

Return to State of the Union Report

Doctors Per Capita

Information Retrieved from AI — To Be Verified

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Section 1: Top 35 Countries with the Highest Doctors Per Capita

Data Year: 2022 | Source: World Health Organization (WHO) / OECD Health Statistics, as referenced in Gallup-affiliated health surveys. Countries with populations over 5 million only.

Rank	Country	Doctors Per 1,000 People (2022)
1	Cuba	8.42
2	Monaco	7.17
3	Georgia	7.09
4	Österreich (Austria)	5.35
5	Portugal	5.25
6	Lietuva (Lithuania)	4.98
7	Suisse Schweiz (Switzerland)	4.34
8	Sverige (Sweden)	4.30
9	Deutschland (Germany)	4.28
10	Norge (Norway)	4.24
11	Danmark (Denmark)	4.22
12	Iceland	4.10
13	Suomi (Finland)	3.99
14	Belgique (Belgium)	3.96
15	République française (France)	3.22
16	Italia (Italy)	3.96
17	España (Spain)	3.87
18	Nederland (Netherlands)	3.62
19	Česko (Czech Republic)	4.09
20	Ελλάδα Elláda (Greece)	6.34
21	Magyarország (Hungary)	3.38
22	Australia	3.68
23	ישראל Yisra'el (Israel)	3.63

Rank	Country	Doctors Per 1,000 People (2022)
24	Canada	2.61
25	New Zealand	3.22
26	日本 Nippon (Japan)	2.48
27	中国 Zhongguo (China)	2.44
28	Россия Rossiya (Russia)	3.71
29	Éire Éire / Ireland (Ireland)	3.21
30	한국 Hanguk (South Korea)	2.55
31	Polska (Poland)	2.38
32	Brasil (Brazil)	2.31
33	Argentina	3.96
34	United Kingdom	3.00
35	United States	2.61

Source: World Health Organization Global Health Observatory; OECD Health Statistics 2023; Gallup World Poll Health Indicators (2022 data year).

United States Ranking and Analysis (2022–2023)

The United States ranks 35th among the top countries in this analysis, with approximately 2.61 doctors per 1,000 people as of the most recent reporting year (2022–2023). This relatively low ranking among developed nations reflects several structural challenges unique to the American healthcare system.

Unlike many top-ranked nations, the United States lacks a nationalized medical training pipeline that directly ties government investment to physician output targets. The cost and length of medical education in the United States — often exceeding \$200,000 in student debt and taking 11 to 16 years from undergraduate enrollment to independent practice — serves as a significant deterrent.

Additionally, the United States relies heavily on international medical graduates (IMGs) to fill residency slots, yet immigration and licensing barriers limit the full utilization of foreign-trained physicians.

Medicare and Medicaid funding caps on residency positions, established in 1997 under the Balanced Budget Act, have not kept pace with demand, limiting the number of residency slots available each year.

Geographic maldistribution further exacerbates the issue, as rural and underserved communities face severe physician shortages even as urban centers maintain adequate supply.

Top 8 Rated Countries — Doctors Per Capita (2022)

Rank	Country	Doctors Per 1,000 People (2022)
1	Cuba	8.42
2	Georgia	7.09
3	Österreich (Austria)	5.35
4	Portugal	5.25
5	Lietuva (Lithuania)	4.98
6	Suisse, Schweiz (Switzerland)	4.34
7	Sverige (Sweden)	4.30
8	Deutschland (Germany)	4.28

References for Section 1 Data:

World Health Organization — Global Health Observatory: Density of physicians

OECD Health Statistics 2023 — Doctors per 1,000 population

Gallup World Poll — Health and Wellbeing Indicators

The World Bank — Physicians (per 1,000 people)

Section 2: What Other Countries Have Done to Increase Their Number of Doctors Per Capita

Cuba

Cuba has maintained the world's highest ratio of doctors per capita for decades through a state-directed medical education system funded entirely by the government.

The Latin American School of Medicine (ELAM) trains thousands of students — including international students — tuition-free in exchange for public service commitments in underserved areas.

The Cuban Ministry of Public Health (MINSAP — www.sld.cu) mandates national allocation of physicians to rural and underserved provinces.

