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Health Worker Shortages & the Potential of Immigration Policy

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National Health Worker Shortages and the Potential of Immigration Policy

Executive Summary

Foreign-born and foreign-trained professionals play an important role in the delivery of health care in the United States. This report examines the important role of immigrant doctors and nurses – many of whom have received their training abroad – in the U.S. health industry, using new Census Bureau data as well as information from numerous interviews with health industry experts.

The findings of the report include:

- 1.1 million immigrants account for 13 percent of health care providers in the United States.
- The foreign born account for 25.2 percent of all physicians; 17 percent of nursing, psychiatric and home health aides; 15.8 percent of clinical laboratory technicians; 14.8 percent of pharmacists; and 11.5 percent of registered nurses.
- During the 1990s, immigrant employment grew by 114 percent in home health care, 72 percent in nursing care facilities, and 32 percent in hospitals.
- 35 million Americans live in areas with too few doctors to adequately serve their medical needs. Overall, the lack of doctors affects more than 1,600 geographic areas in the United States. Nearly 16,000 doctors would be needed to alleviate this shortage.
- Foreign-born professionals play a crucial role in filling severe shortages within the two largest health care occupations: physicians and nurses.
- The most significant federal program sponsoring foreign-trained doctors to work in underserved areas – managed by the U.S. Department of Agriculture – was abandoned in February 2002. The program established in its place - managed by the U.S. Department of Health and Human Services - has sponsored few doctors and has become increasingly restrictive.
- In 2001, about 1,050 immigrant doctors with temporary J-1 exchange visitor visas were permitted to stay in the United States in exchange for their commitment to treat patients exclusively in underserved areas.
- Despite a national shortage of 126,000 nurses, federal policies designed to permit entry of foreign-trained nurses have become increasingly restrictionist since the mid 1990s.
- In 1990, most nurses were made ineligible for H-1B temporary worker visas, even while an exemption was made for fashion models. In 1995, the federal government ended the H-1A program under which employers had sponsored 6,512 foreign-trained nurses as temporary workers since 1989.
- Credential evaluation, tests of English and nursing skills, and other requirements result in waits of up to one year for nurses who have a U.S. employer willing to sponsor them for legal residence. The long wait makes it difficult for hospitals and other health providers to efficiently fill staffing shortages.
- Largely as a result of more stringent requirements, the average number of nurses granted legal residence in the United States each year fell to about 4,800 in the late 1990s, compared to nearly 8,600 at the beginning of the decade.

Introduction

Health care reform is one of the most pressing social and political issues of our time. Despite major advancements in medical technology, the number of Americans who have access to medical care continues to decline. Together with factors such as widespread lack of health insurance, persistent poverty and low profit margins at medical institutions, the lack of access to health care is exacerbated by significant shortages of doctors and nurses. These shortfalls in health care professionals are found in both rural and inner city areas, where primary care physicians are often in short supply, and in hospitals and medical centers nationwide that are unable to locate and hire sufficient numbers of nurses.

Immigration policy is a tool available to the United States to address the shortage of health care workers. While programs are available to bring talented foreign-trained medical professionals into the country, the number of such persons actually admitted is low compared to the overall need for doctors and nurses in many health care settings. Indeed, immigration policy regarding doctors and nurses has become more restrictive in recent years, even while shortfalls of these workers have become critical in many communities.

One such community is Grantsville, West Virginia, where the local hospital put a padlock and chain around its emergency room doors and closed for 100 days due to a lack of physicians. The area has trouble recruiting physicians in part because of its rural isolation: the closest shopping mall is an hour and twenty minute drive.

The Minnie Hamilton Health Care Center took over operations for the closed Grantsville hospital in 1995. The Center has been largely unsuccessful in its attempt to hire U.S-trained doctors, having attracted only one physician through the National Health Service Corps in nine years. What makes doctors available to the Hamilton Center and to the Grantsville area are foreign-trained physicians who have entered the United States on J-1 "exchange visitor" visas. A waiver program permits these doctors to stay in the country if they agree to practice in medically underserved areas like rural Appalachia. Currently, these foreign-trained physicians represent six of the nine physicians at the Hamilton Center.

