**United States House of Representatives Committee on Ways & Means, Subcommittee on Health**
Hearing: Advancing the Next Generation of America's Health Care Workforce
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**Testimony**
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## Introduction

Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee, thank you for holding this hearing on ensuring that our nation's health care workforce meets the needs of all of our communities. My name is Dr. Andrew Racine, and I am the President of the American Academy of Pediatrics. The AAP is a non-profit organization comprising more than 67,000 pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. I am also a pediatrician and health economist with more than three decades of experience in clinical practice and system leadership. Throughout my career, I have focused on the policies, economic factors, and system designs that impact children's access to care. In that work, I have closely examined many of the ways that federal policy can support or be a barrier to our shared goals of ensuring children can access the care they need to grow, learn, play, and thrive. I want to thank Chairman Buchanan and Ranking Member Doggett for holding this important conversation about supporting the health care needs of our nation, now and in the future and I want to emphasize our shared interest in working together to achieve that critical goal. My objective today is to provide the committee with insights designed to help inform your important deliberations.

## Current Landscape

The American Academy of Pediatrics is driven by our mission: to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. Achieving that mission requires a national health care infrastructure designed and financed with that goal in mind. An important part of that infrastructure is a pediatric workforce that is large enough, well-trained, properly equipped, effectively motivated, and geographically available to all the nation's children and families. We know that multidisciplinary teams partnering with patients and families are integral to delivering the highest quality health care. As such, we share the subcommittee's goals of ensuring that federal policies are in place to recruit, train and retain the workforce we need for today and into the future. The landscape I am describing is vast. There are many issues worthy of consideration, but today I want to focus on three: (1) the barriers to training enough pediatricians and other members of the pediatric health care workforce, (2) the financial misalignment in the pediatric health care system, and (3) the factors that threaten the retention of our highly trained workforce including burnout and moral injury. In particular, I want to highlight the fundamental underinvestment in pediatrics that creates a misalignment between the goals of promoting children's health and wellbeing and the economic models that underly the pediatric health care system. We know that many health promotion and prevention services can yield lifelong benefits, and yet our health financing system provides little incentive for this care.

As we sit here today, not all children in our country can access the care they need in part because of critical limitations in the pediatric workforce, ranging from outright shortages to uneven geographic distribution. The shortages of pediatric practitioners reflect the sad reality that our country undervalues the importance of children's health care relative to that of adults. The average number of primary care practitioners per 100,00

adults in the U.S. in 2023 was 101, whereas two years later the equivalent number of pediatricians per 100,000 children was 82.[1, 2]

And these aggregate numbers mask vast geographic inequalities. In Idaho in 2025 there were only 38.7 board certified pediatricians per 100,000 children compared with more than 107 per 100,000 children in my home state of New York. Yet those families have as much need for access to quality pediatric primary care as my patients in the Bronx do.

And what is true for primary care pediatrics is even more dire when we look at certain pediatric subspecialties. When I was in clinical practice and encountered a child whose significant behavioral or developmental challenges required referral to a specialist, I could pick up the phone and have them seen by a board-certified developmental behavioral pediatrician on the other side of the borough. If my colleague Dr. Francine Nadine Jacobs in New Mexico encounters a patient with the same needs, she has no one in the entire state to whom she can refer her patient. That child and family would have to travel to neighboring Arizona and hope they could get an appointment with one of the 10 practicing developmental-behavioral specialists in that state of 1.6 million children. If you are caring for a child with chronic kidney disease who needs a pediatric nephrologist anywhere from Oklahoma up the middle of the country to North Dakota, you are lucky if your state has three such pediatric specialists. In North Dakota, there is one, a seeming fortune relative to neighboring Montana where there aren't any.