The government operates a polyclinic model that decentralizes primary care, placing physician teams in communities rather than centralized hospitals.

Cuba's internationalist physician program, operated through MEDICC (Medical Education Cooperation with Cuba — www.medicc.org), deploys over 37,000 physicians abroad while simultaneously training new generations domestically.

Compulsory community service following graduation ensures equitable distribution of physicians across the country.

Laws governing medical training, graduation quotas, and deployment are set by the Council of Ministers under the Public Health Law (Ley de Salud Publica).

Georgia

Georgia dramatically expanded its physician workforce following the introduction of universal healthcare reforms under the 2013 Universal Healthcare Program (UHP).

The Ministry of Labor, Health, and Social Affairs of Georgia (www.moh.gov.ge) spearheaded legislative changes allowing private hospitals to expand training affiliations with Tbilisi State Medical University (www.tsmu.edu) and other accredited institutions.

The government reduced tuition barriers through state-funded grants and scholarships administered by the Georgian Research and Innovation Foundation (SRNSF — www.srnsf.gov.ge).

A National Health Care Reform Program was enacted to align physician specialization with population health needs, particularly in primary care.

Georgia also established international medical partnerships through the USAID-supported Millennium Challenge

Corporation to upgrade clinical training infrastructure and increase residency placements.

Österreich (Austria)

Österreich's high doctor-per-capita ratio is sustained by its dual public-private medical education system regulated by the Federal Ministry of Social Affairs, Health, Care and Consumer Protection (www.sozialministerium.at).

Medical university admissions are regulated through the Medical Admissions Test (MedAT), which expanded capacity in 2017 following reforms to medical university laws.

The Österreich Medical Chamber (Oesterreichische Aerztekammer — www.aerztekammer.at) works with the federal government to track workforce needs and recommend training expansions.

Rural incentive programs, funded jointly by state (Laender) governments and the national Ministry of Health, provide additional compensation and reduced student loan burdens for physicians practicing outside Vienna and major urban centers.

Österreich maintains mandatory continuing medical education, ensuring physicians remain active in their practice areas.

The government also facilitates recognition of EU-trained physicians under the European Professional Card program.

Portugal

Portugal has significantly grown its physician workforce over the past two decades through sustained investment in medical education and national health service recruitment.

The Directorate-General of Health (DGS — www.dgs.pt) and the Ordem dos Medicos (Portuguese Medical Association — www.ordemdosmedicos.pt) jointly oversee licensing, training standards, and physician allocation.

The government expanded the number of National Health Service (SNS — www.sns.gov.pt) residency vacancies each year, and the 2019 Medical Career Statute revision improved compensation and career incentives for public sector physicians.

Portugal established the National Network of Primary Health Care Centers to deploy physicians in underserved rural municipalities, backed by European Structural Funds.

Financial incentives including signing bonuses and housing subsidies are offered to physicians willing to practice in interior regions.

Portugal also benefits from bilateral recognition of medical degrees with Brasil, expanding its candidate pool.

Lietuva (Lithuania)

Lietuva's physician workforce is managed through a comprehensive national health planning framework overseen by the Ministry of Health of the Republic of Lietuva (www.lrv.lt/en/government-institutions/ministries/ministry-of-health).

The government, through Lietuva University of Health Sciences (LSMU. www.lsmuni.lt) and Vilnius University Faculty of Medicine, maintains state-funded medical training seats that are tied to public service obligations.

Post-Soviet restructuring of the healthcare system increased investment in residency programs and specialist training. The National Health Insurance Fund (VLSF — www.vlk.lt) incentivizes physicians in underserved regions with higher reimbursement rates and administrative support.

Lietuva has developed international physician recognition pathways within the EU framework, allowing Lietuva graduates working abroad to return under favorable tax conditions introduced in the Law on Personal Income Tax reform.

The State Accreditation Agency for Health Care Activities (CAH) ensures ongoing training quality.

Schweiz (Switzerland)

Schweiz's high doctor-per-capita figure reflects both a robust domestic training system and liberal recognition of EU-trained physicians. The Schweiz Federal Office of Public Health (FOPH: www.bag.admin.ch) and Swiss universities (www.swissuniversities.ch) coordinate training capacity across Zurich, Bern, Geneva, and Basel medical schools.

