



Statement

**Submitted for the Record to the
Committee on Health, Education, Labor and Pensions (HELP)
U.S. Senate**

**Roundtable Discussion on
“How Can We Improve Health Workforce
Diversity and Address Shortages?
A Conversation with Historically Black College and University
Leaders and Students”**

By

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**Morehouse School of Medicine
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The AAMC appreciates the opportunity to participate in the Roundtable on Historically Black Colleges and Universities (HBCU) medical schools and health care workforce diversity, held at Morehouse School of Medicine, one of our member institutions.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

The need for a more diverse health workforce is clear, and the need for Black physicians cannot be underestimated. A recent study found that Black people live longer in places with more Black doctors.¹ Looking at primary care physician supply and population health at the county level, greater Black representation among physicians was associated with higher life expectancy for Black individuals, and inversely associated with all-cause Black mortality and mortality rate disparities between Black and White individuals. We know physician workforce diversity is in the best interest of the health of people everywhere. We all should work on policies and partnerships that move towards this goal.

The Flexner Report

In 1910, Abraham Flexner published what would be known as the Flexner Report,¹ which held as its thesis “that the country needs fewer and better doctors.” While the stated intention was to normalize medical education for the majority of physicians and there were significant problems in medical education, the actual result was that the Flexner Report was weaponized to severely limit opportunities for Black Americans pursuing medical education and as a result, deepened health inequities for Black Americans for decades. When Flexner traversed the country in 1909 and visited 155 medical schools, he advocated for the closing of almost 80 percent of all the contemporary programs in what he labeled as, “medical sects” including chiropractic, osteopathy, homeopathy, and physical therapy programs. Flexner included professional requirements that brought about the closure of many medical schools, and the report was particularly harmful to the existence of Black medical schools. Unfortunately, institutions in the Midwest and the South bore the brunt of these closures, and the largely underserved and rural communities in those locations were left with even fewer local medical resources.

Flexner pushed to close for-profit medical schools, which had filled the need to educate Black people for medical training. During the time of the report, white institutions would not admit Black students to train as physicians or treat Black patients. In 1910, there were seven medical

¹ Snyder, John E.; Upton, Rachel D.; Hassett, Thomas C.; Lee, Hyunjung; Nouri, Zakia; & Michael Dill. 2023. Black representation in the primary care physician workforce and its association with population life expectancy and mortality rates in the US. *JAMA Network Open*. 2023; 6(4):e236687. DOI:[10.1001/jamanetworkopen.2023.6687](https://doi.org/10.1001/jamanetworkopen.2023.6687).

schools that filled this unmet need and admitted Black students who then became physicians. I list them in this testimony to honor their contributions to society, which were truncated or scaled back following the Flexner Report

1. Howard University Medical School (est. 1868, remains in existence today)
2. Meharry Medical College (est. 1876, remains in existence today)
3. Leonard Medical School / Shaw University (est. 1882, closed in 1915)
4. New Orleans University Medical College (est. 1887, closed 1911)
5. Knoxville Medical College (est. 1895, closed 1910)
6. Chattanooga National Medical College (est. 1902, closed 1908)
7. University of West Tennessee College of Physicians and Surgeons (est. 1904, closed 1923)

Key Statistics and Factors Demonstrating the Need for Change

The lack of sufficient physicians and insufficient diversity in the physician population continues to affect the health of the population today amid a complex and multifactorial landscape of challenges.

1. The US will face a projected physician shortage of up to 124,000 physicians by 2034.

The AAMC continues to project that physician demand will grow faster than supply (primarily driven by a growing, aging U.S. population) leading to a projected total physician shortage of up to 124,000 physicians by 2034. Within this total, we project a shortage of up to 48,000 primary care physicians and a shortage of up to 77,100 non-primary care specialty physicians (e.g., psychiatry, infectious disease, and general surgery) by 2034. These shortages build on existing measured shortages of behavioral health and primary care providers. Moreover, the AAMC’s “Health Care Utilization Equity” scenario finds that if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the U.S. would need up to an additional 180,400 physicians just to meet *current* demand.² Make no mistake – these shortages in the physician supply have real impact on patients, particularly those living in rural and other underserved communities.