Aside from numbers alone, children and families experience wide variation in how easily they can access needed care based on what type of insurance coverage they have. Nearly half of all of the children in the U.S. rely on Medicaid and the Children's Health Insurance Program (CHIP) for insurance coverage, which means that Medicaid and CHIP have outsized impact on pediatric care from community practices to specialty clinics to freestanding children's hospitals. Because states operate their Medicaid and CHIP differently, children living in one state may face much greater barriers to timely care than their counterparts in another. Even within states, this variation disproportionately affects rural communities. In fact, nearly 41% of children in small towns and rural areas depend on Medicaid/CHIP, compared to about 38% in metro areas.[3] In six states—New Mexico, Louisiana, Arizona, Florida, South Carolina, and Arkansas—at least half of all children living outside metro areas are covered by Medicaid/CHIP, underscoring how essential the program is to pediatric access in rural communities. Children living in urban areas face barriers to access as well, particularly children with complex medical needs who may require specialized diagnostic or treatment services that are not readily available in their geographic area.

It's important to recognize the interaction between adult Medicaid coverage and child enrollment. We know that when parents have insurance coverage, their children are more likely to have coverage, get timely care, and

[1] Health Resources and Services Administration (HRSA) National Center for Health Workforce Analysis. "State of the Primary Care Workforce, 2025." December 2025. Available at: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-the-Primary-Care-Workforce-2025.pdf

[2] The American Board of Pediatrics data on geographic distribution of General Pediatricians in the United States. December 2025. Available at: https://www.abp.org/dashboards/general-pediatricians-us-state-and-county-maps

[3] Joan Alker, Aubrianna Osorio, and Edwin Park. Georgetown University Center for Children and Families. "Medicaid's Role in Small Towns and Rural Areas." January 2025. Available at: https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/

be healthier.[4, 5, 6, 7, 8] Many adults, when they lose coverage for themselves, automatically assume that their children are also no longer eligible. The more barriers we erect to prevent parents and family members who are eligible from enrolling in Medicaid, the more we will see eligible children lose coverage.

Even when children have coverage, they may not have timely access to care. We have critical shortages in the pediatric workforce, particularly in pediatric specialty care. In adult medicine, the workforce shortages are largely in primary care. While primary care pediatricians face many of the same challenges as their colleagues in adult medicine, the shortage of pediatric medical subspecialists and pediatric surgeons is more acute. We are not recruiting, training, or retaining the subspecialists needed to keep up with the increasing needs of children, especially those with special health care needs.

We must do more to address all of these limitations. Decades of research tells us that early investments in child health yield lifelong benefits for that child as they grow into adulthood and provide economic returns to society as a whole.

I am honored to have the opportunity to share with you today's challenges in recruiting, educating, and training the pediatric health care workforce we need.

## Recruiting and Training the Pediatric Workforce

Children are not just little adults; they require medical care that is appropriate for their unique needs and stage of development. Pediatricians, including primary care pediatricians, pediatric medical subspecialists, and pediatric surgeons, undertake substantial specialized training in order to provide children safe and high-quality care.

Training to become a pediatrician generally includes 4 years of medical school education, followed by at least 3 years of residency, "hands on," intensive medical training devoted solely to all aspects of medical care for children, adolescents, and young adults. All told, this training to become a primary care pediatrician consists of approximately 12,000 to 14,000 hours of clinical training. Like our colleagues in adult medicine, pediatricians may elect for additional specialized training to care for children with serious diseases and other specialized health care needs.