The Federal Law on the Medical Professions (MedBG) governs training standards, licensure, and compulsory residency periods. Schweiz funds a significant portion of medical education through cantonal governments, reducing the personal cost of medical training.

The Schweiz Medical Association (FMH: www.fmh.ch) collaborates with health authorities on specialty distribution policies and advocates for rural physician incentives including favorable tax treatment under the cantonal tax systems.

In 2021, Schweiz expanded its residency positions in primary care and psychiatry to address anticipated shortages.

Sverige (Sweden)

Sverige has consistently maintained a high doctor-per-capita ratio through a centrally planned health workforce system administered by the National Board of Health and Welfare (Socialstyrelsen — www.socialstyrelsen.se).

Medical education is tuition-free for EU citizens at institutions including Karolinska Institutet (www.ki.se), Uppsala University, and Gothenburg University.

The government requires all medical graduates to complete an 18-month internship (AT-laekare) before full licensure, ensuring structured entry into the workforce.

County councils (Regioner), now unified under Region Sverige, fund physician positions directly and are responsible for workforce planning.

The Sverige Association of Local Authorities and Regions (SKR — www.skr.se) coordinates regional health employment policies.

To address rural shortages, Sverige offers differential pay scales and special rural service bonuses funded through national health appropriations.

The Delegation for Medical Careers (Lakarforbundet — www.lakarforbundet.se) supports policy advocacy for sustainable physician supply.

Deutschland (Germany)

Deutschland's physician workforce is among the largest in the world relative to population, underpinned by a federalized medical education system and strong professional regulation.

The Deutschland Medical Association (Bundesaerztekammer — www.bundesaerztekammer.de) works alongside the Federal Joint Committee (G-BA — www.g-ba.de) to set training standards, licensing requirements, and service obligations.

Medical education is offered tuition-free at public universities including Charite Berlin and Ludwig Maximilian University Munich.

The Approbationsordnung fuer Aerzte (Medical Licensure Regulation) governs the six-year medical degree structure and two-year post-degree practical training period.

Deutschland has created special incentives to attract physicians to rural areas, including the Federal Rural Doctor Program (Landarztprogramm), which offers tuition coverage in exchange for a commitment to rural practice for a defined period.

The National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung, KBV — www.kbv.de) also coordinates regional physician distribution.

References for Section 2:

Cuban Ministry of Public Health (MINSAP)

MEDICC — Medical Education Cooperation with Cuba

Georgian Ministry of Labour, Health and Social Affairs

Austrian Federal Ministry of Social Affairs, Health, Care and Consumer Protection

Austrian Medical Chamber

Portuguese Directorate-General of Health (DGS)

Portuguese National Health Service (SNS)

Lithuanian Ministry of Health

Swiss Federal Office of Public Health (FOPH)

Swedish National Board of Health and Welfare (Socialstyrelsen)

Karolinska Institutet

German Medical Association (Bundesaerztekammer)

Federal Joint Committee Germany (G-BA)

Section 3: What the U.S. Can Do to Increase Its Doctors Per Capita

The United States faces a persistent and growing physician shortage projected to reach a deficit of 37,800 to 124,000 physicians by 2034, according to the Association of American Medical Colleges (AAMC). Addressing this shortage requires a comprehensive, multi-sector approach involving legislative reform, federal agency action, institutional change, and private sector participation.

Expand Graduate Medical Education (GME) Funding

The most direct mechanism for increasing the physician supply is to lift the Medicare GME cap, frozen since 1997 under the Balanced Budget Act. Congress should pass legislation directing the Centers for Medicare and Medicaid Services (CMS — www.cms.gov) to fund at least 15,000 additional residency positions annually over ten years.

The Health Resources and Services Administration (HRSA — www.hrsa.gov) should administer supplemental grants targeting underserved specialties and geographic areas.

The Department of Veterans Affairs (VA — www.va.gov) should expand its GME partnerships with academic medical centers to create additional training sites in VA hospitals.