2. The number of HBCU medical schools has not rebounded since the Flexner Report.

Today, there are four HBCU medical schools: Howard University College of Medicine, Meharry Medical College, Morehouse School of Medicine, and most recently, the Charles S. Drew College of Medicine. These institutions comprise less than 3% of all MD-degree granting institutions, but are responsible for producing more than 50% of all Black medical graduates. They also train other racial and ethnic groups who become physicians. We are looking forward to Xavier University of Louisiana and Ochsner Health opening a College of Medicine. We also acknowledge that Morgan State University in Baltimore will open a college of osteopathic medicine in 2023. Collectively, the HBCU medical schools have the potential to train more physicians, including underrepresented physicians, but those institutions must be supported to execute their important mission.

3. Black male physician totals have remained relatively stagnant over 40 years. In 1978, there were 1,140 Black male applicants to medical schools across the country, with

² [The Complexities of Physician Supply and Demand: Projections From 2019 to 2034](#), Prepared for the AAMC by IHS Markit Ltd., June 2021.

542 Black male matriculants in that same year. In 2014, the number of Black male applicants stayed relatively the same – 1,137 – but resulted in 515 Black male matriculants for 2014. In essence, for more than 30 years, the number of Black male applicants and matriculants at institutions across the country were stable or on the decline. This was the sounding of an important alarm, and groups like the AAMC have leaned into this problem to come up with solutions. Through the Action Collaborative for Black Men in Medicine, a joint effort between the AAMC and the National Medical Association, and through one core facet of the AAMC’s recently adopted strategic plan, Action Plan 4: Increase Significantly the Number of Diverse Medical School Applicants and Matriculants,³ we are starting to see improvement in these areas.⁴ Programs that have demonstrated impact on exposing historically excluded racial and ethnic groups to careers in medicine and that support the pathway to becoming a physician must be funded and replicated.

4. A United States Supreme Court decision not allowing race as one factor to consider in medical school admissions would be detrimental to addressing physician diversity. Longitudinal studies in states that have bans on race-conscious admissions demonstrate significant decreases in the number of underrepresented minority medical school matriculants. Should the Supreme Court’s opinion result in greater restriction or prohibition of race-conscious admissions, it is foreseeable that similar decreases in diversity will be experienced nationwide, ultimately reducing the overall diversity of the physician workforce. **In that scenario, it will be even more important for Congress to support programs, noted below, that are designed to increase the diversity of our nation’s healthcare workforce.**

Legislative Priorities and Policies to Increase Health Care Workforce Diversity There are programs that will have a positive impact on health care workforce diversity and the training of more diverse physicians. We urge the enactment of legislation and the funding of programs to ensure the success of these efforts that will deliver meaningful results.

1. Expanding the Workforce and Graduate Medical Education. The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act of 2023 (S. 1302 / H.R. 2389) which would gradually add 14,000 new Medicare-supported GME positions over seven years. These positions would be strategically targeted at a wide variety of teaching hospitals, including those affiliated with HBCU medical schools, helping to strengthen and diversify the health care workforce and improve access to care for patients, families, and communities across the country. AAMC strongly supports the expansion of Medicare support for GME and urges the inclusion of additional GME positions in any health care legislation.

GME programs administered by the Health Resources and Services Administration (HRSA), including Children’s Hospitals GME and Teaching Health Centers, are important

³ For more information on the Action Collaborative, please visit [Action Collaborative for Black Men in Medicine | AAMC](#). The AAMC Action Plan 4 updates can be accessed at [Action Plan 4: Increase Significantly the Number of Diverse Medical School Applicants and Matriculants | AAMC](#).

⁴ In 2020, there were 1,457 Black male applicants to medical school and 2020 Black male matriculants. In 2021, there were 1,895 Black male applicants to medical school and 813 Black men matriculants. These represent some of the highest totals since the data has been collected. For additional data, please visit <https://www.aamc.org/data-reports/students-residents/interactive-data/2021-facts-applicants-and-matriculants-data>

complements to Medicare GME that help to increase the number of residents training in children's hospitals and community health centers, respectively. Funding for HRSA programs specifically targeting GME at children's hospitals and teaching health centers will help alleviate physician workforce shortages in those settings.

