AMERICAN ACADEMY OF FAMILY PHYSICIANS

May 2, 2024

The Honorable Bernie Sanders
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy
Ranking Member
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to thank you both for your bipartisan leadership in addressing issues impacting family physicians and their patients through today's hearing entitled "What Can Congress Do to Address the Severe Shortage of Minority Health Care Professionals and the Maternal Health Crisis?"

The lack of a diverse physician workforce has significant implications for public health, including maternal health outcomes. Physicians who understand their patients and the larger context of culture, gender, religious beliefs, sexual orientation, and socioeconomic conditions are better equipped to address the needs of specific populations and the health disparities among them. Studies show that racial, ethnic, and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[i,ii] However, our current health care workforce does not accurately resemble our nation's diversity. For example, Black and Hispanic Americans account for nearly one-third of the U.S. population but just eleven percent of physicians.[iii,iv]

While physicians from racial and ethnic minorities are more likely to practice primary care, there is still significant work needed to develop a health care workforce that reflects the communities it serves. The AAFP believes that achieving a more diverse family medicine workforce is essential to improve patient outcomes and society's overall health, and it is with this in mind that we offer the following feedback to inform today's conversation.

Address the Maternal Health Crisis

The United States has one of the highest maternal mortality rates in the developed world. Recent studies have shown that U.S. maternal mortality rates have stagnated or even worsened over time, while rates around the globe continue to fall.[v] According to the World Health Organization, maternal mortality globally declined nearly 38% between 2000 and 2017.[vi] During roughly the same period, maternal mortality in the United States increased by over 26%. In the U.S., approximately 700 women a year die as a result of pregnancy or related complications, yet

the vast majority (84%) are preventable.[vii]

Significant disparities exist when these rates are broken down across demographic groups, with higher rates of mortality occurring among Black women, low-income women, and those living in rural areas.[viii] The AAP believes family physicians can play a significant part in addressing the disparities in maternal morbidity and mortality because they are trained to provide comprehensive care across the life course, including prenatal, perinatal, and postpartum care for people in the communities where they live. More than one in ten family physicians (13%) reported they delivered babies in 2022.

The factors driving these disparities are complex and multi-faceted. They include but are not limited to access to and affordability of care, the intersection of demographic factors, and structural and systemic bias and discrimination. For example, the closure of rural hospitals and obstetrics programs has led to enormous gaps in access to prenatal and perinatal services for pregnant people living in rural communities. Between 2011 and early 2023, 217 hospital obstetric units closed, creating many maternity care deserts across the nation.[ix] In addition to the loss of facilities, there are compounding factors such as lack of transportation, increased poverty, increased rate of chronic diseases, and difficulty recruiting and retaining physicians to live and work in rural communities.

The AAFP has two courses to provide education and build skills focused on recognizing obstetrical emergencies. Advanced Life Support in Obstetrics (ALSO®) is a program that equips the entire maternity care team with skills to effectively manage obstetrical emergencies. Basic Life Support in Obstetrics (BLSO®) is designed to improve the management of normal deliveries, as well as obstetrical emergencies, by standardizing the skills of first responders, emergency personnel, and maternity care providers.

To further address this issue, the AAFP recommends that Congress pass the Rural Obstetrics Readiness Act (S. 4079), which would establish training programs to help non-specialists respond to obstetric emergencies. The bill would also provide grants for rural facilities to provide better equipment to train for and handle these emergencies and develop a pilot program for teleconsultation services so a maternal care expert can provide consulting services in an emergency.

Gaps in insurance coverage and availability of affordable care also increase the risk of morbidity and mortality, particularly during the postpartum period. We appreciate that Congress permanently extended the voluntary option for states to provide postpartum Medicaid coverage for up to a year in the Consolidated Appropriations Act of 2022. However, a permanent solution across all states is needed to ensure access to continuous care for pregnant people throughout the full, one-year postpartum period.