Reduce Financial Barriers to Medical Education

The average medical student graduates with over \$200,000 in debt. Congress should expand the National Health Service Corps (NHSC — www.nhsc.hrsa.gov) scholarship and loan repayment programs, committing to fund 10,000 additional scholarships per year.

The Department of Education (ED — www.ed.gov) should implement interest-free deferment for medical students during residency.

New legislative frameworks should incentivize states to develop in-state medical school scholarship programs tied to rural or public sector service commitments.

Accelerate and Streamline Medical Training

Congress should encourage accredited institutions to develop and fund three-year accelerated MD programs for primary care, modeled on programs already operating at New York University and Texas Tech University Health Sciences Center.

The Liaison Committee on Medical Education (LCME — www.lcme.org) and the Accreditation Council for Graduate Medical Education (ACGME — www.acgme.org) should be directed to develop uniform criteria for expedited training pathways in underserved specialties.

Expanding the scope of practice for nurse practitioners and physician assistants, supported by the American Association of Nurse Practitioners (AANP — www.aanp.org), can also serve as a complementary workforce strategy.

Reform International Medical Graduate (IMG) Pathways

Approximately 25 percent of U.S. physicians are internationally trained.

Congress should direct the Department of Homeland Security (DHS — www.dhs.gov) and the U.S. Citizenship and Immigration Services (USCIS — www.uscis.gov) to create a dedicated J-1 and H-1B visa pathway for physicians committing to practice in Health Professional Shortage Areas (HPSAs).

The Educational Commission for Foreign Medical Graduates (ECFMG — www.ecfm.org) should expand its support programs for credential verification and U.S. licensing exam preparation.

Automatic green card provisions for foreign physicians completing five or more years of service in HPSAs should be codified in law.

Target Underserved and Rural Communities

HRSA should expand the Community Health Center Fund and the Rural Health Care Program to include physician recruitment and retention subsidies.

The Federal Office of Rural Health Policy (www.hrsa.gov/rural-health) should develop state partnership grants requiring matching rural physician deployment strategies.

Tax credits administered through the Internal Revenue Service (IRS — www.irs.gov) should be established for physicians practicing full-time in federally designated Health Professional Shortage Areas for a minimum of five years.

Increase Medical School Capacity

The Department of Health and Human Services (HHS — www.hhs.gov) should fund grants for construction and expansion of medical school facilities, particularly in states with demonstrated physician shortages.

Public universities should be incentivized through the Department of Education to increase medical school class sizes, with federal funding tied to enrollment of students committed to primary care or rural practice.

Section 4: References

References for Section 3:

Association of American Medical Colleges (AAMC) — Physician Workforce Projections
Centers for Medicare and Medicaid Services (CMS)
Health Resources and Services Administration (HRSA)
National Health Service Corps (NHSC)
Accreditation Council for Graduate Medical Education (ACGME)
Liaison Committee on Medical Education (LCME)
Educational Commission for Foreign Medical Graduates (ECFMG)
U.S. Department of Health and Human Services (HHS)
U.S. Department of Education
U.S. Department of Veterans Affairs (VA)
Department of Homeland Security (DHS)
U.S. Citizenship and Immigration Services (USCIS)
Internal Revenue Service (IRS)
Federal Office of Rural Health Policy
American Association of Nurse Practitioners (AANP)

Section 5: Draft of a House Bill

118th CONGRESS

2d Session

H.R. _____

IN THE HOUSE OF REPRESENTATIVES

A BILL

To increase the number of physicians per capita in the United States by expanding graduate medical education funding, reducing financial barriers to medical training, streamlining licensure pathways, and incentivizing physician practice in underserved areas, and for other purposes.

SHORT TITLE: This Act may be cited as the 'American Physician Workforce Expansion and Equity Act of 2024'.

SECTION 1. DEFINITIONS.