Mary Ann Padilla, RN

Hundreds of miles away, in the historic African American neighborhood of Bronzeville on the South Side of Chicago, Mercy Hospital cannot find enough registered nurses to fill its full-time staff because of an acute shortage of nurses affecting the entire nation. The shortage of nurses has forced the hospital to use expensive and temporary contract nurses. Mercy's nursing shortage has staffing levels "right on the edge," according to Catherine Walsh, Vice President for Patient Care Services at the hospital. Walsh says that Mercy "could use 50 nurses tomorrow" if they could only find them.

For Mercy Hospital, one of the few bright spots in the nursing situation is the ability to locate and hire highly skilled foreign-trained nurses. Mary Ann Padilla is one such nurse. A native of the Philippines, where she received her bachelor's degree and nursing education, Ms. Padilla entered the United States in the early 1990s under an H-1A temporary worker visa designed especially for nurses. The H-1A program once brought thousands of needed nurses to the United States, but Congress allowed the program to expire in the mid-1990s despite a nationwide shortage of nurses currently estimated at 126,000.

Grantsville, West Virginia and Chicago, Illinois are just two of the places where thousands of foreign-born professionals are serving basic health care needs in the

United States. Frequently delivering care to underserved populations and often filling positions for which native-born professionals cannot be found, immigrant doctors, nurses and other specialists play a critical role in filling gaps in the American health care system; gaps that prevent neighborhoods, from poor communities in inner cities to middle-income communities in large swaths of rural America, from having access to adequate medical care.

Despite the importance of these workers, the procedures and programs under which the United States permits the temporary and permanent immigration of health care professionals are highly complex, involving constantly evolving laws and multiple federal and state agencies. These procedures and programs are at once both centrally authorized but locally implemented. Statistics and data on the immigrants involved are hard to come by and in some instances have never been compiled, even by the federal agencies that play key roles in running the programs.

The Role of Immigrants in U.S. Health Care

Foreign-born professionals are indispensable in thousands of doctors' offices, hospitals, nursing homes and other places where health care is delivered every day to millions of Americans. As in the U.S. economy in general, immigrants in the health care industry play a significant role at both the high-skilled and low-skilled ends of the occupational spectrum. Foreign-born professionals play a particularly crucial role in filling severe shortages within the two largest health care occupations: physicians and nurses.

The 2000 census counted 1.7 million immigrants in the health care industry, accounting for about 11.7 percent of all workers, including non-medical personnel such as administrators or janitors who work in a health care setting but are not themselves delivering health care directly. Among health care delivery occupations, such as doctors, nurses and physical therapists, some 1.1 million immigrants comprise about 13.0 percent of all workers.[1]

Immigrants in the Health Care Workforce: 2000

	Number of Immigrant Workers	Immigrant Percent of Workforce
All U.S. Workers (*Including non-health*)	16,073,543	12.4%
Health Care — All Workers	1,695,372	11.7%
Health Care — Health Care Providers	1,101,792	13.0%

Within specific health care occupations, the representation of immigrants varies widely. For instance, among optometrists (8.3 percent of whom are foreign born), dental hygienists (4.6 percent) and speech-language pathologists (3 percent), the number of immigrants in the workforce is below the national average of 12.4 percent. However, there are higher than average numbers of immigrants working as physicians (25.2 percent); nursing, psychiatric and home health aides (17 percent); clinical laboratory technicians (15.8 percent); and pharmacists (14.8 percent).[2]

