AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement for the record to the
House Energy and Commerce Committee,
Health Subcommittee
hearing
Supporting Tomorrow's Health Providers:
Examining Workforce Programs Under the Public Health Service Act
September 14, 2017

On behalf of the American Academy of Family Physicians (AAFP), representing 129,000 family physicians and medical students, thank you for the opportunity to submit this Statement for the Record for the U.S. House Energy and Commerce Committee Health Subcommittee regarding critical primary care workforce programs. The AAFP strongly supports the key primary care programs under discussion during today's hearing, specifically the Teaching Health Center Graduate Medical Education Program (THCGME), the National Health Service Corps (NHSC), and Title VII's Primary Care Training and Enhancement Program.

In particular, the AAFP urges legislators to support the funding levels contained in the *Training the Next Generation of Primary Care Doctors Act of 2017* (HR 3394), sponsored Rep. Cathy McMorris Rodgers and supported by 13 bipartisan members of the Energy and Commerce Committee. The bill reauthorizes and funds the THCGME program to train primary care physicians for three years. Unless Congress acts, the efficient and highly successful THCGME program will expire on September 30, 2017.

P*rimary Care is Associated with Better Patient Outcomes and Lower Costs*
Primary care (comprehensive, first contact, whole person, continuing care) is the foundation of an efficient health system. It is not limited to a single disease or condition, and can be accessed in a variety of settings. Primary care (family medicine, general internal medicine and general pediatrics) is provided and managed by a personal physician, based on a strong physician-patient relationship, and requires communication and coordination with other health professionals and medical specialists.

The benefits of primary care do not just accrue to the individual patient. Primary care also translates into healthier communities.[i] For instance, U.S. states with higher ratios of primary care physician-to-population ratios have better health outcomes, including lower rates of all causes of mortality: mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health, even after controlling for sociodemographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and smoking).[ii]

The dose of primary care can even be measured – an increase of one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3%, or 49 fewer deaths per 100,000 per year.[iii] High quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering per capita costs.[iv]

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

Primary Care Access is Vital for Improving Senior Care, Population Health, Disparities
The AAFP believes building the primary care workforce is an important return on investment and workforce programs help ensure high quality, efficient medical care is more readily available. By reducing physician shortages and attracting physicians to serve in communities that need them, these programs also help improve the way care is delivered and help meet the nation's health care goals.

Elderly Populations
With the aging of the U.S. population, primary care access is critical. By the year 2050, the number of people 65 years of age and older will nearly double increasing the population of Medicare patients, 82% of whom have chronic health conditions.[v] As a country, we will only succeed at caring for this population by strengthening primary care, a specialty that is highly skilled in addressing the needs of patients with chronic diseases and multiple conditions. Better chronic care management is associated with fewer trips to the hospital and appropriate utilization of less expensive medical care.[vi]

Patients, particularly the elderly, with a usual source of care, such as a physician and a medical home, are healthier and have lower medical costs because they use fewer health care resources and can resolve their health needs more efficiently.[vii] In contrast, those without a usual source of care have more problems getting health care and more often do not receive appropriate medical help when it is necessary.[viii] Research also indicates that patients who gain a usual source of care adjust their health seeking behavior, which again translates into fewer expensive emergency room visits, unnecessary tests and procedures, and better care coordination.[ix] Therefore, it is in the national interest to support programs with the potential to help improve patient access for this population.

Population Health Concerns
Primary care access is also essential for achieving better population health outcomes. For example, immunizations are a 21st century public health success, yet less than half of the adult population is fully immunized. A 2016 report published *in Health Affairs* indicates that the economic costs of vaccine-preventable disease is between $4.7 billion and $14 billion per year.[x] Although vaccines are available in many different locations, such as pharmacies and in workplaces, primary care physicians play an important role as immunizers. The doctor-patient relationship can be instrumental in helping patients overcome their hesitancy or educating them when new immunizations are recommended. Doctors also understand patients' medical histories and risk factors. For example, primary care physicians can help diabetes mellitus patients understand how the condition compromises their immune system and why their vaccinations should be up-to-date.

Health Disparities
The current uneven distribution of physicians has an impact on the health of a population. A U.S. Centers for Disease Control and Prevention study indicated that patients in rural areas tend to have shorter life spans, and access to health care is one of several factors contributing to rural health disparities.[xi] The report recommended greater patient access to basic primary care interventions such as high blood pressure screening, early disease intervention, and health promotion (tobacco cessation, physical activity, healthy eating).[xii] The findings highlighted in the CDC's report are consistent with numerous others on health equity, including a longitudinal study published in *JAMA Internal Medicine*, indicating that a person's zip code may have as much influence on their health and life expectancy as their genetic code.[xiii] Therefore, it is imperative that physician care is accessible for all.