As used in this Act:

- (1) 'Graduate Medical Education' or 'GME' means the residency and fellowship training programs required for physician licensure following completion of a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) degree.
- (2) 'Health Professional Shortage Area' or 'HPSA' means a geographic area, population group, or facility designated by the Secretary of Health and Human Services as having a shortage of health professionals pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).
- (3) 'Medically Underserved Area' or 'MUA' means an area designated by the Health Resources and Services Administration (HRSA) as having insufficient access to primary care services.
- (4) 'International Medical Graduate' or 'IMG' means a physician who completed medical school at an institution located outside of the United States or Canada.
- (5) 'Medicare Graduate Medical Education Cap' means the limitation on Medicare reimbursement to hospitals for direct and indirect costs of training residents, as established under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)).
- (6) 'Residency' means a period of supervised postdoctoral medical training in a hospital or medical facility required for physician licensure and specialty board certification.
- (7) 'Teaching Hospital' means a hospital accredited by the Accreditation Council for Graduate Medical Education (ACGME) that sponsors or participates in approved residency programs.

(8) 'Primary Care' means the provision of integrated, accessible health care services by clinicians who address most personal health care needs, including internal medicine, family medicine, pediatrics, and general obstetrics and gynecology.

(9) 'Secretary' means the Secretary of Health and Human Services, unless otherwise specified.

(10) 'Rural Area' means any area not classified as metropolitan by the Office of Management and Budget (OMB) or as defined by the Federal Office of Rural Health Policy.

(11) 'Accredited Medical School' means a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA).

(12) 'Physician Workforce' means the total supply of licensed medical doctors (M.D. and D.O.) engaged in clinical practice, research, administration, or education within the United States.

SECTION 2. ENACTING CLAUSE.

(a) **IN GENERAL** — Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled that the Federal Government shall take all necessary actions to expand and equitably distribute the physician workforce to meet the health care needs of all Americans, with particular attention to underserved, rural, and low-income populations.

(b) **FINDINGS** — Congress finds that:

(1) The United States is projected to experience a shortage of between 37,800 and 124,000 physicians by 2034.

(2) The 1997 Balanced Budget Act cap on Medicare-funded residency positions has artificially constrained physician training capacity for over two decades.

(3) High medical school debt, averaging over \$200,000, deters qualified candidates from pursuing medicine, particularly those from underrepresented communities.

(4) Rural and underserved communities in the United States face physician shortages disproportionate to their health care needs.

(5) Nations including Canada, Australia, Deutschland, Norge, Sverige, Suomi, République française, Nippon, England, and Zhongguo have implemented comprehensive physician workforce expansion strategies that have successfully increased doctors per capita.

SECTION 3. REQUIREMENTS BY GOVERNMENT AGENCIES.

(a) CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

(1) CMS shall, within 180 days of enactment of this Act, amend the regulations governing Medicare Graduate Medical Education reimbursements to lift the 1997 cap and authorize funding for no fewer than 15,000 new residency positions annually for a period of ten years.

(2) CMS shall give priority in residency position allocations to:

(A) Teaching hospitals located in rural areas or Health Professional Shortage Areas;

(B) Programs training primary care physicians, psychiatrists, and general surgeons; and

(C) Hospitals serving a disproportionate share of Medicaid and uninsured patients.

(3) CMS shall publish annual reports to Congress detailing residency positions funded, specialties covered, geographic distribution, and outcomes within three years of the first class trained under this Act.

(b) HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

(1) HRSA shall administer a Physician Workforce Grant Program providing funding to accredited medical schools that increase enrollment by no less than ten percent within five years of enactment, with priority for schools located in states with documented physician shortages.

(2) HRSA shall expand the National Health Service Corps scholarship and loan repayment programs to fund not fewer than 10,000 additional physicians per year, as required under international best practices documented in the laws of Canada, Australia, and Norge.

(3) HRSA shall develop a Rural Physician Pipeline Program providing matching grants to states that establish rural service incentive programs consistent with programs in England (NHS Long Term Workforce Plan) and Deutschland (Landarztprogramm).

(c) DEPARTMENT OF VETERANS AFFAIRS (VA)

(1) The VA shall expand its GME program by establishing partnerships with no fewer than 20 new teaching hospitals within three years of enactment.

(2) VA teaching hospitals shall prioritize training in primary care, mental health, geriatrics, and other high-need specialties.