Just as in adult medicine, safe and high-quality care of children requires this specialized training. In addition to a general knowledge of diseases, pediatric specialists must know and understand the various ways that diseases present and are managed with consideration of the age of the child. As children grow, their risk of each illness changes, as does its management. The pediatric specialist must continuously monitor and address each child's growth and development, as well as behavioral issues. Pediatric specialists must also be trained in the care of not just children, but appropriate interaction and shared-decision making with parents, family members, and other guardians. As a result of advances in medical care and advances in immunization, the United States has greatly increased the survival of children in general, including those with special health care

[4] Hudson JL and Moriya AS. "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children." *Health Affairs*. September 2017. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0347
[5] Venkataramani M, Pollack CE, Roberts ET. "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services." *Pediatrics*. December 2017. Available at: https://doi.org/10.1542/peds.2017-0953
[6] Gifford EJ, Weech-Maldonado R, Short PF. "Low-income children's preventive services use: implications of parents' Medicaid status." *Health Care Financ Rev*. 2005;26(4):81-94. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC4194911/
[7] Thompson O. "The long-term health impacts of Medicaid and CHIP." *Journal of Health Economics*. January 2017. Available at: https://doi.org/10.1016/j.jhealeco.2016.12.003
[8] Goodman-Bacon A. "The Long-Run Effects of Childhood Insurance Coverage: Medicaid Implementation, Adult Health, and Labor Market Outcomes." *American Economic Review* 2021;111 (8): 2550–93.DOI: 10.1257/aer.20171671. Available at: https://www.aeaweb.org/articles?id=10.1257/aer.20171671

needs. These children require specialist physicians with expertise in complex and specialty care to meet their healthcare needs.

Unfortunately, we have seen a troubling contraction of the pediatric health care system in recent years that limits children's access to care. A recent examination of hospitals with inpatient pediatric units and designated inpatient pediatric beds found a 30% reduction in pediatric inpatient units from 2008 to 2022 compared to only 4% reduction in adult units.[9] We have seen a significant decrease in the pediatric capability of hospitals over the past 20 years, with nearly two-thirds of hospitals having no capacity for pediatric inpatient and surgical care by 2022.[10]

These workforce shortages and system contractions severely impact patient care. Primary care pediatricians report having difficulty locating trained subspecialists to whom they can refer their patients. Wait times to see pediatric subspecialists are unacceptably high among many specialties, and families often need to travel long distances (many times to another state) to see the appropriate specialists. Similarly, there is a severe shortage of pediatric mental health practitioners that has contributed to the ongoing crisis in children's mental and behavioral health, and more than half of the children across the country face difficulties obtaining needed mental health care.[11, 12]

I mentioned at the outset that the health care infrastructure supporting child health is vast and complex. In addition to the numbers of pediatric practitioners available to care for children in the community, children's hospitals report significant pediatric physician vacancies, with shortages in several specialties largely unchanged since 2017, and three of the four most severe shortages in neurological, behavioral, and mental health fields.[13] Several pediatric subspecialties now have fewer than 700 active practitioners nationwide; in pediatric nephrology there is approximately one specialist per 100,000 children.[14] These gaps translate into 6–12 month wait times and long-distance travel for families. Using information about board-certified pediatricians, modeling projects worsening geographic maldistribution through 2040, with specialists increasingly mismatched to where child populations are growing.[15, 16] This challenge is not limited to physicians; children's hospitals also report a shortage of pediatric nurses, pediatric allied health professionals like respiratory therapists and imaging techs.[17]

A strong pediatric workforce begins with substantial investments of time, effort, and resources. The federal investment in medical training is essential in making this happen.

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[9] Michelson KA, Cushing AM, Bucholz EM. "National Trends in Pediatric Inpatient Capacity." *JAMA Pediatr*. 2025;179(2):208–209. doi:10.1001/jamapediatrics.2024.5110. Available at: https://jamanetwork.com/journals/jamapediatrics/fullarticle/2826774

[10] Michelson KA, Bucholz EM, Ramgopal S, Remick KE, Samuels-Kalow ME. "Pediatric Capabilities in US Hospitals: 2003–2022." *Pediatrics* January 2026; 157 (1): e2025072434. 10.1542/peds.2025-072434. Available at: https://doi.org/10.1542/peds.2025-072434

[11] American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, Children's Hospital Association. "Four Years On: Children's Mental Health Remains a National Emergency." October 2025. Available at: https://www.aap.org/en/news-room/news-releases/aap/2025/four-years-on-childrens-mental-health-remains-a-national-emergency/