Immigrant Percent of Health Care Occupations

Occupation	Percent
Dentists	**14.4%**
Dietitians & Nutritionists	10.7%
Optometrists	8.3%
Pharmacists	**14.8%**
Physicians	**25.2%**
Physician Assistants	11.2%
Podiatrists	8.0%
Registered Nurses	11.5%
Occupational Therapists	7.4%
Physical Therapists	7.4%
Respiratory Therapists	9.9%
Speech-Language Pathologists	3.0%
Therapists, all other	8.1%
Health Diagnosing & Treating Practitioners, all others	11.0%
Clinical Laboratory Technologists & Technicians	**15.8%**
Dental Hygienists	4.6%
Licensed Practical & Vocational Nurses	8.8%
Medical Records & Health Information Technicians	8.7%
Other Heath Care Practitioners & Technical Occupations	7.9%
Nursing, Psychiatric, & Home Health Aides	**17.0%**
Dental Assistants	11.7%
Medical Assistants & other Health Care Support Occupations	9.3%
All Medical Professions	**13.0%**
All Occupations (not exclusively medical)	12.4%

Note: boldface type denotes categories with higher-than-average numbers of immigrants.

According to the U.S. Department of Health and Human Services, roughly 34.9 million Americans live in areas designated as health professional shortage areas.

However, whether the number of immigrant workers in the health care industry is currently below or above the national average tells only part of the story. Foreign-born workers have also had a profound impact on the growth of the health care workforce. The American medical industry grew by 1.7 million workers during the 1990s, with nearly 25 percent of this growth attributable to the entry of immigrants into the labor force. While this is relatively low when compared to the more than 72 percent of net employment growth attributable to immigrants entering the U.S. labor force as a whole during the 1990s, their presence in the medical industry played a critical role in increasing the availability of health care in this country.

Immigrant health workers have been particularly important in home health care, hospitals, and nursing care facilities. In home health care, immigrant workers more than doubled in number during the 1990s, increasing by 114 percent, while the native born workforce grew by only 31 percent. In hospitals, immigrant employment grew by about one third, 32 percent, while native-born employment was essentially flat, growing by less than 1 percent. The number of immigrants working in nursing care facilities jumped by 72 percent, while the number of native-born workers grew by only 3 percent. At the same time, native-born employment in physicians' offices and outpatient care centers nearly doubled, increasing by 91 percent, while immigrant employment grew by only 14 percent.

Health Care Practitioner Shortages

Medical care in the United States is envied throughout the world for its extraordinary sophistication and quality, but the reality is that high-quality health care is unavailable to millions of U.S. residents. The lack of access to health care is caused by many factors, including poverty, lack of health insurance, and high costs for medical services. But other key factors are a growing national shortage of doctors and an already critical national shortage of nurses.

The increasing shortage of physicians is already being felt in many geographic areas. According to the U.S. Department of Health and Human Services, roughly 34.9 million Americans live in areas designated as health professional shortage areas.[3] These are urban and suburban neighborhoods and rural areas where there is less than one primary care physician for every 2,000 persons. In addition to shortages of medical doctors, some 28.5 million Americans reside in areas where there is a shortage of dentists and 44.4 million persons live in areas that lack sufficient mental health professionals.

Relieving the shortages of medical personnel would necessitate placing an additional 16,000 doctors in areas of need, as well as 8,500 dentists and 4,000 mental health professionals. One-third of all areas with short-

Growth of the Health Care Workforce in Selected Health Care Sectors: 1990-2000

	Industry Employment Growth	Native Born Growth	Foreign Born Growth	Pct. Of Growth Due to Foreign Born
Health Care Industry	25%	21%	62%	25%
Offices of Physicians/outpatient care centers	80%	91%	14%	14%
Home Health Care Services/Other Health Care Services	40%	31%	114%	30%
Hospitals	4%	0%	32%	97%
Nursing Care Facilities	8%	3%	72%	70%

ages of primary care givers are located in metropolitan areas, while two-thirds are located in rural areas. Half the underserved population nationally lives in metropolitan areas and half in rural areas. Overall, the lack of doctors affects more than 1,600 geographic areas in the United States.

