May 15, 2025

The Honorable Scott Fitzgerald
Chairman
Subcommittee on Administrative State
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

The Honorable Jerry Nadler
Ranking Member
Subcommittee on Administrative State
Committee on the Judiciary
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Dear Chairman Fitzgerald, Ranking Member Nadler, and Members of the Subcommittee:

My name is Jeffrey A. Singer. I am a Senior Fellow in Health Policy Studies at the Cato Institute. I am also a medical doctor specializing in general surgery and have been practicing that specialty in Phoenix, Arizona, for over 40 years. The Cato Institute is a 501(c)(3) non-partisan, non-profit, tax-exempt educational foundation dedicated to the principles of individual liberty, limited government, free markets, and peace. Cato scholars conduct independent research on a wide range of policy issues. To maintain its independence, the Cato Institute accepts no government funding. Cato receives approximately 80 percent of its funding through tax-deductible contributions from individuals. The remainder of its support comes from foundations, corporations, and the sale of books and other publications. The Cato Institute does not take positions on legislation.

I appreciate the opportunity to share with the subcommittee my thoughts on how the monopoly over accrediting medical postgraduate training programs (residency programs), granted by state licensing boards and supported by the Centers for Medicare and Medicaid Services (CMS), creates a bottleneck in residency positions. This bottleneck affects the production of new licensed physicians and limits patients' access to care.

States will only grant medical school graduates a license to practice medicine if they complete at least one year of an accredited postgraduate education (residency). States recognize one US-based independent third-party residency accrediting organization, the Accreditation Council on Graduate Medical Education (ACGME).[1] States permit physicians to treat patients provided they have attended an ACGME-accredited program.[2] However, in recent years, most states have also permitted physicians who have attended residency programs

accredited by the Royal College of Physicians and Surgeons of Canada to treat patients.[3] The Centers for Medicare and Medicaid Services (CMS) only subsidizes residency programs that are ACGME-accredited.

Yet the number of medical school graduates exceeds the number of accredited postgraduate residency positions.[4] In 2025, 6.9 percent of medical school graduates could not find a residency position during the annual "Match Week" of the National Residency Matching Program (NRMP).[5]
Other countries with advanced health care systems do not require physicians to train in ACGME-accredited residencies to obtain a medical license. Various organizations accredit residency programs in countries such as Canada, the United Kingdom, Australia, New Zealand, the Republic of South Africa, Singapore, Ireland, Israel, and the European Union.[6]

In March 2024, the Association of American Medical Colleges released an updated report on physician supply and demand projections through 2036. The study used "multiple supply and demand scenarios" and was "updated with the latest information on trends in health care delivery and the state of the health care workforce, such as data on physician work hours and retirement trends."[7] The AAMC projects that, by 2036, there will be a shortage of up to 86,000 physicians, including 40,000 primary care physicians. The report found that, in 2021, 17 percent of active physicians were over age 65, with an additional 25 percent of the active workforce between age 55 and 64. The report concluded, "Therefore, it is very likely that more than a third of currently active physicians will retire within the next decade."[8]

A March 2023 study by the National Association of Community Health Centers found 30 percent of Americans lack a primary care physician.[9] A 2022 study of 15 major metropolitan areas by Merritt Hawkins for AMN Healthcare, a physician staffing company, found the average wait for a first-time appointment with a primary care physician was 26 days, the average wait for an Ob-Gyn appointment was 31.4 days, the average wait for a new cardiology appointment was 26.6 days, and the average wait for a new appointment with an orthopedist was 16.9 days.[10]

The Health Resources and Services Administration claims that, as of April 2025, more than 77 million people lived in what it designates as Health Professional Shortage Areas (HPSAs), with a shortage of 13, 382 primary care providers to meet the population's medical needs.[11]

Many experienced international medical graduates (IMGs)—doctors who received their training and are actively licensed and practicing in other countries—would like to come to the United States and provide health care services to Americans. They could reduce the growing health care access bottlenecks.

However, unlike Canada, Australia, the European Union countries, and many other developed countries, most states require such doctors to repeat their entire residency training in an accredited residency program in the US—even if they have been practicing for years in their home countries—and pass the standardized US Medical Licensing Exam (USMLE). Such demanding requirements cause many experienced physicians who can't get a spot in a residency program—or can't afford to repeat the education and training they already received—to find work in other fields.[12] This requirement to repeat an accredited residency program also increases the number of medical school graduates competing for residency positions at a time when there are already not enough positions available for every graduate.

I believe that states should broaden medical residency accreditor options to recognize other organizations that accredit residency programs, including those in several other developed countries when granting physicians medical licenses. CMS should stop subsidizing residency programs and end its preferential treatment of the ACGME. Implementing these changes will offer more accreditation options for health centers establishing residency programs, increase residency choices and positions for medical school graduates, and reduce the need for foreign physicians to repeat residency programs in the United States.