[12] The Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health. "Interactive Data Query: National Survey of Children's Health (2022-Present)" Available at: https://www.childhealthdata.org/browse/survey/results?q=11114&r=1

[13] Children's Hospital Association. "Fact Sheet: Pediatric Workforce Shortages Persist in 2024." Accessed February 20, 2026. Available at: https://www.childrenshospitals.org/content/public-policy/fact-sheet/pediatric-workforce-shortages-persist-in-2024

[14] Opipari V, Millican WD. "We Must Act Now to Address The Pediatric Specialty Care Crisis." *Health Affairs Forefront*. June 2025. Available at: https://www.healthaffairs.org/do/10.1377/forefront.20250618.506309/full/

[15] Orr CJ, McCartha E, Vinci RJ, Mink RB, Leonard MB, Bissell M, Gaona AR, Leslie LK. "Projecting the Future Pediatric Subspecialty Workforce: Summary and Recommendations." *Pediatrics* February 2024; 153 (Supplement 2): e2023063678T. 10.1542/peds.2023-063678T. Available at: https://doi.org/10.1542/peds.2023-063678T

[16] ABP Microsimulation Dashboard (2025). https://www.abp.org/content/projecting-future-us-pediatric-subspecialty-workforce

[17] Children's Hospital Association. Fact Sheet: Pediatric Workforce Shortages Persist in 2024. Accessed February 20, 2026. https://www.childrenshospitals.org/content/public-policy/fact-sheet/pediatric-workforce-shortages-persist-in-2024

1. Federal Graduate Medical Education Funding: Medicare GME and CHGME

The federal government has long played a critical role in financing physician training. Medicare is the single largest, public program providing graduate medical education (GME) and helps offset a portion of the direct costs of training residents and fellows, including stipends and benefits, and costs associated with providing complex patient care in the teaching hospital setting. While Medicare does not cover children, Medicare GME does pay for training costs associated with pediatric trainees when the pediatric department is integrated into a health system that serves adult Medicare patients. This investment in training by Medicare is critical to the pediatric workforce. Congress can increase the number of Medicare-supported GME positions by advancing legislation like Reps. Fitzpatrick and Sewell's bipartisan Resident Physician Shortage Reduction Act of 2025 (H.R. 4731).

While Medicare is the largest source of GME funding, the Children's Hospitals Graduate Medical Education (CHGME) program is an essential funding component for standalone children's hospitals that do not receive Medicare GME support. Today, the small number of hospitals that receive CHGME funding—only 59 hospitals in FY 2025—train approximately half of all primary care and subspecialty pediatricians in the United States. This program represents less than 2% of total federal spending on GME but is highly effective. We know that more than 60% of CHGME-funded physicians stay and practice in the state where they complete their residency. I would like to offer my gratitude for Congress's recent funding increase in CHGME in the FY 2026 HHS funding bill and ask that you continue to support this essential program.

2. Federal Loans and Loan Repayment Programs

Addressing the health care workforce shortage requires recruiting and retaining aspiring health professions students in health care careers, particularly students from rural areas and other underserved backgrounds who often return to similar communities to practice. Federal financial support for students, including federal student aid and loan repayment programs, plays a key role in facilitating this recruitment effort. These programs help ensure that working in rural areas and other areas where compensation might be lower is financially tenable for physicians.

The changes made to this federal financial support over the past year, including caps on federal graduate loans and the elimination of the GradPLUS loan program, will present significant new barriers for students pursuing medical school. The reduced availability of federal student loans is expected to force many future medical students into the private student loan market, which will offer higher interest rates and less favorable terms than those offered by the federal government, to finance a portion of their education. Some students may not be able to secure private loans at all. At a time when the average medical school graduate is leaving school with approximately $235,000 in medical school debt, or $265,000 of combined medical and premedical education debt, new caps on student loan borrowing are unlikely to be sufficient for many students. These changes will significantly increase medical student debt burden and could impact critical career decisions, such as whether physicians choose to practice in underserved communities or pursue additional subspecialty training.

