Statement

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

Submitted for the Record to the Senate Committee on Finance

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The Association of American Medical Colleges (AAMC) welcomes the opportunity to submit this statement for the record in junction with the March 12, 2009 Senate Finance Committee hearing "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future." The AAMC applauds the Committee for conducting this hearing and for identifying the physician workforce as an essential component of the national dialogue on health care reform.

The AAMC is a not-for-profit association representing all 130 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

A more effective health system will require a wide range of health professionals, other care givers and ancillary staff. They will need to be well-educated, able to work together in teams, distributed across the nation and all its communities, and focused on the needs of each patient. The AAMC and its member institutions—who deliver approximately one fifth of all clinical care in this country—are committed to helping design and implement an improved delivery system and to educating and training the workforce necessary to assure access to high quality care. We are prepared to work with Congress, the federal government, other health professions and the education community in this effort.

Medical schools educate recipients of MD degrees, while teaching hospitals both train and provide a dynamic learning environment for future physicians and almost all other health professionals (e.g., nurses, physical therapists, physician assistants, and other members of the health care team). Medical schools and teaching hospitals work in partnership to maintain a setting where the creation of new knowledge and treatments, cutting edge care, provider training, and care for the most vulnerable can all occur together. Congress recognized the value of supporting this environment when it created Medicare's Prospective Payment System by ensuring adequate patient care payments through the Indirect Medical Education (IME) adjustment.

The AAMC thanks the Committee for its long-standing recognition that IME payments are intended to cover the higher costs of patient care at teaching hospitals. As specified in House Ways and Means and Senate Finance Committee reports from March 1983, "This adjustment is provided in light of doubts… about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents … the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals."

Teaching hospitals and teaching physicians are a critical piece of the health care safety net. Health care reforms must include a redesign of the health care delivery and financing system, while preserving the greatest strengths of the current health care system, including its educational and training capacity.

The nation is facing a shortage of physicians, nurses and other health professionals that could endanger both access to and quality of care. The nation must adopt a multi-faceted strategy to assure access and quality including both health systems redesign and increasing the supply of health professionals.

I. The AAMC's Health Care Reform Principles

The AAMC and its members are committed to the following principles and believe that academic medicine must play a pivotal role in improving health and health care and in achieving positive changes in the health care system. We believe that, with a concerted national effort from both the private and public sectors, the goal of affordable, quality health care for all is achievable and sustainable within the next decade. The AAMC's reform principles are available at: http://www.aamc.org/newsroom/pressrel/2008/081028.htm. In summary they state that:

- Health care coverage that is affordable, transportable, and continuous, and that combines the best of public and private systems, should be available to all.
- The health care delivery system must be restructured to facilitate health promotion and disease prevention while providing high-quality, cost-effective diagnosis and treatment of illness as well as palliative care.
- Health care financing mechanisms should be sustainable, equitable, explicit, accountable, and promote efficiency and quality.
- Existing programs that serve defined populations should be maintained until superior alternatives can fully replace them.
- The supply of health care practitioners must be adequate and reflect the population and its health care needs.
- Any reconfiguration of the health care system should recognize and provide stable support for the costs inherent in health research, technology development, and the provision of necessary specialized services to the broader society.

II. Background on the Physician Workforce

Physicians are an essential component of an effective health system. Yet the nation faces a number of interrelated challenges to assuring access to physician services for all Americans. These workforce challenges have the potential to undercut the ability of the nation to effectively implement health reform. These include:

- An overall shortage of physicians that is particularly serious among historically underserved populations;
- Geographic maldistribution which will be exacerbated by the overall shortage;
- Specialty maldistribution which is also likely to be exacerbated by the overall shortage;
- A physician workforce that does not adequately reflect the racial and ethnic diversity of the U.S. population; and
- Heavy reliance on graduates of foreign medical schools.

Addressing these challenges will require a variety of policies and programs. Fortunately, the nation has a number of policy levers and programs that can help address these issues. However,

it is critical to understand which policies and programs are most effective in addressing each challenge. For example, the AAMC believes that the National Health Service Corps (NHSC), the Title VII health professions training programs, and physician payment policies are the best tools to address the geographic and specialty maldistribution problems while direct graduate medical education (GME) support through Medicare and Medicaid is most effective in helping assure an adequate overall supply of physicians.

