. Job postings may only be needed to replace staff turnover. Not all new hires are publicly posted and not all job postings lead to new hires. Some postings remain online long after hiring is complete. Companies may post jobs to build candidate pipelines or for market testing of recruitment and salary expectations. These can sometimes be referenced as “ghost jobs”. The existence of ghost jobs is one reason many are cautious about using online job postings to estimate future employment growth. A large number of postings can make the labor market look stronger than actual hiring activity.



Appendix A - DOPL supply survey

Questions were asked about practitioners' Utah status, practice characteristics, demographics, employment plans, and patient population types.

The survey can be found at:

<https://ruralhealth.utah.gov/wp-content/uploads/2024-Physician-Assistant-Survey-Final-1.pdf>

Objectives

The HWAC has developed and adopted, with support from the Data Subcommittee, the Utah cross-profession minimum data set (UCPMDS). The UCPMDS is the underlying set of questions covering the highest priority data elements needed for health workforce planning throughout Utah.

Seven national healthcare regulatory organizations worked with Veritas Health Solutions, a consultant in health workforce data, policy, and planning, to create the UCPMDS. The UCPMDS intends to standardize certain information captured from various health professions to support within-profession and between-profession analyses to better inform health policies and strategies. The UCPMDS serves as a fundamental data system, upon which individual profession-specific tools are being developed and implemented into the re-licensure process.

Profession-specific surveys are being created for all licensed health professions. They are optional and are being implemented into the application process through the Division of Professional Licensing.

Target population

All DOPL physician assistant-related licenses were included in the license renewal process. Physician assistant-related license types include:

- Physician Assistant
- Physician Assistant CS
- Temporary Physician Assistant
- Time Limited Physician Assistant

Response rates

Observing the count of eligible practitioners provided by DOPL, the survey response rate was approximately 57%.

The following item response rates are based on those who provided a valid license number and responded to at least one question rather than those who were eligible to receive the survey.



Accompanying the item response rate is the question text. The question text displayed is as it appeared on the survey instrument.

Table 8. Item response rates

Number	Text	%
1	What is your sex?	100.0
2	What is your race? Mark one or more boxes.	99.5
3	Are you of Hispanic, Latina/o, or Spanish origin?	99.5
4	What type of degree/credential first qualified you for this license?	99.9
5	Year completed qualifying education?	99.7
6	Where did you complete the education program/degree that first qualified you for this license? (Note: for online programs, please select the location where this program was housed)	99.4
7	Please indicate your highest-level physician assistant degree.	99.8
8	What year did you complete your highest level of physician assistant education?	99.7
9	What is your employment status?	99.7
10	What best describes your employment plans for the next 2 years?	99.7
11	If you previously indicated you plan to increase or decrease hours in a field related to this license in the next 2 years, please estimate the total number of hours per week you expect to work after the change. If this does not apply, please select not applicable.	10.4
12	Which of the following best describes the specialty/field/area of practice in which you spend most of your professional time?	99.4
13	Please indicate your surgical subspecialty.	15.8
14	Please indicate your pediatrics subspecialty.	2.9
15	Please indicate your internal medicine subspecialty	5.9
16	Which of the following best describes your secondary specialty/field/area of practice?	87.8
17	Please indicate your surgical subspecialty. (secondary)	4.7



Number	Text	%
18	Please indicate your pediatrics subspecialty. (secondary)	1.5
19	Please indicate your internal medicine subspecialty. (secondary)	3.9
20	Of the hours per week spent in direct patient care, estimate the average number of hours per week delivering patient care via telehealth.	98.7
21	Please indicate the population groups to which you provide clinical services. Please check all that apply.	98.8
22	What is your primary practice location? If this does not apply, please enter "N/A".	94.6
23	Which of the following best describes your current employment arrangement at your principal practice location?	99.0
24	Please identify the role/title(s) that most closely corresponds to your primary employment/practice type.	98.8
25	Which of the following best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable".	98.5
26	Estimate the average number of hours per week spent at your primary practice location. If this does not apply, please select not applicable. Does not include time on call.	98.5
27	Estimate the average number of hours per week spent IN DIRECT PATIENT CARE at your primary practice location. If this does not apply, please select not applicable.	98.5
28	What is your Secondary Practice location? If this does not apply, please enter "N/A".	81.0
29	Which of the following best describes your current employment arrangement at your secondary practice location?	65.0
30	Please identify the role/title(s) that most closely corresponds to your secondary employment/practice type.	63.2
31	Which of the following best describes the practice setting at your secondary practice location? If this does not apply, please select not applicable.	54.7
32	Estimate the average number of hours per week spent at your secondary practice location. If this does not apply, please select not applicable. Does not include time on call.	56.1