The Pediatric Specialty Loan Repayment Program (PSLRP) administered by HHS helps to ameliorate shortages of pediatric medical subspecialists and pediatric surgical specialists by addressing the financial barriers to training and practicing in a pediatric subspecialty. The additional time and expense required to become a pediatric subspecialist can make pediatric subspecialty training and practice financially infeasible. Pursuing subspecialty training requires forgoing a salary for two to four additional years while receiving specialized training, often accruing interest on outstanding educational debt. PSLRP offers $100,000 in loan repayment for pediatric medical subspecialists, pediatric surgical specialists, and child and adolescent behavioral health providers who serve in underserved areas for three years.

We are grateful for Congress's ongoing commitment to this program, which received continued funding in the FY26 HHS spending bill. In FY 2025, the federal government was able to use this program to provide loan

repayment to 67 pediatric subspecialists, an important investment in the pediatric subspecialty workforce. We also know that we will need many more subspecialists in the future to maintain and expand healthcare access, and we encourage Congress to provide additional investments in this crucial support.

3. Recruiting International Medical Graduates

International medical graduates (IMGs) are vital to physician supply in underserved regions, particularly in rural communities. IMGs account for nearly 25% of the total physician workforce in the U.S., with 64% practicing in Medically Underserved Areas (MUA) or Health Professional Shortage Areas (HPSA).[18] In addition, 45% of IMGs practice in a rural area. Over the past year, significant new barriers have impeded the recruitment and retention of IMG physicians. For example, the Department of Homeland Security (DHS) has proposed substantial fixed duration limits on several common student visas including the J-1 visa commonly used for IMG physicians pursuing residency training in the United States. This change would cause significant disruption to the training of thousands of physicians who train in teaching hospitals across nearly every state. Similarly, a September 2025 Presidential Proclamation imposed a new $100,000 supplemental fee for new H-1B visas, an untenable cost for the health care systems recruiting physicians and other health care professionals.[19] The result is that many health systems have paused active recruitments that they were relying on to fill critical shortages. As the DHS proposal moves forward, we ask Congress to intervene as needed to ensure that DHS exempts medical professionals from this policy and that you work to rescind the supplemental fee for physicians.

## Financing the Pediatric Health Care System

It is nearly impossible to describe the pediatric health care system in the U.S. separately from Medicaid and CHIP. Children make up the single largest group of people who rely on Medicaid. Nearly 40 million children currently rely on Medicaid and CHIP coverage, including children with special health care needs and those from low-income families. Medicaid also provides comprehensive prenatal care to pregnant women, enabling millions of pregnant women to have healthy pregnancies and thereby helping millions of children get a healthy start. Unlike many private health insurance plans, Medicaid guarantees specific benefits designed especially for children. Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits are the definitive standard of pediatric care, covering an array of services like developmental, dental, vision and hearing screenings, and allowing health problems to be diagnosed and treated appropriately and as early as possible. The EPSDT benefit includes coverage of the Bright Futures Guidelines, theory-based and evidence-driven guidance for all preventive care screenings and health supervision visits for children. Together, the reach and design of the program make Medicaid the backbone of pediatric care—particularly for children with complex needs.[20] As a result, the pediatric health care system depends on Medicaid for viability, meaning that even children with commercial insurance often receive care at facilities and within pediatric systems that depend on Medicaid.