In-depth analyses demonstrate that under all reasonable scenarios for the future, including expanded access and increased emphasis on primary care and prevention, the nation will face a significant shortage of physicians.

The AAMC has carefully analyzed the most current available data on the physician workforce and population trends and concluded that the nation is likely to face a major shortage of physicians in the future – including both primary care physicians and specialists. In fact, millions of Americans already face shortages. An estimated 64 million Americans live in a federally designated Health Professional Shortage Area (HPSA). Over the past six years studies by 23 states and 20 specialties have concluded that their state or specialty is likely to face a shortage. The nation's community health centers are reporting growing difficulties recruiting needed physicians. Hospitals and health systems have had to increase their efforts and investments to recruit and retain physicians.

Between 1980 and 2005, the nation's population grew by 70 million people—a 31 percent increase. By 2030, as baby boomers age, the number of Americans over age 65 will double from 35 million to 71 million. These changes will significantly increase the demand for physician services because patients 65 and older typically average six to seven physician visits per year, compared with two to four visits annually for those under age 65. While medical advances and enhanced prevention will enable Americans to live longer, healthier lives, these individuals also will require additional health services as they age. The aging of the nation will be mirrored by the aging of its physicians; over one-third of the current physician workforce is aged 55 or older and is likely to retire in the coming decade.

The AAMC recently updated its analysis of future supply and demand for physicians and concluded that under any set of plausible assumptions, the U.S. is likely to face a growing shortage of physicians. While physician supply is projected to increase slightly between now and 2025, demand is projected to rise at a far faster rate, potentially leading to a shortage of between 125,000 and 159,000 physicians by the same year. While most specialties will face shortages, we are particularly concerned with the potential impact of a shortage on the delivery of primary care. Primary care services are a critical component of an effective and efficient health care system. These shortages are expected to have a disproportionately negative effect on those populations that are already underserved; the Health Resources and Services Administration (HRSA) estimates that an additional 30,000 health practitioners are already needed to alleviate current health professional shortages.

An acute physician shortage will profoundly affect access to health care, including longer waits for appointments and the need to travel farther to see a physician. Shortages can also contribute to higher costs through increased use of emergency rooms and decreased use of preventive

services. In addition, physician shortages can reduce the quality of care if practitioners are overloaded or if individuals are forced to delay treatment.
Some researchers suggest that the overall supply is adequate and that the access problems we are experiencing today are caused by the geographic and specialty maldistribution as well as inefficiencies of the health care system. The AAMC recognizes that there is a maldistribution problem and that there are inefficiencies, but based on our analyses we have concluded that even if these problems were addressed the nation is still likely to face a shortage of physicians.

We are very concerned that documented variations in current physician distribution and utilization are occurring, but this does not obviate the need for additional physicians. There are also errors of omission, or underuse of services, and identifying and eliminating individual over-utilization is difficult and fraught with moral hazard. There is a growing literature and concern nationally with health care disparities, especially for racial and ethnic minorities and the economically disadvantaged. Study after study has concluded that lack of access to care has contributed significantly to these disparities. Health reform is likely to lead to a needed increase in use of health services, including physician services, to reduce disparities. It will take several years to identify preferred interventions and there is no guarantee that this will significantly reduce the use of services in the foreseeable future—more likely, it will shift the nature of services that are provided in an effort to improve health care outcomes.

In response to growing uncertainty regarding the adequacy of the physician supply, in 2004 the AAMC established its Center for Workforce Studies to gather and analyze data on the supply, demand and use of physicians. The Center is committed to providing the medical education community, the public, and policymakers with data on current and likely future physician workforce needs. In recent months, the Center has issued a number of documents including its 2008 report *The Complexities of Physician Supply and Demand: Projections Through 2025,* the *2008 Physician Specialty Databook*, and the compilation document *Recent Reports and Studies of Physician Shortages in the U.S.* These reports are available, along with additional information, at http://www.aamc.org/workforce.