RESIDENCY PROGRAMS AND THEIR ACCREDITORS

In the 19th century and early 20th century, medical school graduates did not always choose specialty residency training programs as their sole postgraduate medical education option. Instead, many sought more practical experience by apprenticing with experienced physicians, working as "house physicians" under "hospital chief "physicians, or apprenticing with renowned physicians in other countries before starting independent practice. William Osler and William Halsted established the first formal residency programs in internal medicine and surgery, respectively, at Johns Hopkins University in 1889. These programs were the templates of modern postgraduate medical education.[13] As residency programs became more numerous and medical knowledge and technology became more sophisticated, innovative and entrepreneurial doctors developed medical specialties and specialty certification

boards. Specialty boards required medical graduates to obtain residency training, rendering alternative sources of postgraduate education obsolete.[14]

In 1914, the American Medical Association (AMA) Council on Medical Education established standards for evaluating postgraduate hospital-based training programs. In 1920, the organization became the Council on Medical Education and Hospitals. It produced its first list of approved hospital-based residency programs. The Council on Medical Education and Hospitals partnered with the Association of American Medical Colleges (AAMC) to create the Liaison Committee on Medical Education (LCME) to accredit medical schools in 1942. The National Student Internship Committee partnered with the AAMC to establish the National Residency Matching Program (NRMP) in 1951, which to this day uses mathematical algorithms to annually assign medical school graduates to accredited residency programs based on their mutual preference hierarchies. In 1972, the AAMC and the AMA created the Liaison Committee on Graduate Medical Education (LCGME) to accredit residency programs in place of the Council on Medical Education and Hospitals. In 1981, the American Board of Medical Specialties, American Hospital Association, AMA, AAMC, and the Council on Medical Specialty Societies formed the Accreditation Council for Graduate Medical Education (ACGME) to accredit residency programs in the United States. In 2020, the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) merged their residency accreditation program with the ACGME, resulting in a unified system to accredit residency programs in the United States.[15] State licensing boards require medical school graduates to complete at least one year of ACGME-accredited postgraduate training before permitting them to practice medicine.[16] As mentioned above, in recent years, most states have also begun granting licenses to medical school graduates who have trained in Canadian-accredited postgraduate programs.

UNNECESSARY CMS SUBSIDIES STIFLE INNOVATION IN ACCREDITING

CMS pays hospitals to help cover their direct costs (e.g., resident salaries) and indirect costs (e.g., additional tests and time required to teach residents) of operating a residency program. CMS conditions the subsidy on the ACGME accrediting the program.[17] This removes incentives from postgraduate educational organizations to develop alternative accreditation schemes.

It is also an unnecessary expenditure of taxpayer dollars. Chandra and colleagues argue in the New England Journal of Medicine that taxpayer financing of the direct

costs of graduate medical education does little to offset physician training costs and that "residents pay the full costs of their training, while the DME [direct medical education] program simply transfers money to recipient hospitals."[18] During their training, residents accept lower wages while generating considerable hospital revenues that exceed their compensation. Studies indicate that if residents were allowed to bill for their procedures, they could earn a substantial portion of their wages.[19] Research by economists Maria J. Perez-Villdóniga and colleagues led them to conclude that "the overall contribution of resident physicians to hospitals' overall production allows considering them as an input in most cases"[20]

Researchers at the University of Massachusetts Medical School postulated that eliminating residency programs would be cost-saving if CMS funding were necessary to defray the hospital's costs of maintaining residency programs. Yet they noted that many hospitals had to hire hospitalist physicians and nurse practitioners (NPs) who work fewer hours for higher wages than residents when the ACGME imposed an 80-hour-per-week cap on resident work hours in 2003. This increased patient care costs. They concluded that replacing residents "one-for-one with NPs is not financially viable."[21]

Dr. Brian Carmody points out that residents allow attending physicians to manage and bill for services to more patients more efficiently. By sharing the workload with critical care physicians, residents allow hospitals to accommodate more acute care patients. He also claims that "having a residency program can give the institution access to a steady stream of junior (i.e., lower-paid) attendings without paying for third-party recruiters and expensive national searches."[22]

The aftermath of the 1997 Balanced Budget Act (BBA), in which Congress capped the number of residency positions that CMS subsidizes at 1996 levels, provides more evidence that taxpayer subsidies are unnecessary to sustain graduate medical education. Chandra and colleagues demonstrated that "there was a hiatus in the growth in positions immediately after the BBA was passed, but growth rates returned to pre-BBA levels within five years." They further concluded, "The evidence is consistent with the view that residents bear the costs of their own training, which would mean that GME funds are treated as general monies going to their institutions; in fact, these funds are often used in ways that are difficult to trace, assess, and justify."[23] NRMP data on the growth in first-year residency positions (PGY-1) during the same time period also support this conclusion.

