AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement for the Record to the
House Energy and Commerce Committee,
Subcommittee on Health Hearing,
Investing in America's Health Care
June 4, 2019

On behalf of the American Academy of Family Physicians (AAFP) thank you for the opportunity to submit this Statement for the Record for the U.S. House Energy and Commerce Committee's Subcommittee on Health's hearing, *Investing in America's Health Care.*

The AAFP appreciates the Committee's interest in examining health care access and underserved communities. Consistent with the World Health Organization's definition, the AAFP believes that health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." As the largest society of primary care physicians, we are committed to helping patients achieve health and in supporting evidence-based initiatives that build healthy communities as well as through collaborative investments from citizens, community-based organizations, educational institutions, governments, and the private sector.

The Importance of Investing in Primary Care

The AAFP acknowledges that family physicians play an important role in community health, both as clinicians, but also as community partners who understand that factors outside of the doctor's office (the social determinants of health) impact patient health and the health of a community. Still, primary care (comprehensive, first contact, whole person, coordinated and 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. 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. This is true even after controlling for sociodemographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and tobacco use).[i]

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.[ii] High quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering per capita costs.[iii]

Patients, particularly the elderly, with a usual source of care are healthier and have lower medical costs because they use fewer health care resources and can resolve their health needs more efficiently.[iv] In contrast, those without a usual source of care have more problems

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accessing health care and more often do not receive appropriate medical help when it is necessary.[v] Patients with a usual source of care have fewer expensive emergency room visits, unnecessary tests and procedures. They also enjoy better care coordination.[vi] We believe it is in the national interest to support programs with the potential to help improve patient access for primary medical care, particularly for vulnerable populations.

Primary Care Workforce and Health Care Programs

The current physician shortage and uneven distribution of physicians impacts population health. 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.[vii] 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).[viii] 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.[ix] Therefore, it is imperative that primary care by a physician is accessible to all.

The current primary care physician shortage and maldistribution remain significant physician workforce challenges. An Annals of Family Medicine study projects that the changing needs of the U.S. population will require an additional 33,000 practicing primary care physicians by 2035.[x] A 2017 Government Accountability Office (GAO) report indicates that physician maldistribution significantly impacts rural communities.[xi] 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.[xii] According to the 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 has remained concentrated in the Northeast and in urban areas, which continue to house 99% of medical residents.[xiii] 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%.[xiv]

Current Reauthorization Priorities

Primary care workforce programs, such as the Teaching Health Center Graduate Medical Education Program and the National Health Service Corp Program, are essential resources to begin to increase the number of primary care physicians and to ensure they work in communities that need them most. The AAFP is urging Congress to act swiftly to reauthorize these programs.

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 evidence-based care coordination protocols.[xv] Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.[xvi] Residents who train in underserved communities are likely to continue practicing in those same environments.[xvii]

We appreciate the leadership of Representatives Raul Ruiz and Cathy McMorris Rodger' and their efforts to introduce ***Training the Next Generation of Primary Care Doctors Act of 2019 (*****HR 2815.** The legislation authorizes the THCGME program for over five years and supports the

creation of new programs with a priority for those in rural and underserved communities. The bills would also increase funding from $126.5 million per year (current law) to an average of $151 million/year.

The legislation not only reauthorizes the program; it provides enhanced funding and a pathway for increasing the number of residents trained. Most important, the legislation will continue to build the primary care physician pipeline necessary to reduce costs, improve patient care, and support underserved rural and urban communities. **This is an important and productive program; it must receive greater funding over a longer period in order to train residents in a sustainable fashion.. Congress should provide for the Teaching Health Center Graduate Medical Education (THCGME) program immediately to prevent a disruption in the pipeline of primary care physician production.** Given the importance of the THCGME program, permanent funding should be the ultimate outcome pursued by Congress as one part of an overall effort to assure an adequate primary care physician workforce.

American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.[xviii] By comparison, **fewer than 5% of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.[xix] 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.** Similarly, the National Health Service Corps (NHSC) offers 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). The NHSC is vital for supporting the needs of our nation's vulnerable communities. The AAFP believes building the primary care workforce is an important return on investment. We also believe that 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.

Community health centers (CHCs) play an important role in primary care graduate medical education as well. The nation's 9,800 CHCs provide care for 25 million patients, 71 percent of whom are low-income.[xx] CHC facilities, along with other safety net providers, are also valuable training settings for THCGME residents who care for patients like those they are likely to treat in primary care outpatient settings. Residents who train in CHCs also have the unique opportunity to be trained in delivery system models using electronic health records, providing culturally competent care, and following care coordination protocols.[xxi] Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.[xxii] Residents who train in underserved communities are likely to continue practicing in those same environments.[xxiii] An important, but unique element within the THCGME program is that its accountability measures require an evaluation of the number of physicians who continue practicing after residency and if they continue serving in rural and underserved communities.

Conclusion
The AAFP appreciates the opportunity to share these comments on health access and vulnerable communities and welcomes the opportunity to work with policy makers to achieve positive outcomes on these and other policies. For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@aafp.org.

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