AMERICAN ACADEMY OF FAMILY PHYSICIANS

October 14, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 133,500 family physicians and medical students across the country, I am writing to share the family physician's perspective as the committee considers investing in Graduate Medical Education (GME) and adding residency slots in upcoming legislation.

The AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. It is projected that the U.S. will face a shortage of up to 48,000 primary care physicians by 2034.[1] We also know most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.[2] As a result, the current distribution of trainees leads to physician shortages in medically underserved and rural areas.

The federal government spends nearly $16 billion on GME annually, but it does not assess how those funds are ultimately allocated or whether they are effectively addressing physician shortages.[3] We know the committee has previously engaged on this issue, and in 2020 CMS responded to then Chairman Grassley indicating that agency's authority is limited to making payment to hospitals for the costs of running approved GME residency programs. Without authority to collect and analyze data, policymakers cannot be strategic about producing the physician workforce that our nation needs.

The lack of a diverse physician workforce also has significant implications for public health. 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.[4,5] While primary care specialties fares better than other specialties in representation of racial and ethnic minorities in the workforce, the entire physician workforce lags significantly behind the racial and ethnic diversity of the U.S. population. Today, Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11 percent of physicians.[6,7]

Together, physician shortages, the lack of diversity, and the absence of GME funding transparency result in access barriers and health disparities for patients living in rural and underserved

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communities.[8] **To correct the shortage and maldistribution of physicians, and ultimately improve equitable access to high-quality care, any expansion of federal GME programs must be designed to meet the health care needs of our nation, not merely an expansion of our current system.**

We look forward to working with the committee to develop policy solutions that invest in the future of primary care, and ultimately improve the health of our entire nation. If you have any questions please contact Erica Cischke, Senior Manager, Legislative and Regulatory Affairs, at ecischke@aafp.org.

Sincerely,

Ada D. Stewart, MD

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians

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[1] The Complexities of Physician Supply and Demand: Projections from 2019 to 2034. Association of American Medical Colleges. June 2021. Available at: The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org)

[2] Fagan BE, Finnegan SC, Bazemore AW, Gibbons CB, Petterson SM. Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training - Graham Center Policy One-Pagers - American Family Physician. Washington DC: Robert Graham Center; 2013. https://www.aafp.org/afp/2013/1115/p704.html. Accessed October 8, 2021.

[3] Congressional Research Service. Federal support for graduate medical education: an overview. https://fas.org/sgp/crs/misc/R44376.pdf Published December 27, 2018. Accessed October 11, 2021.

[4] Cooper LA, Powe NR. Disparities in patient experiences, health care processes, and outcomes: the role of patient-provider racial, ethnic, and language concordance. The Commonwealth Fund. Accessed October 8, 2021.

[5] Poma PA. Race/ethnicity concordance between patients and physicians. J Natl Med Assoc. 2017;109(1):6-8.

[6] https://www.census.gov/quickfacts/fact/table/US/PST045219

[7] https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018

[8] Garcia MC, Rossen LM, Bastia B, et al. Potentially excess deaths from the five leading causes of death in metropolitan and nonmetropolitan counties—United States, 2010–2017. (2019) MMWR 68(10): 1–11.