NOT ALL INTERNATIONAL RESIDENCY ACCREDITATION ORGANIZATIONS ARE HOMEGROWN

In 2009, Singapore's Ministry of Health invited the ACGME to develop a pilot program as an alternative to Singapore's postgraduate medical education accreditation system. Seeking a clear separation between domestic and international accreditation, ACGME founded ACGME International (AGME-I), a limited liability corporation (LLC) subsidiary of ACGME.[24] By 2010, ACGME-I accredited 19 programs in three Singaporean health institutions. In 2023, these programs transitioned from ACGME-I accreditation to the Accreditation of Postgraduate Medical Education Singapore system, which the health ministry oversees. The pilot program's success attracted requests for accreditation services from other countries. The earliest requests came from Qatar and the United Arab Emirates. Today, ACGME-I accredits more than 150 postgraduate medical education programs in 12 countries, including Kenya, Vietnam, Lebanon, Jordan, and Guatemala.[25] However, in the US, state licensing boards will grant licenses to applicants who completed their residencies at ACGME-accredited programs, but not ACGME-I programs.

THE ACCREDITOR MONOPOLY CREATES PHYSICIAN SUPPLY BOTTLENECKS

The "one best way" that characterizes granting monopoly status to the ACGME creates physician supply bottlenecks by rejecting alternative strategies and criteria for establishing and evaluating residency program curricula.

For example, in 2014, the AOA, AACOM, and ACGME agreed to merge, with ACGME becoming the sole accreditor effective in 2020. During the five-year transition period beginning in 2015, all AOA-accredited programs were required to apply for ACGME accreditation and to meet ACGME standards. These standards are generally more rigorous concerning faculty qualifications, scholarly activity, and institutional resources.

Several smaller or more rural osteopathic programs found it challenging to meet these requirements, particularly in areas such as:

- Faculty research expectations
- Resident scholarly activity
- Faculty-to-resident ratios
- Institutional financial support

Some programs chose not to seek ACGME accreditation, while others applied but failed to make the transition. Consequently, this led to the closure or restructuring of certain programs.

One study found that, out of 252 AOA accredited family medicine residency programs in 2014, only 131 applied for ACGME accreditation by June 2020. Nine programs later withdrew from the transition process, resulting in 122 programs achieving ACGME accreditation.[26] Another study found that only 47 percent of AOA-accredited ophthalmology residency programs and 62 percent of AOA-accredited otolaryngology programs gained ACGME accreditation by 2020.[27] The researchers concluded, "Doctors of Osteopathic Medicine (DOs) actively participate in serving underserved communities, and the loss of AOA surgical specialty programs may decrease access to surgical care in rural and nonmetropolitan areas."

The merger also resulted in a loss of 41 osteopathic surgical residency programs, including programs in orthopedic surgery.[28]

ACGME standards require dedicated roles such as associate program directors with at least 40% protected time and program coordinators dedicating a minimum of 50% effort. Additionally, faculty are expected to engage in scholarly activities and participate in committees like Clinical Competency Committees and Program Evaluation Committees, which demand significant time and resources. These requirements were more demanding than those of the AOA and posed challenges for programs with limited resources.[29]

ACGME programs often require a higher minimum number of residents than AOA programs. This poses difficulties for smaller programs.[30]

The Federation of State Medical Boards (FSMB) maintains records of closed residency programs, including those previously accredited by the AOA.[31]

The ACGME's rigid accreditation criteria are not the sole measure of quality in residency training. But by granting the ACGME a monopoly, states have stifled innovation and eliminated meaningful alternatives in accreditation**.**

For example, independent medical specialty credentialing organizations, such as the American Board of Internal Medicine, the American Academy of Family Physicians, and the American Board of Surgery, can develop criteria for evaluating and accrediting residency programs in their specialties. Higher education graduate/postgraduate certification organizations can use their expertise to expand into certifying postgraduate medical education programs.

Finally, just as other countries recognize accreditors from outside their own nation, such as ACGME-I, state licensing boards could also acknowledge accreditors from countries other than Canada.

POLICY RECOMMENDATIONS

State medical boards should end the monopoly status they grant the ACGME by accepting licensure applications from physicians who complete postgraduate training through other credible accrediting bodies. These could include international accreditation organizations from countries with advanced health care systems, recognized higher education accreditors, specialty boards, and medical societies with established standards for postgraduate training.