Despite its centrality, Medicaid pays less for pediatric services than Medicare and private insurance, contributing to pediatricians' lifetime earnings being about 25% lower than adult medicine physicians and

[18] Malayala S, Adhikari R, Vasireddy D, Atluri P, Bali A. Medically underserved areas and International Medical Graduates (IMGs) in the United States: challenges during the COVID-19 era. *Journal of Community Hospital Internal Medicine Perspectives*. 2021;11(4):457–463. https://doi.org/10.1080/20009666.2021.1915548

[19] Presidential Proclamation: Restriction on Entry of Certain Nonimmigrant Workers, September 19, 2025. https://www.whitehouse.gov/presidential-actions/2025/09/restriction-on-entry-of-certain-nonimmigrant-workers/

[20] Kusma JD, Raphael JL, Perrin JM, Hudak ML. Medicaid and the Children's Health Insurance Program: Optimization to Promote Equity in Child and Young Adult Health. *Pediatrics.* 2023;152(5). https://doi.org/10.1542/peds.2023-064088

worsening recruitment and retention.[21, 22] Similarly, on average, more than 50% of children's hospitals' patients are covered by Medicaid/CHIP, but total Medicaid payments cover less than 80% of children's hospitals' costs of providing care.[23]

Pediatric care—including services like health promotion, nutrition counseling, developmental screening, immunizations, and chronic condition management—remains undervalued even though this care is central to prevention and early intervention. For example, a 2025 analysis lays out how pediatric practices lose money by providing integrated behavioral health care due to the undervaluation of these services, despite the widely recognized shortage of mental health care for children and adolescents.[24] Pediatrics and pediatric specialties consistently receive the lowest compensation across physician specialties, including a significant gap between pediatric and adult medicine physicians despite similar levels of training and responsibility.[25] For example, in 2024 adult hematology/oncology physicians earned 93% more than pediatric hematology/oncology physicians; pediatric specialists earned less than their adult medicine peers in gastroenterology, cardiology, pulmonology, emergency medicine, infectious disease, neurology, and others.

Many of these limitations are driven by system-wide underinvestment in child health. Our health care system incentivizes billable encounters and procedures or lowering costs, and not long-term health outcomes of individuals and communities. This model is in conflict with pediatrics' focus on prevention of illness, early recognition of problems, and health promotion – core activities such as immunizations, developmental screening, anticipatory guidance to parents, nutrition counseling, early identification of developmental delays, and management of emerging chronic conditions. These interventions generate profound long-term benefits for the individual child and for society as a whole.[26, 27, 28] For example, Medicaid coverage in childhood improves long-term outcomes, including higher educational attainment, better health in adulthood, greater workforce participation, higher wages, and reduced justice system involvement.[29, 30] However, the health financing system does not recognize the value of early investment in child health and provides fewer resources in this area.

Looking forward, the Medicaid financing changes in the *One Big Beautiful Bill Act* pose a serious threat to the pediatric health care system and to children's access to care regardless of whether they have private or public insurance coverage. The limits on financing options to raise the state share of program costs will lead to cuts in payment rates, covered services, and changes in optional coverage pathways and benefits. For example, Idaho and Colorado have already implemented across-the-board Medicaid physician payment cuts due to the

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[21] Skopec L, Pugazhendhi A, Zuckerman S. Updated Medicaid-To-Medicare Fee Index: Medicaid Physician Fees Still Lag Behind Medicare Physician Fees. *Health Affairs*. 2025;44(5). https://doi.org/10.1377/hlthaff.2024.01530

[22] Cornell Health Policy Center. State Policy Levers to Improve Medicaid Pediatric Provider Payment. September 2025. Accessed February 20, 2026. https://amspdc.org/wp-content/uploads/2025/10/Medicaid-Pediatric-Provider-Payments-Research-Brief-003.pdf

[23] Children's Hospital Association. Securing Kids' Futures: A federal policy blueprint to bolster the pediatric workforce. February 2026. https://www.childrenshospitals.org/-/media/files/public-policy/cha-workforce-blueprint-2026.pdf