Current law only requires states to provide Medicaid coverage based on pregnancy status up to 60 days postpartum. As the largest single payer of maternity care in the U.S., covering 41 percent of births nationwide, Medicaid has a critical role to play in ensuring healthy moms and babies.[x] According to the Centers for Disease Control and Prevention, more than half (53%) of pregnancy-related deaths occur between one week and one year postpartum, during which time many postpartum individuals lose Medicaid coverage.[xi] The AAFP therefore continues to

advocate for requiring one year of postpartum Medicaid coverage as an important way to address the disparities in maternal health and improve outcomes. Specifically, **Congress should pass the Healthy Maternal and Obstetric Medicine (Healthy MOM) Act (S.3509 / H.R. 6716) to create a special enrollment period for marketplace plans for pregnant people and require states to offer Medicaid coverage to pregnant people up to 12-months postpartum.**

Further, the AAFP recognizes that the root causes of racial and ethnic disparities in maternal morbidity and mortality include institutional racism in the health care and social service delivery system and social and economic inequities. Implicit bias is pervasive among all health care professionals and has deleterious effects on patient health.[xii] It reduces trust, self-efficacy, understanding, and satisfaction between a patient and their physician, affecting a patient's ability to manage their health and adhere to treatment. For physicians, implicit bias limits their level of cultural proficiency, patient-centeredness, and job satisfaction.

Formal medical education and training curricula often lack content that provides a framework for identifying and mitigating implicit biases in clinical practice. Faculty who seek to incorporate this topic in training are often faced with barriers, such as the limited number of subject matter experts who can provide instruction, a lack of opportunities for participants to observe and demonstrate mitigation strategies in practice, and a lack of opportunities to engage with patients who can share experiences of encountering implicit bias in the delivery of prenatal care.

The implicit biases of health care professionals toward people of color, particularly Black women, have been shown to be a contributing factor to racial and ethnic disparities in adverse maternal health outcomes. For example, studies have demonstrated that implicit bias of health care professionals affects rates of racial and ethnic disparities in contraception use,[xiii] access to and quality of prenatal care,[xiv,xv] and clinical decision-making[xvi] in the intrapartum and postpartum periods.

Diversifying the Health Care Workforce

We know that a physician's background and upbringing influences where and how they practice. Evidence has shown that students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers and are more likely to practice primary care.[xvii] We have also seen that these two factors compound, leading to more minority primary care physicians practicing in underserved communities. For example, Black, Native American, and Hispanic groups have higher proportions practicing in Health Professional Shortage Areas (HPSA), Medically Underserved Areas/Populations (MUA/P), and rural areas compared with White and Asian primary care physicians, who have smaller proportions practicing in these areas.[xviii]

Importantly, research has shown that patient satisfaction and health outcomes are improved when health care clinicians and their patients have concordance in their racial, ethnic, and language backgrounds.[xix] However, while primary care specialties lead other specialties in the representation of racial and ethnic minorities in the workforce, all of medicine lags significantly behind the racial and ethnic diversity of the U.S. population.[xx] It is critically important that federal policymakers prioritize opportunities to invest in and diversify our health care workforce to ensure better, more culturally component care for patients.

One federal program that has been successful at embedding physicians into underserved communities is the Teaching Health Center Graduate Medical Education (THCGME) program. THCGME is the only federal program that trains physicians and dentists in community-based settings focusing specifically on rural and underserved communities. It has trained more than 2,027 primary care physicians and dentists, 61% of whom are family physicians. However, the THCGME program's authorization expires at the end of this year, which further jeopardizes the stability of this program for its current and future residents as well as the patients they serve. Historically, the program has received piece-meal, short-term reauthorizations from Congress. This fails to consider the fact that family medicine residencies are three-year programs, meaning many medical students are dissuaded from applying to THC residencies because they have no certainty that the program will even be around long enough for them to complete their training. We have unfortunately seen this instability result in some THCGME programs accepting fewer or no new residents for next year or closing their program entirely.

For these reasons, the AAFP strongly cautions against a short-term extension. **Instead, the AAFP recommends that Congress pass the Doctors of Community (DOC) Act (H.R. 2569) to permanently authorize the THCGME program.** Absent a permanent solution, we urge Congress to, at a minimum, provide a multi-year reauthorization that provides sufficient funding levels to support the true per-resident costs to each program.