III. Summary of Recommendations

1. The AAMC recommends a multi-faceted response to growing shortages to assure an adequate supply of physicians to support health care reform.

2. The AAMC supports efforts to shape the physician workforce through the use of incentives, such as payment policies, and programs like the NHSC and Title VII (which have a proven track record). The AAMC opposes the use of GME financing policies which have not proven effective for this purpose.

3. The AAMC strongly supports the development of the medical home, which – though not a cure-all for current fragmentation of the delivery system – offers a powerful potential model likely to improve patient care satisfaction and outcomes.

4. Access problems are most severe in rural and inner city communities with limited economic resources, the areas where we need physicians the most. The AAMC strongly

supports the NHSC which has proven to be the most effective program for addressing needs in underserved areas.

5. The AAMC strongly supports a robust, sustained investment in the Title VII health professions training programs, which help improve the diversity, distribution, and supply of the health professions workforce, with an emphasis on primary care and interdisciplinary training.

6. The AAMC continues to advocate for and promote efforts to increase the enrollment and graduation of racial and ethnic minorities from medical school; it is committed to promoting the education and training of medical education and health care leaders from racial and ethnic minorities.

IV. Recommendations

1. The AAMC recommends a multi-faceted response to growing shortages to assure an adequate supply of physicians to support health care reform

AAMC has recommended a multi-faceted response to help address the growing shortages of physicians including a modest increase in physician supply and improvements in health services delivery. Perhaps our most widely recognized recommendation for forestalling future shortages is our call for a 30 percent increase in medical school enrollment and a commensurate increase in GME positions to accommodate this growth. However, it is important to make clear that this is only one part of our recommended solution – a necessary part – but only one component. We also strongly support efforts to improve efficiency and productivity and to increase the development of health care teams and the use of non-physician clinicians. The AAMC's projections of future shortages estimate that two-thirds of the projected shortage would need to be made up by systems improvements and that the recommended 30 percent increase in medical school enrollment and GME would only address about one-third of the projected shortages.

The AAMC recommended a phased increase of 30 percent in medical school enrollment between 2002 and 2015 and a commensurate increase in GME. Over the past 20 years, the number of first-year enrollees in U.S. medical schools per 100,000 people has declined annually as the number of physicians entering medical school has remained constant while the population has grown. Consequently, the U.S. has been producing fewer doctors each year relative to our growing and aging population. As a result, the current system relies on physicians educated outside the country, some of whom are U.S. citizens, but most are foreign-born and immigrate to the U.S. to train and practice. Today, one in four residents-in-training and physicians practicing in the U.S. attended medical school abroad. In addition to concerns about self-sufficiency in the health professions, U.S. reliance on foreign physicians has been criticized for contributing to the global "brain-drain" of physicians from developing nations challenged by severe health professional shortages of their own.

It is important to note that we must act today to prevent tomorrow's shortages. It can take several years to add medical school capacity, as such efforts involve obtaining approvals and/or funding and adding infrastructure such as faculty and laboratories. Any increase in first-year

medical school enrollment will then require, at minimum, seven more years before the nation will see an increase in the size of the physician workforce. Medical students must complete four years of medical school before then entering residency training in their chosen specialty, which can take anywhere from three to seven years.

The AAMC projections of future supply estimate that the overall number of physicians will only increase by 8 percent between now and 2025 if current enrollment and retirement patterns remain the same; yet, the U.S. Census Bureau estimates that the U.S. population will grow by 20 percent during this same interval and demand is projected to increase 27 percent during this same interval due to the population growth and aging of the population. Assuming that GME can expand to accommodate the 30 percent increase in allopathic medical school enrollment, this would only result in an additional 7 percent increase in the overall physician workforce by 2025. In comparison, HRSA estimates the number of nurses was able to increase by 8 percent in a four year span between 2000 and 2004.

Because capacity-building and educating/training a physician may require a decade or more, the nation must invest in the growth of the physician workforce while it concurrently works to improve the delivery system and achieve a better balance between the health workforce and the needs of the population.