While the federal government reports an existing need for 16,000 more doctors, other estimates suggest that the United States will be short 50,000 physicians by 2010, with the gap growing to 200,000 by 2020.[4] These shortages are due in part to a lack of graduate medical education infrastructure, and it has been argued that alleviating just one-third of the coming shortfall in doctors would require the opening of an additional 25 medical schools.[5]

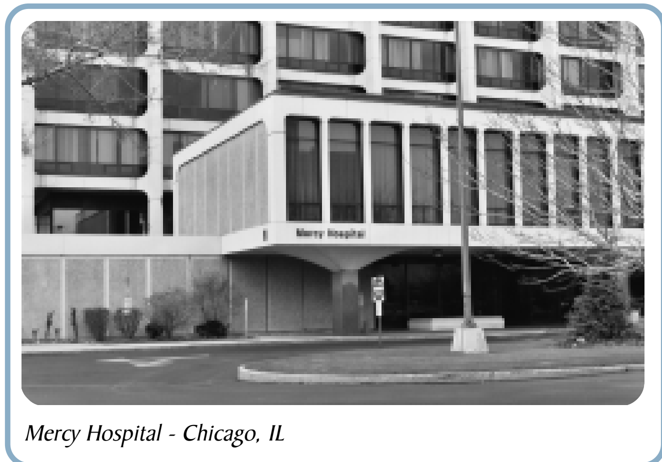
National Health Professional Shortages: September 2003

	Underserved Population	Practitioners Needed
Primary Medical	34,948,853	15,898
Dental	28,508,452	8,526
Mental Health	44,412,800	4,404

Source: National Center for Health Workforce Analysis, HRSA

While the shortage of physicians looms large in the future and is currently impacting certain regions, the United States has already been hit hard by dramatic shortages of nurses across the country. The nation's hospitals currently need an additional 126,000 nurses, and 90 percent of long-term care organizations are short on nurses.[6]

At Mercy Hospital in Chicago, the shortage of nurses is so severe that the hospital participates in a program designed to help foreign-trained nurses who are already in the United States (usually through family reunification visas) to obtain the English skills and refresher training needed to pass the Illinois nurse licensure process. At Oakton Pavillion, a nursing home in DesPlaines, Illinois, administrator Jay Luchowicz explains that 26 of his staff of 45 nurses are foreign trained because he cannot locate enough native-born nurses.



Mercy Hospital - Chicago, IL

The shortage of nurses is leading many institutions to rely on contract nurses; individuals who work not for the health care institution but for a labor contractor. At Mercy Hospital, these nurses are about 20 percent of all nurses, and the hospital is forced to pay a premium for them, with contract nurses costing $50 to $55 per hour compared to $30 per hour for a full-time, on-staff nurse. As Luchowicz puts it, ruefully considering the almost 100 percent premium he pays for contract nurses, "How would you like to spend your money?" The salaries Luchowicz pays for nurses – from $60,000 for an on-staff employee to the equivalent of more than $100,000 for a contract employee – underscore that the nursing shortage is not a result of low salaries. Rather, there simply aren't enough nurses available.

The Role of Immigration in Relieving Health Worker Shortages

The admission of immigrants into the United States based upon their ability to provide needed labor and skills is an essential part of the immigration system. Employment-based immigrants represent almost 10 percent of all immigrants admitted each year. American immigration policy has experienced a slight shift in favor of these immigrants, even while family reunification remains the cornerstone of our admissions policies.[7]

In Texas, 231 counties qualified for HHS waiver processing under the agency's old rules. Under new rules, the program is restricted to 46 counties, and only about two dozen of those have qualifying health clinics.

In addition to those seeking a permanent immigration status, U.S. immigration laws include provisions for non-immigrant visas that are available for persons coming to the United States on a temporary basis. The admission of physicians occurs primarily through use of the J-1 and H-1B visa categories. Physicians who enter the United States as "exchange visitors" with temporary J-1 visas can receive permission to remain in the country as employment-based immigrants if they commit to practicing in areas with health care shortages. These physicians thus represent Congress' overt effort to place foreign-trained doctors into areas with acute health care needs.