[24] Jane M Zhu, Sandy Chung, Mary Giliberti, Integrated behavioral health care in pediatric practices: the dollars don't add up, *Health Affairs Scholar*, Volume 3, Issue 4, April 2025, https://doi.org/10.1093/haschl/qxaf046

[25] Doximity. Physician Compensation Report 2025. Accessed February 20, 2026. https://www.doximity.com/reports/physician-compensation-report/2025

[26] Campbell F, Conti G, Heckman JJ, et al. Early childhood investments substantially boost adult health. *Science*. 2014;343(6178):1478–1485. doi:10.1126/science.1248429

[27] Heckman JJ. The case for investing in disadvantaged young children. In: Big Ideas for Children: Investing in Our Nation's Future. Washington, DC: First Focus; 2008:49–58. Available from https://heckmanequation.org/wp-content/uploads/2017/01/Heckman20Investing20in20Young20Children.pdf

[28] Perrin JM, Flanagan P, Katkin J, Barabell G, Price J. The Unique Value Proposition of Pediatric Health care. *Pediatrics*. 2023;151(2). https://doi.org/10.1542/peds.2022-060681

[29] Flanagan P, Tigue PM, Perrin J. The Value Proposition for Pediatric Care. *JAMA Pediatr*. 2019;173(12):1125–1126. doi:10.1001/jamapediatrics.2019.3486

[30] Ash E, Carrington W, Heller R, Hwang G. Exploring the Effects of Medicaid During Childhood on the Economy and the Budget: Working Paper 2023-07. Congressional Budget Office. November 1, 2023. https://www.cbo.gov/publication/59231

looming budget gaps from these policies, directly impacting pediatricians.[31, 32] Due to the primacy of Medicaid in financing the child health system as a whole, these cuts will be particularly impactful for pediatricians and ultimately for children. We are deeply concerned about how these changes will further limit children's timely access to care, particularly in rural areas.

### Devaluation of the Profession

The practice of medicine—especially pediatrics—is built on a trusted relationship between a child, their family and their pediatrician. Pediatrics is rooted in a deep professional commitment to promoting children's health and well-being. Yet today's practice environment increasingly devalues that commitment. Physicians face a combination of societal, political, and administrative pressures that erode the meaning of their work, contribute to moral injury and burnout, and make it harder to recruit and retain the workforce children depend on.

1. Moral Injury and the Erosion of Professional Values

Moral injury occurs when physicians are placed in situations where they cannot act in accordance with their professional and ethical commitments. Research shows that the structure of the U.S. health care system—and its focus on profitability and administrative control—drives moral injury across medical specialties.[33, 34, 35] The accumulation of repeated moral distress leads to an "existential misalignment" between physicians and the work they entered medicine to do. The consequences are visible in the physician workforce: national surveys show extremely high rates of emotional exhaustion, anxiety, and hopelessness among practicing physicians, with more than half reporting debilitating stress in 2025.[36] We are grateful that Congress has recognized the threat of burnout and poor physician mental health and has recently reauthorized the Lorna Breen Health Care Provider Protection Act through FY 2030.

2. Anti-Vaccine and Anti-Science Rhetoric Undermines Trust

Pediatricians have always counseled families about the efficacy and safety of vaccines and engaged in a dialogue with parents about what's best for their child. That trusted relationship and candid conversations is at the heart of pediatrics. Unfortunately, pediatricians are increasingly encountering confused parents and those who have been exposed to misinformed rhetoric about vaccines. Clinicians describe exam-room interactions transformed into ideological standoffs, with patients arriving already distrustful and resistant to medical guidance or citing dubious information they've heard online. Other parents are expressing deep concern about their ability to access vaccines even as vaccine-preventable diseases like measles impact an increasing number of communities around the country.

