AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

June 2, 2023

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

The Honorable Bill Cassidy, MD
Ranking Member
Committee on Health, Education Labor and Pensions
United States Senate
Washington, D.C. 20510

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of the American Academy of Family Physicians (AAFP) and the 129,600 family physicians and medical students we represent, I write to express our appreciation for the Committee's continued interest in health care workforce issues.

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. Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes.[1] Studies have shown that more than 127,000 deaths could be averted through an increase in the number of primary care physicians.[2] Despite the significant role that primary care plays in our health system, primary care only accounts for a mere 5-7 percent of total health care spending [3] and it is projected that we will face a shortage of up to 48,000 primary care physicians by 2034.[4]

Earlier this year, we provided detailed policy recommendations in response to the Committee's request for information on the health care workforce. As you work to identify bipartisan legislative solutions, the AAFP continues to encourage the Committee to consider the following policy recommendations to strengthen and sustain our primary care workforce.

Strengthen and Target Federal Graduation Medical Education Programs

We 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.[5] As a result, the current distribution of trainees leads to physician shortages in medically underserved and rural areas.

Today's 72 Teaching Health Centers (THCs) play a vital role in training the next generation of primary care physicians and addressing the physician shortage. To date, the Teaching Health Center GME (THCGME) program has trained more than 1,730 primary care physicians and dentists, 63 percent of whom are family physicians. The THCGME program's authorization expires in FY 2024, and we strongly caution against a short-term extension since it does not provide the needed stability for current and future residents. In fact, flat funding of the program would mean a 40-50 percent reduction in per resident allocation for THC programs, putting them at risk of closure. **Congress should permanently authorize and expand the THCGME program or at a minimum, reauthorize the program for three years to provide needed stability.**

Additionally, additional action is needed to address disparate access to care in rural and other medically underserved areas. Merely expanding the existing Medicare GME system will not fix the shortage and maldistribution of physicians. **Any expansion of Medicare GME slots should be targeted specifically toward hospitals and programs in areas and specialties of need,** including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas.

One barrier to creating a more equitable and effective Medicare GME program is the lack of transparency in how funds are used. Medicare is the largest single payer, spending about $16 billion annually on GME, but it does not assess how those funds are ultimately used or whether they actually address physician shortages.[6] CMS has indicated their authority is limited to making payment to hospitals for the costs of running approved GME residency programs. **Congress should pass legislation granting the Secretary of HHS and the CMS Administrator the authority to collect, analyze data on how Medicare GME positions are aligned with national workforce needs, and publish an annual report.**

Diversify the Physician Workforce

The lack of a diverse physician workforce has significant implications for public health. Physicians who understand their patients' languages and understand 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. Several 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.[7,8] However, Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11 percent of physicians.[9,10]

We urge the reintroduction and passage of the Strengthening America's Health Care Readiness Act, which increases investment in the National Health Service Corps and, notably, allocates 40 percent of the funding for racial and ethnic minorities and students from low-income urban and rural areas. The **AAFP also supports federal programs, such as Title VII workforce training programs that are crucial in increasing underrepresented minority participation in the health professions.** Unfortunately, sustainable federal funding for pathway programs has not been consistent over the years. Congress should invest in efforts to diversify the health care workforce to improve access to health care, reduce spending, and better meet the needs of our increasingly diverse population.

Address the Burden of Medical Student Debt

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.[11] Research has shown that loan forgiveness or repayment programs directly influence physician practice choice. The rising level of educational debt disproportionately affects underrepresented and low-income students and limits their representation in the health workforce. Reducing student debt will diversify the physician pipeline and help reduce physician shortages. Congress should expand funding for federal programs, including the National Health Service Corps Program, that incentivize physicians to go into primary care practice by providing loan forgiveness. **The Academy also urges the passage of the Resident Education Deferred Interest (REDI) Act (S. 704) to allow medical residents to defer their student loans interest free during residency, and we recommend that the interest on medical student loans be deductible on federal tax returns.**

Strengthen and Sustain our Health Care Safety Net

Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), 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.[12] 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.[13] **We urge Congress to increase investment in 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.**

Support Physician-Led Team-Based Care

Physician-led team-based care is the most efficient for patients. A July 2018 survey found that more than four out of five patients prefer a physician-led health care team. Nine out of ten respondents said that a physician's additional years of education and training are vital to optimal patient care, especially for complex or emergency conditions. There have been efforts to expand the scope of practice for non-physicians to address workforce shortages. However, they have not solved the access problem - research shows that since 2004, the number of nurse practitioners entering primary care has dropped by 40 percent.[14,15]

The AAFP recognizes non-physician providers (NPP), such as nurse practitioners and pharmacists, as an integral part of physician-led health care teams. However, NPPs cannot substitute for physicians especially when it comes to diagnosing complex medical conditions, developing comprehensive treatment plans, ensuring that procedures are properly performed, and managing highly involved and complicated patient cases. **The AAFP opposes federal efforts to inappropriately expand NPP and pharmacist scope of practice that undermine physician-led care teams, potentially lead to fragmented care, and worse quality of care.**

Thank you in advance for consideration of our recommendations. The AAFP looks forward to working with the committee to develop and implement bipartisan, bicameral policies to strengthen and sustain our nation's health care workforce during the 118th Congress. Should you have any questions, please contact David Tully, Vice President of Government Relations at dtully@aafp.org and Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Sterling N Ransone, Jr MD FAAFP

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

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