Physician Shortage and Maldistribution
The current physician shortage and maldistribution remain significant physician workforce challenges. A 2017 Government Accountability Office (GAO) report indicates that physician maldistribution significantly impacts rural communities.[xiv] The patient-to- primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.[xv] According to GAO, one of the major drivers of physician maldistribution is that medical residents are highly concentrated in very few parts of the country. The report stated that graduate medication education (GME) training remained concentrated in the Northeast and in urban areas, which continue to house 99% of medical residents.[xvi] The GAO also indicated that while the total number of residents increased by 13.6% from 2001 to 2010, the number expected to enter primary care decreased by 6.3%.[xvii]

Combined, the primary care workforce programs at issue in today's hearing are essential resources to begin to solve the lack of primary care physicians and patient access to primary care. We urge the committee to support these programs with an understanding of their potential for helping meet the country's health care needs. Supporting primary care workforce programs also makes primary care specialty a more attractive and economically viable choice for medical students.

Teaching Health Center Graduate Medical Education (THCGME) Program
The THCGME program is a highly successful primary care training program that has been proven to be effective in increasing primary care training and retention in community-based settings. This program directly addresses three major concerns regarding physician production: the serious shortage of primary care physicians, their geographic maldistribution, and the need for physicians who serve underserved populations. In addition, its accountability requirements serve as a model for other GME programs.

Residents in the THCGME program train exclusively in primary-care specialties. Two-thirds of the THCGME residents are training in family medicine or pediatrics.[xviii] The THCGME program accounts for less than 1% of the annual federal spending devoted to GME, yet it is the only program dedicated to training primary-care physicians and dentists. Residents in the program train in community-based settings (including federally qualified health centers), and tend to be concentrated exactly where more primary care is sorely needed: rural and underserved areas.

The THCGME program appropriately trains residents who then stay in the community. THCGME residents are trained in delivery system models using electronic health records, providing culturally competent care, and following care coordination protocols.[xix] Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.[xx] Residents who train in underserved communities are likely to continue practicing in those same environments.[xxi]

American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.[xxii] By comparison, fewer than 5% of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.[xxiii] Thus, the most effective way to encourage family and other primary-care physicians to practice in rural and underserved areas is not to recruit them from remote academic medical centers but to train them in these settings.

AAFP urges the extension of the efficient and highly successful THCGME program.

National Health Service Corps
The AAFP supports the objectives of the National Health Care Corps (NHSC) and assists the Health Resources and Services Administration in making information available to family medicine residents regarding practice opportunities and benefits in the program. The AAFP advocates for reauthorization and appropriate funding of the NHSC and for reinstitution of the goal of full funding for the training of the health workforce and the elimination of disparities in health care due to race, class, income, geography, language, or immigration status.

Since 1972, the NHSC has offered financial assistance to recruit and retain health care providers to meet the workforce needs of communities across the nation designated as health professional shortage areas (HPSAs). NHSC providers served more than 10 million people, providing a range of clinical services. NHSC providers represent a diverse group of clinicians – 13% are African American, 10% are Hispanic, 7% are Asian or Pacific Islander, and 2% are American Indian or Alaska Native. Clinician types include physicians (26%), dentists and dental hygienists (14%), nurse practitioners, physician assistants and certified nurse midwives (21%), and behavioral health providers (28%). NHSC members are placed in areas of highest need based on the HPSA site score. Scores range from 0-25 for primary care, dental, and mental health HPSAs.

Congress, as part of the bipartisan *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), provided a trust fund for the NHSC which expires at the end of FY 2017. The Administration's budget proposed that the NHSC receive mandatory funding in FY 2018 at the MACRA-authorized level of $310 million. However, this will fall short of the need for NHSC placements in two-thirds of the nation's HPSAs. The AAFP urges that the Committee support a program level of at least $380 million for the NHSC in FY 2018 to allow for an increased NHSC field strength to meet the need of Americans in the many HPSAs with no NHSC placements.

Title VII, §747 Primary Care Training & Enhancement (PCTE)
Title VII, Section 747 of the *Public Health Service Act*, as administered by HRSA, strengthens medical education for physicians to improve the quantity, quality, distribution, and diversity of the primary care workforce. An Annals of Family Medicine study[xxiv] projects that the changing needs of the U.S. population will require an additional 33,000 practicing primary care physicians by 2035. Another study[xxv] noted that meeting the increased demand for primary care physicians requires the expansion of the PCTE program. The AAFP was grateful to the House for providing $39 million for the PCTE program in the FY 2018 appropriation package. AAFP also strongly supports the introduction by Dr. Michael Burgess and Congresswoman Jan Schakowsky of the *Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness Act of 2017* (HR 3728, EMPOWER Act) to reauthorize this important program.

Conclusion
Given their role in supporting high quality, low cost primary care access for those who need it, we urge the committee to support long term reauthorization and to provide full funding to help ensure these programs meet country's essential health care needs.

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