J-1 Physicians

Exchange visitors with a J-1 visa are defined as persons with a residence in a foreign country who come temporarily to the United States to teach, conduct research or receive training.[8] Categories of J-1 visas include teachers, students, scholars and physicians. For physicians, the J-1 visa allows graduates of foreign medical schools to pursue continued training for a maximum of seven years in an institution in the United States. The presence of J-1 visa holders in the residency programs of many hospitals is due in part to the insufficient number of graduates from American medical schools, which leads residency programs to utilize J-1 temporary immigrants to remain fully staffed.

The training program of a J-1 visa holder must be accredited by the Accreditation Council for Graduate Medical Education (ACGME) and each physician must be sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG). In order to receive ECFMG sponsorship, foreign-born physicians must pass the U.S. Medical Licensing Exam, just like native-born doctors, and a Test of English as a Foreign Language (TOEFL).

After completing their training, physicians with J-1 visas are usually required to return to their home country for at least two years prior to applying for permission to work in the United States or being granted permanent residence. A J-1 physician may request a waiver of the two-year return rule if returning home would result in persecution to the physician or cause exceptional hardship to the physician's U.S.-citizen or permanent-resident spouse or child, or if an interested U.S. government agency recommends that it is in the public interest for the physician to remain here to practice medicine.

Federal Agencies Are Requesting Fewer J-1 Waivers at a Time of Growing Need

Federal law permits interested federal government agencies to recommend a waiver of the requirement that a J-1 physician return home for two years. These include agencies such as the Department of Health and Human Services (HHS), Department of Veterans Affairs (VA), and lesser-known entities such as the Appalachian Regional Commission (ARC) and Delta Regional Authority (DRA).

Prior to February 2002, the U.S. Department of Agriculture (USDA) processed J-1 waiver recommendations for physicians practicing primarily in rural areas.[9] This program brought more than 3,000 physicians into underserved rural areas since the mid-1990s.[10] In the months following the terrorist attacks of September 11, 2001, however, the USDA terminated its involvement in the program. As a result, there was no national program to bring primary care physicians to underserved areas for approximately 18 months, until July 2003, when HHS established a program to allow J-1 physicians to practice in "health professional shortage areas" (HPSAs).[11]

Soon after getting its program off the ground, however, HHS suspended it for several months, after which the program was re-opened with substantially tightened

eligibility rules. The agency announced that future applications would only be accepted from areas with a high HPSA score of at least 14, and waivers would only be granted to doctors serving in community health centers and rural health clinics. This leaves out for-profit hospitals even if they are the only medical center in an area.

The new HHS rules for J-1 waivers will further limit a program that had already been minimally functional. In the state of Texas, for example, 231 counties qualified for HHS waiver processing under the agency's old rules. The new guidelines, however, restrict the program to 46 counties, and only about two dozen of those have qualifying health clinics.[12]

States Are Increasingly Responsible for J-1 Waiver Applications

In 1994, state governments gained permission to recommend waivers of the two-year return rule for physicians who practice in medically underserved areas.[13] At that time, the so-called Conrad 20 program (named after Senator Kent Conrad of North Dakota, who sponsored the legislation) allowed each state to recommend up to 20 waivers. The limit was later raised to 30 per state.

Under the Conrad program, a state department of health or other entity designated by a governor identifies a physician willing to serve in an area of need. Usually, an employer wishing to hire a physician approaches the state to report the physician's interest in working in an underserved area, and commitment to work in such an area for at least three years. The state agency files a petition on behalf of the doctor with the U.S. Department of State Visa Waiver Office, stating that the employment of the physician is in the public interest. The State Department then makes a recommendation to U.S. Citizenship and Immigration Services (USCIS). State agencies play a critical role in enforcing the rules of the Conrad program by requiring employers to certify that Conrad doctors are actually practicing in the areas they commit to serving.