2. Investing in HRSA Title VII and Title VIII Workforce Programs and the National Health Service Corps. The AAMC supports doubling funding for a broad range of HRSA's Title VII & VIII workforce development and diversity pathway programs to help shape the workforce to meet patient needs, including:

- Centers of Excellence (COE), student support and minority health training programs at health professions institutions;
- Health Careers Opportunity Program (HCOP), K-16 diversity pathway programs;
- Scholarships for Disadvantaged Students (SDS), scholarships for minority and/or disadvantaged health professions students; and
- Faculty Loan Repayment (FLRP), loan repayment program for minority health professions faculty to serve as mentors.

The HRSA Title VII diversity programs are smaller today than they were two decades ago (\$115 million in 2002, compared to \$106 million for 2023). The AAMC calls on Congress to adequately fund these programs in order to address the imperative to improve our commitment to diversity.

Many medical schools aim to identify potential candidates from rural and under-resourced communities and encourage them to pursue a career in medicine.^{5 6} Additional Title VII programs support these and other efforts to help address gaps in the workforce. For example:

- HRSA Title VII Area Health Education Centers (AHECs) specifically focus on recruiting and training future physicians in rural areas, as well as providing interdisciplinary health care delivery sites; and
- HRSA Title VII Primary Care Training and Enhancement (PCTE) and Medical Student Education (MSE) programs support education and training programs for future primary care physicians.

The AAMC urges Congress to provide at least \$1.51 billion combined for all Title VII and Title VIII programs in the FY 2024 spending bill. Additionally, the AAMC looks forward to working with the HELP Committee and the full Congress to reauthorize these programs before they expire at the end of fiscal year 2025.

Additionally, the National Health Service Corps (NHSC) in particular has played a significant role in recruiting primary care physicians to federally designated Health Professions Shortage Areas (HPSAs) through scholarships and loan repayment options. Despite the NHSC's success, it still falls far short of fulfilling the wide-ranging health care needs of all HPSAs due to growing demand for health professionals across the country.

⁵ [Attracting the next generation of physicians to rural medicine](#), Peter Jaret, Special to AAMCNews, Feb. 2020.

⁶ To facilitate new rural residency programs, the HRSA Office of Rural Health Policy provides technical assistance and start-up funding to rural hospitals under the Rural Residency Planning and Development programs.

Supporting Title VII, Title VIII, and the NHSC not only would help address pervasive gaps in the health workforce, it also would encourage a whole health care, team-based approach to health care so the entire system can be fortified.

3. Expanding Medical Schools at Minority Servicing Institutions, Historically Black Colleges and Universities, and in Underserved Communities. The AAMC encourages increasing federal investment in minority serving institutions (MSIs), including Historically Black Colleges and Universities (HBCUs), Predominantly Black Institutions (PBIs), Hispanic Serving Institutions, and Tribal Colleges and Universities. The AAMC supports the Expanding Medical Education Act, which would authorize HRSA grants to establish or expand medical schools, including regional branch campuses, and would prioritize HBCUs, MSIs or those institutions that propose to establish or expand schools in medically underserved communities or areas with shortages of health professionals where no such schools exist.

4. Reducing or eliminating financial obstacles to medical education. Medical education costs can be a significant deterrent for individuals interested in medicine and can impact the physician pathway.⁷ The “Pathway to Practice” proposal and National Medical Corps Act scholarship programs introduced in the 117th Congress (H.R. 9105) would help address the high financial debt for students who are underrepresented in medicine. Importantly, the Pathway to Practice program would prioritize applicants who attended HBCUs or MSIs, as well as those who participated in certain HRSA pathway programs.

Public service loan repayment programs offered by HRSA, the National Institutes of Health, Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are effective, targeted incentives for recruiting physicians and other health professionals to serve specific marginalized populations. Increasing federal investment in these programs is a proven way to increase the supply of health professionals serving HPSAs, nonprofit facilities, and other underserved communities.