It is also important to note that increasing the number of physicians alone will not correct geographic maldistribution, lack of cultural competence in the provision of care, or health care disparities. The nation not only needs more doctors, it also needs a more racially and ethnically diverse workforce that is responsive to and capable of providing optimal care for an increasingly diverse population. Medical students from racial and ethnic minority groups are also more likely to practice in underserved communities and care for a disproportionate number of disadvantaged patients.

A comprehensive strategy must include the increased use of nurse practitioners, physician assistants, and other health professionals while improving efficiency and making better use of physicians' unique knowledge and skills. Health care delivery models also will need to be re-examined to ensure that teams of professionals can provide efficient, effective services that improve the health of populations.

2. **The AAMC supports efforts to shape the physician workforce through the use of incentives (such as payment policies) and programs like the NHSC and Title VII, which have a proven track record. The AAMC opposes the use of GME financing policies which have not proven effective for this purpose.**

An effective health care system requires an adequate supply of physicians in a wide array of specialties. There is extensive concern that the nation does not have an adequate supply in a number of core specialties including primary care specialties, geriatrics, general surgery, and psychiatry. There have been numerous calls for action to address shortages in these and other specialties. The AAMC agrees that action is needed to encourage a physician workforce to meet the priority health needs of the nation. The AAMC believes that there are a range of policies and programs that can be used in support of this goal; this includes payment policy, the NHSC and Title VII.

GME financing policies are not an effective tool to shape physician specialty distribution, especially if the problem to be addressed relates to specialty choice by medical students. Encouraging hospitals to add residency positions does not increase medical student interest in a specialty. Adding support for more training will not increase the overall supply; changes in payment policy that make a specialty more rewarding are likely to be far more effective, as is the availability of NHSC loan repayment awards.

Today, Medicare pays each teaching hospital a portion of a hospital-specific capitated, or "per resident," amount based on the hospital's "direct graduate medical education" (DGME) costs in FY 1984 or FY 1985. The base year per resident amount is updated annually by an inflation factor. Medicare's portion of the per resident amount is calculated based on the program's share of total hospital inpatient days.

Each hospital has two separate per resident amounts. Since 1993, each hospital receives slightly higher payments for residents training in primary care specialties and slightly lower amounts for residents in subspecialties. Primary care specialties include family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, and obstetrics/gynecology.

In addition, Medicare pays lower amounts for residents in subspecialties. After the period required for a resident's initial board certification in the first specialty in which the resident begins training (not to exceed a maximum of five years), Medicare pays only 50 percent of its share of the per resident amount. The 50 percent payment continues indefinitely, as long as the resident remains in an accredited program.

The maximum period of five years is extended for up to two years for training in a geriatric or preventive medicine residency or fellowship. For primary care "combined" residency programs, such as internal medicine/pediatrics, the Balanced Budget Act of 1997 (P.L. 105-33) defined the period of board eligibility to be the minimum number of years of formal training required to satisfy the initial board requirements of the longest program plus one year.

Medicare now imposes a limit on the number of residents it supports. The limit is based on the number of FTE residents in approved allopathic or osteopathic training programs, before application of the 50 percent weighting factor, that were reported on the hospital's most recent cost report period ending on or before December 31, 1996. Dental and podiatric residents are excluded from the residency limits. The Medicare program continues to make DGME payments for residents who graduated from U.S. and foreign schools of medicine, as long as they are in approved residency training programs.

Medicare's GME funding should not be used as an instrument to alter workforce specialty composition. Further, programs should be allowed greater flexibility in order to encourage training in non-hospital settings. Current regulations that prohibit that counting of educational time in outpatient settings must be changed and programs proven to increase the supply of primary care physicians (NHSC, Title VII) should be fully funded to address shortages of primary care physicians.

Peer-reviewed literature suggests that the specialty choice decision process is complex and that students make their decisions based on a variety of factors, including interest in the particular aspect of medicine, access to mentors and role-models in the field, ability to balance work and home life, and not just income potential and education debt (as many often characterize the decision). Medical education and training appear to have less impact on specialty choice than the practice environment for primary care. Previous attempts to alter specialty composition have failed when they relied on changes to Medicare's reimbursement to teaching hospitals that offset some of their GME costs. For instance, current Medicare GME payments for resident costs associated with sub-specialty training are one-half of reimbursement for physician trainees in their first residency; the exception to this policy is for geriatrics fellowships, which are reimbursed at the full rate. Yet, many training positions remain unfilled in geriatrics, and most physicians will go on to sub-specialize despite GME policies that favor primary care.