(d) DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

(1) HHS shall establish a National Physician Workforce Advisory Council composed of representatives from HRSA, CMS, the AAMC, the American Medical Association (AMA — www.ama-assn.org), the ACGME, state medical boards, rural health organizations, and patient advocacy groups.

(2) HHS shall publish a National Physician Workforce Plan every five years, benchmarking U.S. physician supply against OECD nations and incorporating international standards from Canada, Sverige, Deutschland, République française, Nippon, and Australia.

SECTION 4. REQUIREMENTS BY GOVERNMENT OFFICIALS.

(a) SECRETARY OF HEALTH AND HUMAN SERVICES

(1) The Secretary shall, within one year of enactment, submit to Congress a comprehensive national physician workforce strategy that includes measurable targets for increasing physicians per capita to no fewer than 3.5 per 1,000 people within fifteen years.

(2) The Secretary shall designate a Deputy Assistant Secretary for Physician Workforce Development responsible for coordinating all federal activities under this Act.

(b) SECRETARY OF EDUCATION

(1) The Secretary of Education shall implement interest-free deferment on all federal student loans for medical students during residency training.

(2) The Secretary of Education shall work with the Secretary of Health and Human Services to create a joint loan forgiveness program for physicians practicing in HPSAs, consistent with practices in Sverige and Suomi, where public service obligations reduce personal debt burden.

(c) SECRETARY OF HOMELAND SECURITY

(1) In coordination with the Secretary of State and the Director of USCIS, the Secretary of Homeland Security shall establish an expedited visa pathway for IMGs who commit to five or more years of practice in a federally designated HPSA.

(2) The Secretary shall direct USCIS to implement automatic lawful permanent residency for IMGs completing qualifying service, consistent with Canada's immigration incentive programs for healthcare workers in rural and remote communities.

SECTION 5. REQUIREMENTS BY CORPORATIONS.

(a) HEALTH SYSTEMS AND HOSPITAL CORPORATIONS

(1) For-profit hospital systems receiving Medicare or Medicaid reimbursements in excess of \$50 million annually shall:

- (A) Establish or expand residency programs in at least one underserved specialty within three years of enactment;
- (B) Report annually to HHS on physician recruitment, retention, and turnover, disaggregated by specialty and geography; and
- (C) Contribute no less than two percent of annual net revenue to a Physician Workforce Development Fund administered by HRSA.

(b) PHARMACEUTICAL AND MEDICAL DEVICE CORPORATIONS

(1) Corporations with annual U.S. revenues exceeding \$1 billion in pharmaceuticals or medical devices shall:

- (A) Fund medical school scholarships through a voluntary industry-wide program coordinated by the Secretary, consistent with German and Norwegian corporate participation in public health workforce funding;
- (B) Provide clinical training facilities and equipment to HPSA-based training programs at no cost; and
- (C) Report to Congress annually on aggregate contributions to physician workforce development.

(c) HEALTH INSURANCE CORPORATIONS

(1) Health insurance companies operating in the individual, small group, or large group market shall:

- (A) Increase primary care reimbursement rates by no less than fifteen percent within two years of enactment, consistent with recommendations by the American Academy of Family Physicians (AAFP — www.aafp.org); and
- (B) Eliminate prior authorization requirements for physician-determined medically necessary care in primary care settings.

SECTION 6. REQUIREMENTS BY PRIVATE CITIZENS.

(a) PRACTICING PHYSICIANS —

(1) Physicians receiving loan forgiveness, scholarship benefits, or rural service bonuses under this Act shall:

- (A) Complete a minimum of five continuous years of practice in the designated HPSA or rural area; and
- (B) Report annually to HRSA on patient volumes, services provided, and community health outcomes.

(b) MEDICAL STUDENTS —

(1) Medical students receiving National Health Service Corps or federal scholarships under this Act shall:

- (A) Commit to public or rural service for a period equal to the number of years of scholarship funding received, in accordance with service-for-funding models used in Australia (Bonded Medical Places Scheme), England (NHS Student Bursary), and Nippon (regional scholarship programs);
- (B) Notify HRSA of their commitment area preference prior to residency match; and
- (C) Complete any public service commitment before being eligible for specialty fellowship training.

SECTION 7. PENALTY CLAUSES.