We also urge Congress to increase investment in Community Health Centers (CHCs), including a long-term authorization, to meet the health workforce needs of the underserved and to increase access to comprehensive primary care in our most vulnerable communities. CHCs, including Federally Qualified Health Centers and Rural Health Clinics, provide comprehensive primary care and preventive services to some of the most vulnerable and underserved Americans. Family physicians are the most common type of clinician (46%) practicing in CHCs and thus are well-positioned to ensure accessible and affordable primary care and reduce racial, ethnic, and income-based health disparities.[xxi] Research also shows that CHC-trained family physicians are more than twice as likely to work in underserved settings than their non-CHC-trained counterparts.[xxii]

Medical student loan debt remains one of the biggest barriers to diversifying our health care workforce. The average student loan debt for four years of medical school, undergraduate studies, and higher education is, on average, between $200,000 and $250,000 and will continue to increase as the cost of medical school continues to rise. That price tag alone can deter students from applying. For example, one report found that 18.2% of black high-school sophomores said they aspired to apply to medical school, but only 6.7% applied. For Hispanic high-school sophomores, 24.4% said they wanted to go to medical school but only 6.8% applied.[xxiii] Research has also shown that loan forgiveness or repayment programs directly influence physician’s choices about whether to choose primary care specialties. While we appreciate Congress’ recent efforts to help address health workforce shortages, additional action is needed to comprehensively address the current and projected primary care workforce shortages.

The Academy urges Congress to pass the bipartisan Resident Education Deferred Interest (REDI) Act (S. 704 / H.R. 1202), which would allow physicians and dentists to defer their loan payments interest-free through residency. After medical school, physicians

undergo several years of residency with very low pay (averaging around $60,000 in recent years), making it difficult for them to begin repaying loans immediately. The REDI Act would not forgive existing student loan debt. Rather, it is a very incremental but crucial first step to help address the financial burden that has dissuaded many individuals from pursuing careers in medicine or dentistry.

Additionally, the AAFP supports the National Health Service Corps (NHSC), which incentivizes physicians from diverse backgrounds to practice in underserved areas by providing scholarships and loan repayment. Nationwide, nearly 19 million patients are cared for by NHSC providers.[xxiv] We thank Congress for extending the authorization of the NHSC through the end of the year but urge for additional action. Specifically, **the AAFP encourages Congress to pass the Restoring America's Health Care Workforce and Readiness Act (S. 862), which includes a three-year reauthorization that would double the mandatory funding for the NHSC.** We have also supported proposals to allocate a set percent of NHSC funding for racial and ethnic minorities and students from low-income urban and rural areas.

Finally, we also ask Congress to move forward policies that would support international medical graduates (IMGs) practicing in the United States. IMGs play a vital role in caring for some of the most vulnerable populations in the U.S. as they are more likely to practice in rural, low socio-economic status, and non-white communities.[xxv] However, resident physicians from other countries working in the U.S. on J-1 visa waivers are currently required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 Waiver Program allows these IMGs to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. **Congress must pass the Conrad State 30 & Physician Access Act (S. 665), which extends authorization for the Conrad 30 Waiver program for three years, improves the visa process, and allows for an increase beyond 30 waivers per state if states need additional doctors.**

We also support the Healthcare Workforce Resilience Act (S. 3211 / H.R. 6205), which would increase the number of visas available to physicians. Specifically, it would recapture 15,000 unused employment-based physician immigrant visas from prior years, thus enabling more IMGs to practice in communities across the country and ensuring more patients have access to the care they need.

It is imperative that Congress take steps to combat the maternal health crisis and support minority physicians. The AAFP looks forward to working with you and your colleagues to advance policies that will improve outcomes and address disparities by investing in a more diverse health care workforce. Should you have any questions, please contact Anna Waldman, Associate of Legislative Affairs, at awaldman@aafp.org.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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