While the nation engages in discussions to address the long-term threats to the viability of Medicare and Medicaid, we must not de-stabilize the current system's ability to train a health care workforce that serves the needs of these and other patients.

3. **The AAMC strongly supports the development of the medical home concept, which – though not a cure-all for the currently fragmented delivery system – offers a powerful potential model likely to improve patient care satisfaction and outcomes.**

Many Americans feel "medically homeless" in a health care system that is difficult for patients to navigate when they need care or advice. Patients and providers alike are deeply dissatisfied with the current delivery system. New models of care delivery must be developed, focusing on patients and their problems while improving delivery and outcomes.

The medical home is a concept or model of care delivery that includes an ongoing relationship between a provider and patient, around-the-clock access to medical consultation, respect for the patient/family's cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services. Its functions are similar to those of effective primary care proposed several decades ago by the Institute of Medicine (IOM), the World Health Organization (WHO), and others. In fact, the term was originally coined in 1967 by the American Academy of Pediatrics (AAP), but the concept in its current form was formulated by the academy in a 1992 position paper as an "approach to providing comprehensive primary care."

Much evidence supporting the medical home model is extrapolated from the literature evaluating primary care, case management, and other approaches to improving care coordination and prevention. The limited evidence available from studies more closely examining the role of the medical home is encouraging. Further studies are needed to better define the core functions of the medical home, its optimal implementation, and how strategies might need to be adjusted for populations with different degrees of acute and chronic illness. Perhaps the greatest challenge will be the additional resources required to adopt medical homes before cost savings (if any) are realized.

The AAMC's call for an expansion of medical education and training in the U.S. will help ensure that physicians are available to care for a growing population of aging and chronically ill citizens. However, the Association and its members believe that physicians and other health care providers are only the first step to improving the health of communities and that patients must be able to access effective care for both prevention and treatment.

Despite the need for better information about optimal form and function, and the attendant challenges to implementation, the AAMC believes that the medical home model holds great promise for improving the health of populations and individuals.

In March 2008, the AAMC adopted a position statement endorsing the medical home model and committed to working with its member institutions to better understand how the medical home model can be adopted in academic and community settings. Moreover, the Association and its members look to these new models of care to train and educate physicians in a delivery system that improves patient satisfaction and outcomes while improving the value of health care. The AAMC's full statement is available at:
http://www.aamc.org/newsroom/pressrel/2008/medicalhome.pdf

Specifically, the AAMC recommends that:

- Every person should have access to a medical home – a person who serves as a trusted advisor and provider supported by a coordinated team – with whom they have a continuous relationship.
- The federal government must invest in the further research necessary to better understand how to measure the core functions of the medical home and to develop an evidence base for how the model is best implemented.
- Payment for the medical home model should appropriately recognize and reward health care providers for their contributions to prevention, patient care, and care coordination.

4. **Access problems are most severe in rural and inner city communities with limited economic resources, the areas where we need physicians the most. The AAMC strongly supports the NHSC which has proven to be the most effective program for addressing needs in underserved areas.**

The NHSC is widely recognized — in Washington and in the underserved areas it helps — as a success on many fronts. It improves access to health care for the growing numbers of underserved Americans, 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.

The NHSC provides scholarships to health professions students and loan repayment awards to practitioners in exchange for at least two years of service in a HPSA. NHSC awardees can apply for annual award continuations (or "amendments") for additional years of school or to pay down the remainder of their student loan debts. The NHSC also funds a State Loan Repayment

Program (SLRP), which involves a dollar-for-dollar match between the NHSC and the State, to provide loan repayment for practitioners to work in that State.