In addition, continued access to income-driven student loan repayment plans and the Public Service Loan Forgiveness (PSLF) Program ensure payments commensurate with salary and foster engagement in critical public service careers. The PSLF program is an essential tool for nonprofit and government facilities to recruit and retain first-generation and underrepresented students to medical schools, encouraging physicians to practice at nonprofit facilities, and incentivizing physicians to become our next generation of medical researchers.

5. Addressing learner and physician burnout. The AAMC is grateful to Congress for enacting the Dr. Lorna Breen Health Care Provider Protection Act (LBA, P.L. 117-105) in 2022, to support initiatives to address the mental health and well-being of aspiring and practicing health professionals. Demand for such funding far outpaces the limited resources that HRSA has been able to provide for such programming, and the AAMC urges lawmakers to fully fund the LBA in FY 2024.

⁷ [Physician Education Debt and the Cost to Attend Medical School: 2020 Update.](#)

6. Supporting immigration programs that continue to bring physicians and other health professionals to underserved areas. Immigration must be mentioned as we consider health workforce shortages. The U.S. health workforce has been bolstered by individuals who have come from other countries to our nation. Over the last 15 years, the State Conrad 30 J-1 visa waiver program has brought more than 15,000 physicians to underserved areas — comparable to (if not more than) the NHSC, at no cost to the federal government. Bipartisan legislation that would allow Conrad 30 to expand beyond 30 waivers per state would be useful, as well as recognizing immigrating physicians as a critical element of our nation’s health care infrastructure. In addition, the U.S. should address the backlog of green card applications by lifting per country caps that are impeding physicians and other healthcare professionals entering the U.S. from certain countries. To break these backlogs, the bipartisan Healthcare Workforce Resilience Act would authorize the recapture of unused immigrant visas and redirect them to 25,000 immigrant visas for professional nurses and 15,000 immigrant visas for physicians. These visas would be issued in order of priority date, not subject to the per country caps, and premium processing would be applied to qualifying petitions and applications.

Next Steps for Action and Change

The responsibility of increasing diversity in health care, especially among physicians, does not rest solely on the government. We offer here a few suggestions for many stakeholders interested in increasing physician diversity.

1. Support innovative approaches and public-private partnerships for medical education and residency training. Addressing the nation’s physician workforce shortages in both primary care and among needed specialists requires a multipronged, innovative, public-private approach beyond just increasing the overall number of physicians, such as implementing team-based care and better use of technology. While we believe that increasing federal support for GME is an important component to any comprehensive workforce strategy, we are open to, and in fact ask for, these and other innovative solutions to address health workforce shortages.

2. Support the role of HBCUs, minority serving institutions (MSIs), and all other institutions to train a diverse workforce. We must support the important role of HBCUs – undergraduate schools, medical schools, and other allied health schools – in producing the future generation of Black scholars with the funding and infrastructure to have innovative and expanded physical facilities, excellent faculty to teach the latest medical techniques and to conduct groundbreaking, NIH-funded research, and to remain a trusted resource situated in their local communities. We should not overlook the importance of other minority serving institutions, which have been noted as an underutilized resource that is available to help create a diverse STEM workforce.⁸ Tribal colleges and universities should receive additional federal support and be brought into conversations about training future physicians and others in the health care workforce. Hispanic-serving institutions are yet another group of

⁸ National Academies of Sciences, Engineering, and Medicine 2019. *Minority Serving Institutions: America’s Underutilized Resource for Strengthening the STEM Workforce*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25257>.

institutions that are able to help meet the diverse physician goals we describe above. When thinking about diversifying the workforce, an inclusive approach must be pursued.

While recognizing the strong influence of HBCUs and MSIs in producing a diverse workforce, there is an important role for all other institutions in contributing to the diversification of the health care workforce as well. Instead, all institutions should be supported in their efforts to develop and to execute a plan to help increase workforce diversity, understanding that diversity will take on many different forms.

Conclusion

We at the AAMC are committed to working with the entire Senate HELP Committee to move the nation forward in efforts to diversify the physician and health care workforce and to ultimately to achieve better outcomes for our nation. If you have any further questions, please contact AAMC Chief Public Policy Officer Danielle Turnipseed, at dturnipseed@aamc.org.