

**Statement**  
**of the**  
**American Medical Association**  
**to the**  
**Committee on Finance**  
**United States Senate**

**RE: Workforce Issues in Health Care Reform: Assessing the Present and Preparing  
for the Future**

**March 12, 2009**

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to submit a statement on our nation's health care workforce needs. We hope our comments provide you with further guidance on legislative mechanisms needed to address the looming health care workforce shortages. We commend Chairman Baucus, Ranking Member Grassley, and Members of the Committee on Finance for recognizing that the health care workforce is a vital component to health care reform and access to care.

Workforce experts predict that a growing and aging population, advances in medicine that lead to longer life, an aging physician workforce, and universal coverage will significantly impact supply of and demand for physician services in the U.S. There is agreement from many sources that the U.S. faces a physician shortage. A 2005 Council on Graduate Medical Education (COGME) report projected that by 2020, the shortage of physicians will reach 85,000. In November 2008, the Association of American Medical Colleges (AAMC) estimated a shortage of at least 124,000 physicians by 2025 across all specialties. It is critical that Congress, working with the physician community and others in the health care industry, take immediate action to address the future physician workforce needs of the nation, particularly in specialties that face shortages and in underserved areas.

Graduate Medical Education

The current expansion of medical schools and growth in medical student enrollments will not address the physician shortage unless the number of U.S. graduate medical residency slots are increased as well. Only by increasing the number of physicians in residency training will the number of practicing physicians in the workforce grow. A growing and aging patient population will directly benefit from an increase in the number of practicing physicians. Therefore, fully funding graduate medical education (GME) positions and

lifting the cap on Medicare-supported GME slots are essential steps to ensure that we have a fully trained health care workforce to serve the future needs of patients.

The Balanced Budget Act (BBA) of 1997 capped the number of medical residents each teaching hospital could claim for reimbursement under Medicare. Medicare does not generally reimburse teaching hospitals for training residents if the number exceeds the capped number of residency slots. COGME recommends removing the current cap on residency slots and increasing the number of funded slots by 15 percent. Additionally, a peer-reviewed study published in the *Journal of the American Medical Association* (JAMA) in 2008 projects an additional 21,000 residency spots will be necessary within the next decade. A 2008 Institute of Medicine (IOM) report calls for the reduction in duty hour shifts for resident physicians in order to enhance patient safety. Expanding the number of GME positions would also help cover the shorter shifts if the IOM recommendations are adopted.

The AMA also recommends lifting the cap on Medicare-funded residency slots for undersupplied specialties and underserved areas, and fully funding GME by preserving Medicare and Medicaid funding of GME and investigating additional sources of GME funding. In addition, we recommend allowing greater flexibility in GME and other programs to encourage training in non-hospital settings while enhancing the quality of training for resident physicians. Finally, we recommend bringing together a variety of local, regional, and national stakeholders including representatives from state medical schools, academic health centers, teaching hospitals, physician specialty societies, public health, and policy leaders to determine and make recommendations on geographic and specialty distribution physician workforce needs and how meeting these needs should be funded.

#### Title VII Health Profession and Diversity Programs and the National Health Service Corps

Through low interest loans, loan guarantees, loan repayment programs, and scholarships to students, as well as grants and contracts to academic institutions and non-profit organizations, Title VII of the Public Health Service Act is an essential component of the nation's health care safety net. Title VII programs help increase the supply of primary medical care and preventive medicine specialists and help ensure that health care professionals are trained to provide quality care, represent the diverse makeup of the general population, and are available to communities across the country, particularly those in underserved areas. The Title VII primary care cluster is the only federal funding dedicated specifically to the education and training of the primary care workforce. Data indicates that Title VII funded programs have increased the family physician workforce in rural and low income communities.

While the diversity of the population of physicians-in-training and in practice is far from optimal, Title VII programs have helped to increase the diversity of the workforce. They include vital health professions programs such as Centers of Excellence, Scholarships for Disadvantaged Students, Health Careers Opportunity Program, and Faculty Loan

Repayment Program/Minority Faculty Fellowship Program that provide both policy leadership and support for health professions workforce enhancement and educational infrastructure development. Increasing funding for Title VII programs would improve the geographic distribution, quality, and diversity of the health professions workforce. Area Health Education Centers and Regional Centers for Workforce Analysis are necessary to improve the supply, distribution, diversity, and quality of the health care workforce, ultimately increasing access to health care in medically underserved areas.

Congress last reauthorized these Title VII programs in 1998. Since then, many of the Title VII health professions and diversity programs have faced significant cuts. The AMA was pleased that H.R. 1, the “American Recovery and Reinvestment Act of 2009,” (P.L. 111-5) included needed health professions funding that could be allocated toward Title VII health profession and diversity programs. Reauthorizing and fully funding these programs are crucial to developing a well-prepared, well-distributed, and diverse health care workforce.

The National Health Service Corps (NHSC) is also vital to addressing the health care needs of our nation. The NHSC recruits and retains primary care physicians (i.e., general internal medicine, general psychiatry, general pediatrics, OBGYNs, etc.) and other health care providers (i.e., nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, and dental hygienists) in underserved rural areas by providing incentives through loan forgiveness programs and scholarships. The NHSC improves access to health care for underserved areas, provides incentives for practitioners to enter primary care, reduces the financial burden that the cost of health professions education places on new practitioners, and helps ensure access to health professions education for students from all backgrounds. Since its creation, the NHSC consistently has received significantly more applications for positions than it is able to support with the funding provided by Congress.