Number	Text	%
33	Estimate the average number of hours per week spent IN DIRECT PATIENT CARE at your secondary practice location. If this does not apply, please select not applicable.	56.2
34	Please indicate the total amount of educational debt you had at time of graduation from your PA program (exclude pre-physician assistant and non-educational debt).	96.4
35	Have you mentored/precepted students within the last two years?	97.5

PA workforce survey, Utah, 2024



References

American Academy of Physician Associates (2024). *What is a PA?*, (<https://www.aapa.org/about/what-is-a-pa/>)

America's Health Rankings (2025). *Primary Care Providers in Utah*, (https://www.americashealthrankings.org/explore/measures/PCP_NPPES/UT)

Bailey, M., et al. (2024). Probability and Nonprobability Sample in Surveys: Opportunities and Challenges. *Administration for Children & Families*. (https://acf.gov/sites/default/files/documents/opre/opre_nonprobability_samples_brief_september2024.pdf)

Boyd, Robin J. et al (2023). We need to talk about nonprobability samples. *Trends in Ecology & Evolution*, 38(6), 521-531. ([https://www.cell.com/trends/ecology-evolution/fulltext/S0169-5347\(23\)00005-8](https://www.cell.com/trends/ecology-evolution/fulltext/S0169-5347(23)00005-8))

Bureau of Labor Statistics (2023). *Occupational Employment and Wage Statistics*, (<https://www.bls.gov/oes/current/oes291171.htm>)

Bureau of Labor Statistics (2024). *Occupational Outlook Handbook*, (<https://www.bls.gov/ooh/healthcare/physician-assistants.htm#:~:text=127%2C900-,Most%20physician%20assistants%20work%20full%20time.,the%20average%20for%20all%20occupations.>)

Career Explorer (2026). *Physician assistant demographics in the United States*, (<https://www.careerexplorer.com/careers/physician-assistant/demographics/#:~:text=87%25%20of%20physician%20assistants%20work,13%25%20work%20part%20time>)

HRSA Health Workforce (2022). *Scoring Shortage Designations*, (<https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring>)

Lucas, Samuel R. (2014). Beyond the existence proof: ontological conditions, epistemological implications, and in-depth interview research. *Quality & Quantity*, 48, 387-408. (<https://link.springer.com/article/10.1007/s11135-012-9775-3#Bib1>)

Markowski et al. (2023). After 50 Years, Health Professional Shortage Areas Had No Significant Impact on Mortality or Physician Density. *Health Affairs*, 42(11), 1507-1516. (<https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00478#:~:text=41-,Conclusion,and%20mortality%20across%20four%20decades>)

Milbank Memorial Fund (2025). *2025 Primary Care Scorecard Data Dashboard*, (<https://www.milbank.org/primary-care-scorecard/>)



National Commission on Certification of Physician Assistants (2024) *Statistical Profile of Board Certified Physician Assistants: Annual Report*, (<https://www.nccpa.net/wp-content/uploads/2025/05/2024-Statistical-Profile-of-Board-Certified-PAs.pdf>)

Snowden, Lonnie R. et al. (2022). Racial Bias Correlates with States Having Fewer Health Professional Shortage Areas and Fewer Federally Qualified Community Health Center Sites. *Journal of Racial and Ethnic Health Disparities*, 10:325–333. (https://pmc.ncbi.nlm.nih.gov/articles/PMC8744578/pdf/40615_2021_Article_1223.pdf)

Stamper, Andi (2024). *Unlocking Opportunities: The Strategic Advantages of Holding Licenses in Multiple States*, (<https://healthshieldcredentialing.com/licenses-in-multiple-states/#:~:text=Geographic%20Flexibility:%20Holding%20licenses%20in%20multiple%20states,healthcare%20settings%2C%20patient%20populations%2C%20and%20working%20environments.&text=Having%20licenses%20in%20multiple%20locations%20enables%20professionals,demand%2C%20increasing%20their%20employability%20and%20job%20security.>)

Togioka, Brandon M. et al. (2024). Diversity and Discrimination in Health Care. StatPearls, 2025 Jan. (<https://www.ncbi.nlm.nih.gov/books/NBK568721/>)

University of Utah Health (2025). *2025 Year in Review*, (<https://uofuhealth.utah.edu/notes/2025/12/2025-year-review>)

World Health Organization (2021). *Gender and health*, (<https://www.who.int/news-room/questions-and-answers/item/gender-and-health>)



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<https://hwic.utah.gov/>

Phone: 801-538-9375

Appendix B - survey tool

Accessible at:

<https://ruralhealth.utah.gov/wp-content/uploads/2024-Physician-Assistant-Survey-Final-1.pdf>



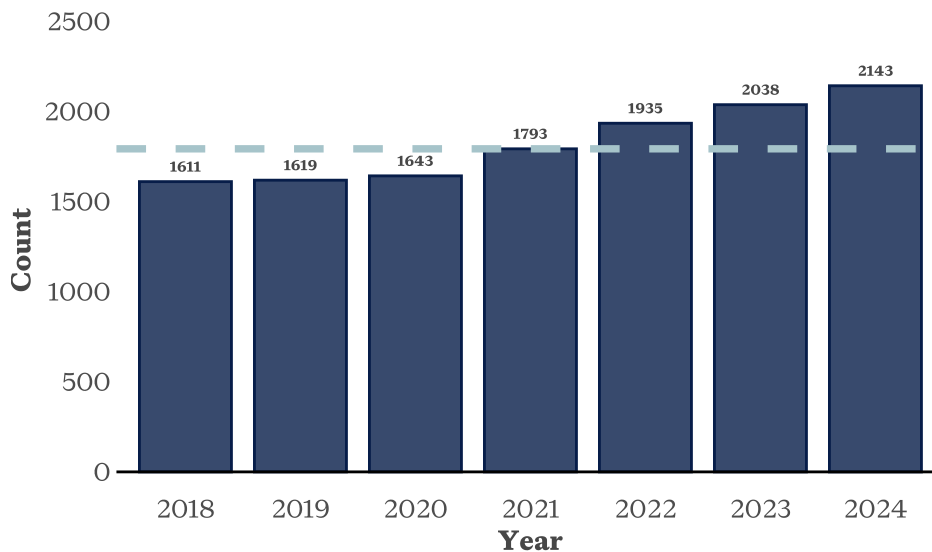
Appendix C - alternative counts

Unemployment insurance (UI)

The following are counts of PAs from DWS's unemployment insurance data. Counts include those with an active DOPL PA license during 2018-2024 with a wage.

Figure 44. PAs with wages

The number of PAs with wages has increased every year from 2018



Unemployment insurance data, DWS, 2024

UI data includes those with reported wages. UI data shows that there were 2,597 providers between 2018 and 2024 with the yearly count increasing every year, from 1,611 in 2018 to 2,143 in 2024. Please note that the counts include all who had an active DOPL PA license during 2018-2024, and includes potential individuals who had reported UI wages but were not working as a PA.

National Plan and Provider Enumeration System (NPPEs)

The following counts are of PAs from the National Plan and Provider Enumeration System (NPPEs). NPPEs serves as the national system designed to assign unique identifiers to healthcare providers and health plans who apply for the National Provider Identifier (NPI). NPIs are used across the health care industry and government health care programs.



Table 9. Count of PAs with active DOPL licenses

Type	Count matching
General	1,424
Medical	248
Surgical	57
Total	1,729

NPPEs, 2025; DOPL, 2025

Table 9 counts the PAs from NPPEs data with a matching active license number from DOPL. Matching providers in NPPEs data with DOPL active license numbers helps filter out inactive providers from the counts.

Table 10. Count of PAs, PCP PAs, and rates per 100,000 population by county

County	PAs	PCP PAs	PAs per 100k	PCP PAs per 100k
Beaver	2	1	27	14
Box Elder	7	5	11	8
Cache	55	45	39	32
Carbon	5	2	24	10
Daggett				
Davis	121	97	32	26
Duchesne	6	6	30	30
Emery	4	1	40	10
Garfield	2	1	39	19
Grand	8	5	81	51
Iron	22	19	33	29
Juab				
Kane	2	2	24	24



County	PAs	PCP PAs	PAs per 100k	PCP PAs per 100k
Millard	5	5	37	37
Morgan	1	1	8	8
Piute				
Rich	4	3	147	110
Salt Lake	840	685	69	56
San Juan	9	8	60	53
Sanpete	15	12	49	40
Sevier	8	5	36	23
Summit	29	23	67	53
Tooele	27	22	34	28
Uintah	7	5	19	14
Utah	299	253	41	35
Wasatch	8	5	21	13
Washington	112	98	56	49
Wayne				
Weber	131	115	49	43
Total	1,729	1,424	50	41

NPPES, 2025; DOPL, 2025

Table 10 provides counts of PAs, primary care providing (PCP) PAs, PA per 100,000 population, and PCP PAs per 100,000 population by county from NPPES data. NPPES data was filtered for individual providers with PA provider taxonomy codes with a Utah practice ZIP code and a license number matching an active DOPL license number.