Designed to provide comprehensive health care that bridges geographic, financial, cultural and language barriers, the NHSC works to unite communities in need with caring health professionals, then supports those communities' efforts to build better systems of care. According to the NHSC Advisory Council, more than 78 percent of clinicians continue to practice within the community where they were placed beyond the term of service; 52 percent of the program's alumni have remained in their original communities of service for more than 15 years. Additional studies have indicated that NHSC awardees contribute positively to the long-term growth of the non-NHSC physician workforce in underserved communities, rather than providing temporary staffing that competed with and impeded the supply of other local physicians.

The high price tag of a medical education can pose a daunting figure to aspiring physicians and may influence their decisions as they shape their careers. In 2008, 87 percent of U.S. medical students graduated with a median indebtedness of $155,000. The NHSC provides financial incentives designed to recruit and retain primary care providers from all backgrounds into geographically underserved areas. However, this task is increasingly more difficult as the program operates under a thinly stretched operating budget.

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 needs. As a result, the NHSC has reduced the number of new annual scholarship and loan repayment awards by over 30 percent during that period (from 1,353 awards in FY 2003 to 943 in FY 2008). At that funding level, the NHSC was unable to award qualified scholar applicants, and 12 students were turned away for every 1 accepted. Similarly, there were 3 times as many practitioners in underserved areas seeking loan repayment than accepted applicants.

By its own calculation, the NHSC falls more than 30,000 short of a field strength that would begin to meet the needs of the nation's underserved areas. Currently, the NHSC estimates its total field strength at just over 3,500 practitioners. While the "American Recovery and Reinvestment Act of 2009" (P.L. 111-5) provides an important boost over the next two years, the NHSC estimates it will result in at most 4,250 additional NHSC practitioners. Furthermore, these additional practitioners will be lost in future years if the NHSC is unable to fund award continuations or maintain the same level of new annual awards.

As the nation faces serious health professions shortages, additional funding is necessary to increase new NHSC annual awards and the total NHSC field strength. The AAMC has joined a group of concerned NHSC stakeholder associations in recommending $235 million for the FY 2010 NHSC appropriations. 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. This recommendation is supported by the National Advisory Council on the NHSC March 2007 report *Priorities for Reauthorization and Legislative Updates*, which called for a doubling of the program.

As we enter a new political era, comprehensive health care reform will require careful consideration and time. However, the NHSC is a proven investment that we can make now. By building on the past success of the NHSC, we can address some of the key challenges facing America's health care system: provider distribution, access to care, medical education debt, diversity in medicine, and a dwindling health professions workforce.

5. **The AAMC strongly supports a robust, sustained investment in the Title VII health professions training programs, which help improve the diversity, distribution, and supply of the health professions workforce, with an emphasis on primary care and interdisciplinary training.**

Through loans, loan guarantees, and scholarships to students, and grants and contracts to academic institutions and nonprofit organizations, the Titles VII and VIII health professions programs under the Public Health Service Act support the education and training of the full range of health care providers, including physicians, dentists, pharmacists, nurses, psychologists, and public and allied health professionals. Designed to improve the supply, diversity, and distribution of the health care workforce, these programs pick up where traditional market forces leave off. For example, the Title VII diversity programs increase minority representation in the health professions by strengthening the pipeline to a health career. Similarly, the primary care medicine and dentistry programs expand the primary care workforce, while the interdisciplinary, community-based linkages programs facilitate training in rural and urban underserved areas.

Together with Title VIII nursing education programs, the health professions programs are a critical component of the health care safety net, training a diverse supply of health professionals who are more likely to serve in community health centers and other rural and urban underserved settings.

As a result of a 51.5 percent funding cut in FY 2006, many Title VII programs were forced to cease their activities. The AAMC thanks Congress for the increases for Title VII health professions programs in the recently enacted "American Recovery and Reinvestment Act" (ARRA, P.L. 111-5) and the FY 2009 Omnibus Appropriations Act (H.R. 1105). This funding will provide a much-needed boon to the health care workforce while improving the health of the country. We look forward to working with Congress to continue to reinvest in the programs, as funding levels for almost all Title VII programs remain below the comparable FY 2005 levels. For example, the component of Title VII tasked with the compilation and analysis of national health workforce needs and shortages – the Workforce Information and Analysis program – has received no appropriation since FY 2006.