This erosion of trust directly harms children—undermining vaccination rates and preventive care—but it also takes an emotional toll on clinicians. As one infectious diseases physician noted, routine conversations about routine vaccines now require rehearsing strategies to avoid triggering defensive reactions, creating sustained

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[31] State of Idaho, Notice of Intent to Submit State Plan and Waiver Amendments and Solicitation of Public Input. August 28, 2025. Accessed February 19, 2026. https://townhall.idaho.gov/DocumentView?DocID=11924

[32] Goodland, M. Colorado senators review budget as Medicaid costs drive $776 million increase. *Colorado Politics*. February 18, 2026. https://www.coloradopolitics.com/2026/02/18/colorado-senators-review-budget-as-medicaid-costs-drive-776-million-increase/

[33] Pittman P, Chen C, Munos L, et al. Understanding and Addressing Health Worker Burnout and Moral Injury. *Health Affairs Forefront*, May 19, 2025. DOI: 10.1377/forefront.20250516.299379

[34] George Washington University Workplace Change Collaborative. Burnout and Moral Injury Framework. Accessed February 19, 2026. https://www.wpchange.org/explore-the-framework

[35] Olson K. Physician's Occupational Distress: Burnout or Moral Injury? *Mayo Clinic Proceedings*, 99(12):1860-1863. https://www.mayoclinicproceedings.org/article/S0025-6196%2824%2900538-X/fulltext

[36] The Physicians Foundation. The State of America's Physicians: 2025 Wellbeing Survey. Published September 17, 2025. Accessed February 19, 2026. https://physiciansfoundation.org/research/the-state-of-americas-physicians-2025-wellbeing-survey/

emotional strain and moral distress. Pediatricians experience this most acutely, as they are responsible for guiding families through essential childhood immunizations and public health protections.

3. Administrative Burden and Prior Authorization

Administrative burdens have become one of the most demoralizing forces in the health care system. Across specialties, prior authorization (PA) is consistently identified as the most burdensome regulatory requirement for physicians. A 2024 AMA survey found that 93% of physicians report that PA delays patient care and 89% say it contributes to burnout.[37]

Research confirms these concerns: prior authorization requirements are associated with treatment delays, disease exacerbation, preventable hospitalizations, prolonged hospital stays, and even lower disease-free survival for patients across specialties—including -pediatrics.[38] The physician time required for prior authorization is staggering. Physicians complete an average of 39 to 43 authorizations per week, consuming 12–16 hours of staff or clinician time, often requiring repeated phone calls, faxes, and appeals. These hours come at the direct expense of patient care, personal well-being, and practice sustainability.

For pediatricians—who already face low payment rates and high demand—these administrative pressures compound existing workforce shortages. As physicians burn out or retire early, fewer providers remain to meet the needs of children and families.

4. Impact on Workforce Retention and the Future of Pediatric Care

The cumulative effect of moral injury, anti-science hostility, political interference, and overwhelming administrative burden is profound. These forces undermine the joy and purpose that define the healing professions and erode the sustainability of pediatrics as a career. Surveys consistently show that physicians experiencing burnout are more likely to reduce clinical hours, change practice settings, or leave medicine altogether. The pediatric workforce—already strained by shortages—cannot afford these losses.

Protecting the pediatric workforce therefore requires more than resources; it demands preserving the integrity of the profession, reducing unnecessary administrative harm, and rebuilding trust in science and the patient-physician relationship. Without addressing these systemic pressures, we risk losing the very clinicians our children depend on.

## Conclusion

Children are 20% of the population and 100% of our future. Congress must invest in the health and wellbeing of children, including addressing the challenges with recruiting, training, and retaining the pediatric health care workforce. One of the most foundational opportunities to promote children's health is to invest in Medicaid and the pediatric health care system to ensure that all children have timely access to high-quality care, no matter what kind of insurance they have or where they live. To directly support the pediatric health care workforce, Congress can invest in pipeline development to recruit more people into training, expand eligibility and bolster funding for training programs for all members of the pediatric health care workforce, and work to reduce attrition by addressing the factors that contribute to moral injury and burnout like administrative burden and anti-science rhetoric.

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