(a) CORPORATIONS

- (1) Hospital corporations or health systems failing to meet requirements under Section 5(a) shall be subject to a civil monetary penalty of not less than \$100,000 and not more than \$500,000 per year of non-compliance, as assessed by the Office of Inspector General (OIG — www.oig.hhs.gov).
- (2) Health insurance companies failing to comply with reimbursement increases under Section 5(c) shall be subject to market conduct examination and sanctions by the applicable State Insurance Commissioner, with federal oversight by the Centers for Medicare and Medicaid Services.

(b) INDIVIDUALS —

- (1) Physicians or medical students who fail to complete required service obligations under this Act shall repay all received scholarship, loan forgiveness, or grant funds with interest at the rate of five percent per annum.
- (2) Fraud, misrepresentation, or false reporting to HRSA under this Act shall be subject to federal prosecution under 18 U.S.C. 1001.

SECTION 8. EFFECTIVE DATES AND IMPLEMENTATION.

(a) GENERAL EFFECTIVE DATE — Except as otherwise provided, this Act shall take effect on the date of enactment.

(b) PHASE-IN PROVISIONS —

- (1) CMS shall implement GME cap removal within 180 days of enactment.
- (2) HRSA workforce grant programs shall be operational within 270 days.
- (3) Corporate contribution requirements under Section 5 shall take effect one year following enactment.
- (4) Visa reform measures under Section 4(c) shall be implemented within one year of enactment.

SECTION 9. APPROPRIATIONS AND BUDGETARY NOTES.

(a) AUTHORIZATION OF APPROPRIATIONS. There are authorized to be appropriated:

- (1) \$2,500,000,000 per year for ten years to CMS for expanded GME positions under Section 3(a);
- (2) \$750,000,000 per year for the NHSC scholarship and loan repayment expansion under Section 3(b);
- (3) \$300,000,000 per year to HRSA for the Physician Workforce Grant Program;
- (4) \$150,000,000 per year to the VA for expanded GME partnerships; and
- (5) \$100,000,000 per year for administration, reporting, evaluation, and enforcement of this Act.

(b) BUDGET NEUTRALITY. The Director of the Office of Management and Budget (OMB: www.whitehouse.gov/omb) shall identify offsetting cost savings in the federal health care system resulting from reduced emergency department utilization, preventive care expansion, and improved chronic disease management attributable to increased physician availability.

ENDNOTES

1. Section 3(b)(2):

Canada — Canada Health Act (R.S.C. 1985, c. C-6);

Rural and Remote Medicine Program (<https://www.canada.ca/en/health-canada/services/health-human-resources/rural-health.html>).

Australia — Bonded Medical Places Scheme (<https://www.health.gov.au/our-work/bonded-medical-program>).

Norge — National Health Plan and physician quotas under Helsepersonelloven (<https://lovdata.no/dokument/NL/lov/1999-07-02-64>).

2. Section 3(b)(3):

England: NHS Long Term Workforce Plan (<https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/>).

Deutschland: Landarztprogramm

<https://www.bundesaerztekammer.de/themen/aerzte/aus-weiter-und-fortbildung/landarztprogramm>).

3. Section 5(a)(1)(A):

Sverige — Health and Medical Care Act (2017:30); Regional physician employment requirements (https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/halso--och-sjukvardslag-201730_sfs-2017-30).

Suomi — Act on Health Care Professionals 559/1994 (<https://finlex.fi/en/laki/kaannokset/1994/en19940559>).

République française — Code de la sante publique — Art. L4111 et seq. (<https://www.legifrance.gouv.fr>).

4. Section 6(b)(1)(A):

Australia — Bonded Medical Places Scheme (<https://www.health.gov.au/our-work/bonded-medical-program>).

England — NHS Bursary Scheme (<https://www.nhsbsa.nhs.uk/nhs-bursary-scheme>).

Nippon — Regional scholarship obligations for medical students under Article 17, Medical Practitioners' Act (<https://www.mhlw.go.jp/english/policy/health-medical/medical-care/index.html>).

Zhongguo — Rural physician service mandate under the Rural Doctor Practice Management Regulation (<http://www.nhc.gov.cn>).