The AAMC is grateful to President Obama for his support for the health professions programs throughout his tenure in the Senate and during the presidential campaign; we also eagerly anticipate details of the Administration's proposal for an investment that "Strengthens the Health Professions Workforce," as outlined in the FY 2010 Budget Overview document. As Congress and the new Administration work to improve health care access for an increasingly diverse nation, it will be essential to ensure that a diverse, well-trained health care provider workforce is in place to meet the additional demand. With its emphasis on diversity, primary care, and special

and underserved populations, continued and increased support for the Title VII programs is critical to any comprehensive federal health care workforce strategy.

Additionally, the AAMC supports the continuation and reauthorization of the Title VII programs with improvements to enhance the productivity and accountability of the programs. Recognizing that a new approach to the Title VII programs is needed to strengthen them and improve their prospects for long-term survival, the AAMC in September 2004 appointed a committee to review the missions and effectiveness of the programs and propose recommendations as Congress considers reauthorization. The AAMC Committee agreed that the programs' shared goals should continue to be enhancing primary care, bringing care to underserved areas, and improving the diversity of the health care workforce. The Committee also agreed that the reauthorization of the Title VII programs should improve accountability of the programs by creating outcomes measures and enhancing the collection and analysis of data to monitor the programs' impact.

A copy of the AAMC Committee's final report is available at: http://www.aamc.org/advocacy/library/laborhhs/t7reauth.pdf . The AAMC looks forward to working with your colleagues on the Senate Committees on Appropriations and Health, Education, Labor, and Pensions, to reinvest in and revitalize the Title VII programs.

Further, the AAMC expects to continue to collaborate with HRSA, which administers the NHSC and the Titles VII and VIII programs. We are optimistic that under the leadership of HRSA Administrator Mary Wakefield, Ph.D., R.N., FAAN, HRSA will again prioritize the nation's health resources programs, including the health professions programs. In particular, we hope that HRSA will bolster the agency's Bureau of Health Professions, which administers most Title VII programs.

6. **The AAMC continues to advocate for and promote efforts to increase the enrollment and graduation of racial and ethnic minorities from medical school; it is committed to promoting the education and training of medical education and health care leaders from racial and ethnic minorities.**

A more culturally and ethnically diverse society requires a more diverse and culturally competent health care workforce to address health disparities among racial, ethnic, and economic groups. The nation's teaching hospitals and physicians provide frontline care for the medically underserved – especially those who are uninsured or underinsured. Supporting the efforts of medical schools and teaching hospitals to mitigate health and health care disparities is fundamental to achieving better health for all.

Efforts to address health and health care disparities have coalesced around evidence that increasing diversity in the health professions workforce and improving cultural competence training for physicians will result in an increased quality of care for all. Studies repeatedly show that African American, Hispanic/Latino, and Native American physicians are more likely to practice in underserved communities and to care for a disproportionate number of disadvantaged patients. Additionally, a diverse physician workforce contributes to greater health care access for the underserved as studies have documented increased patient satisfaction in encounters with physicians from similar racial and ethnic backgrounds. Diverse environments help health

professionals acquire skills for treating people from a wide range of backgrounds and understanding of how culturally determined factors affect health, and cultural competence training across the medical education curriculum equips all physicians to provide optimal health care to patients from diverse backgrounds.

The AAMC maintains an unwavering commitment to expanding diversity in the physician workforce through outreach, pipeline programs, and holistic review in the admissions process. The federal government should renew its commitment to Title VII and other efforts to diversify the health care workforce and improve health status.

V. Conclusion

The issues surrounding the physician workforce and potential shortages are complex, particularly within the context of broad health care reform. As indicated by our reform principles, the AAMC and our member institutions believe that academic medicine must play a pivotal role in improving the health of our nation, as well as achieving positive changes in the health care system as a whole. This includes the development and implementation of policies to assure the production of an adequate supply of well-educated physicians who are prepared to meet the future health care needs of all Americans. We are committed to working closely with you, the Committee, the full Congress, and the Administration to achieve these goals.