However, in the past five years funding for the NHSC has been cut by over \$47 million, a 27 percent reduction from the \$171 million in FY 2003 that was already insufficient to meet the nation’s health care needs. As a result, the NHSC reduced the number of new annual scholarship and loan repayment awards by over 30 percent during that period. While H.R. 1 provides funding for the NHSC over the next 2 years, the NHSC estimates it will only result in an additional 4,250 NHSC practitioners.

The AMA recommends restoring full funding for Title VII health profession and diversity programs and increasing funding for the NHSC program. For FY 2010, the AMA recommends a combined appropriation of \$235 million for the NHSC. This figure represents the amount authorized under the “Health Care Safety Net Act of 2008” (P.L. 110-355) for NHSC Recruitment (\$156,235,150), with a proportionate increase in the NHSC Field appropriation.

## International Medical Graduates

Many communities, including rural and low-income urban areas, have problems attracting physicians to meet their health care needs. To address these unmet needs, many of these communities have turned to international medical graduates. A program that is essential for addressing physician shortages in underserved areas is the J-1 Visa waiver program, which allows international medical graduates to remain in the U.S. after their residency if they have agreed to practice in a medically underserved location for at least 3 years, working specifically in H-1B Temporary Worker status. The AMA supports permanent reauthorization of the Conrad State 30 J-1 Visa Waiver Program; a program authorizing state health agencies to place physicians annually in either federally designated Health Professional Shortage Areas or Medically Underserved Areas where it is difficult to recruit physicians. The AMA also recommends increasing the number of Conrad 30 program slots and exempting from immigration caps physicians with H-1B visas who have completed their J-1 visa waiver service requirements.

## Medical Student Debt

With an average debt for medical student graduates of \$155,000, debt plays a major role in medical students' career decisions, as well as discouraging individuals from socioeconomically-disadvantaged backgrounds from applying to medical school. High medical student debt is a significant hardship throughout the loan repayment period, especially during the three to seven years of training in medical residency programs. The average first-year stipend for medical residents is low, and makes it difficult for residents to train in urban areas where the cost of living is high. The high debt burden that many medical graduates face often influences their career choices. Borrowers with high loan debt are often deterred from entering public health service, practicing medicine in underserved areas, starting a career in medical education or research, or practicing primary care medicine. Loan deferment and forgiveness programs are necessary for ensuring that health care professionals represent the diverse makeup of the general population, and are available to communities across the country, particularly those in underserved areas.

In order to alleviate high medical student debt burdens, the AMA recommends creating more opportunities for debt relief through tuition assistance and loan forgiveness for service programs, low interest rates for medical student loans, income tax exemptions for medical student scholarships, inclusion of dependent costs in the "cost of attendance" definition to permit trainees to claim dependent costs in loan eligibility calculations, and expansion of loan forgiveness programs to medical teaching faculty. Loan forgiveness should especially be considered for primary care and other specialties with critical shortages. Additionally, the AMA strongly supports reestablishing the "20/220 pathway" for economic hardship loan deferment. The elimination of the economic hardship deferment, also known as "the 20/220 pathway," which expires on June 30, 2009, requires new medical residents to choose between making required monthly payments under the newly created income-based repayment program or deferring under forbearance, which dramatically increases their repayment costs. Reinstating the 20/220

pathway would allow medical residents to better manage their high debt burden and focus on their medical training and development during the critical and challenging years of residency.

### Medicare Physician Payment System Reform

We need to find ways to keep practicing physicians caring for seniors and encourage the best and brightest students to become physicians; permanent Medicare physician payment reform will help us achieve that goal. As a result of the flawed Medicare physician payment formula, known as the sustainable growth rate, or SGR, physicians face cumulative cuts of over 40 percent in the coming decade, including a 21 percent cut scheduled for January 1, 2010. Physicians cannot absorb these steep losses, especially when physician practice costs are expected to increase by at least 20 percent at the same time that rates are being cut. In addition, these cuts affect physician workforce issues. As discussed above, the COGME and AAMC are already predicting severe physician shortages across all specialties by 2020 and 2025, respectively. Other studies forecast shortages in a number of specialties, including primary care, cardiology, emergency medicine, general surgery, geriatric medicine, oncology, neurosurgery, and thoracic surgery. Multi-year cuts in Medicare are nearly certain to exacerbate these shortages by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older.

### Conclusion

The AMA appreciates the leadership of the Committee and remains committed to working closely with you on further developing legislation in order to ensure that the nation has an adequate, fully trained, accessible health care workforce to meet the needs of our growing and aging population. Addressing the current and future physician workforce needs of the nation is a critical component of health care reform. Fully funding GME and increasing GME positions, particularly in specialties that face shortages and in underserved areas, bringing together a variety of health care experts to assess and make recommendations on our physician workforce needs and how meeting these needs should be funded, increasing funding for the Title VII health profession and diversity programs and the NHSC, alleviating high medical student debt burdens, and reforming the Medicare physician payment system will help to ensure that every American has access to physicians and high-quality health care in the coming years.