CMS should stop funding graduate medical education. Federal subsidies are unnecessary and distort the residency accreditation market by linking funding to approval from specific accrediting bodies.

Thank you once again for allowing me to share my thoughts with the subcommittee.

Respectfully submitted,

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[1] https://www.acgme.org
[2] https://www.fsmb.org/step-3/state-licensure/
[3] https://www.ama-assn.org/education/international-medical-education/state-licensure-board-requirements-international-medical
[4] Patrick Boyle, "Medical School Enrollments Grow, but Residency Slots Haven't Kept Pace," AAMCNews, Association of American Medical Colleges, September 3, 2020. See also https://www.cato.org/briefing-paper/expand-access-primary-care-remove-barriers-assistant-physicians
[5] https://www.ama-assn.org/medical-students/preparing-residency/biggest-match-day-ever-here-s-what-2025-numbers-reveal

[6] https://www.royalcollege.ca/en/accreditation-pgme-programs.html; https://www.gmc-uk.org/education/how-we-quality-assure-medical-education-and-training/approving-medical-education-and-training and https://global.hee.nhs.uk/ipgmts/#:~:text=the%20partner%20Government.-,IPGMTS%20programmes%20can%20be%20in%20any%20of%20the%2065%20specialties,systems%20for%20each%20training%20programme ; https://cpmec.org.au/postgraduate-medical-councils/; https://www.hpcsa.co.za/?contentId=0&menuSubId=5&actionName=Core%20Operations; https://www.ima.org.il/eng/ViewContent.aspx?CategoryId=4602; https://www.healthprofessionals.gov.sg/smc; https://postgraduatemedicaltraining.ie/fellowship-opportunities/; https://www.uems.eu/areas-of-expertise/postgraduate-training/european-standards-in-medical-training

[7] https://www.aamc.org/media/75236/download?attachment

[8] https://www.aamc.org/media/75236/download?attachment pages vi, vii.

[9] https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf

[10] https://www.wsha.org/wp-content/uploads/mha2022waittimesurveyfinal.pdf

[11] https://data.hrsa.gov/topics/health-workforce/shortage-areas

[12] https://www.detroitnews.com/story/opinion/2020/07/15/opinion-solve-physician-shortage-licensing-foreign-doctors/5438210002/ also https://journals.law.harvard.edu/jlpp/wp-content/uploads/sites/90/2019/02/Larkin-Final.pdf , https://www.cato.org/blog/more-states-move-let-experienced-foreign-doctors-serve-their-patients. and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954136/

[13] https://www.michiganmedicine.org/news-release/doctors-house-history-medical-interns-and-residents-u-m-hospitals#:~:text=At%20Johns%20Hopkins%20University%2C%20William,founded%20a%20few%20years%20before. Also https://www.ama-assn.org/education/improve-gme/history-residency-and-what-lies-ahead **;** https://www.hopkinsmedicine.org/surgery/about/history ; and https://www.facs.org/media/2tfpbi0n/14_halsted.pdf

[14] https://www.ama-assn.org/education/improve-gme/history-residency-and-what-lies-ahead

[15] https://medicine.hsc.wvu.edu/media/2616/historygmeaccreditationunited-states.pdf . Also https://www.cato.org/sites/cato.org/files/2023-04/BP152_update.pdf page 2; https://www.acgme.org/about/overview/ ; https://www.acgme.org/about/transition-to-a-single-gme-accreditation-system-history/

[16] https://www.fsmb.org/step-3/state-licensure/

[17] https://crsreports.congress.gov/product/pdf/IF/IF10960#:~:text=Medicare%20GME%20payments%20cover%20Medicare's,physician%20salaries%2C%20and%20administrative%20costs.

[18] https://www.nejm.org/doi/full/10.1056/NEJMp1402468

[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7308777/

[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8882103/

[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5559250/

[22] https://thesheriffofsodium.com/2022/02/04/how-much-are-resident-physicians-worth/

[23] https://www.nejm.org/doi/full/10.1056/NEJMp1402468

[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6697280/

[25] https://www.acgme-i.org/about-us/history/ see also https://www.acgme-i.org/about-us/where-we-are/

[26] https://journals.stfm.org/familymedicine/2022/february/fugazzi-2020-0281/

[27] https://www.degruyterbrill.com/document/doi/10.1515/jom-2021-0088/html

[28] https://www.sciencedirect.com/science/article/abs/pii/S1931720421000490; see also https://www.sciencedirect.com/science/article/abs/pii/S1931720421000490

[29] https://pmc.ncbi.nlm.nih.gov/articles/PMC7723134/

[30] https://pubmed.ncbi.nlm.nih.gov/28657554/

[31] https://www.fsmb.org/closed-programs/cplist/