Estimated J-1 Physician Waivers Processed by State Department, FY2001

Total Federal and State	1,050
Federal Agency	525
USDA*	375
Appalachian Regional Commission	60
Delta Regional Authority**	0
Other Federal Agencies***	90
State Governments	525

**Annualized estimate based on approximately 3,000 USDA waiver recommendations submitted in 1994-2001 period, per USDA.*

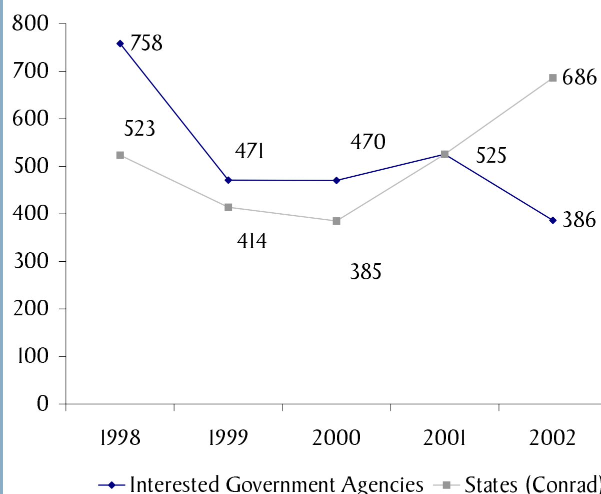
*** Delta Regional Authority was constituted in 2001 and began operations in 2002.*

**** Represents a residual estimate*

Numbers and Types of J-1 Waivers

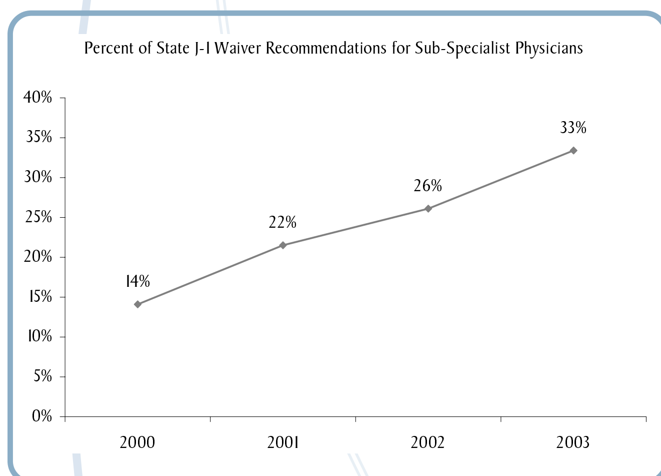
Based on interviews with personnel from numerous federal agencies,[14] an estimated 1,050 waivers of J-1 visas were granted to physicians destined to practice in underserved areas in 2001.[15] The majority of federal agency recommendations likely originated from the USDA.

While the number of J-1 waiver recommendations from federal agencies outnumbered those originating from state agencies for several years prior to 2001, this trend



is changing. In 2002, state governments for the first time recommended more J-1 waivers than the federal government. This is due in part to the demise of the USDA program and the corresponding decline in federal waiver recommendations for physicians in underserved areas.

The Texas Primary Care Office, which has been conducting a survey of states with regard to their use of Conrad waivers, has found a steady increase in the percentage of state recommendations for sub-specialists. Whereas in 2000 only about 14 percent of state waiver requests were reportedly for sub-specialists, this share of waiver requests grew steadily to about 33 percent by 2003.



The increasing rate at which states are recommending sub-specialists testifies to their perception that the need for medical care in underserved areas extends past primary care. Data from the Texas Primary Care Office surveys show that roughly a fifth of all J-1 physician waiver requests processed in 2001 were for non-primary care physicians via the Conrad program.[16]

In its surveys, the Texas Primary Care Office also asked states whether they used all 30 Conrad slots allotted to them and, if so, how many more slots they would recommend to the State Department. Recommendations ranged from 5 to 50 additional slots (the latter in the case of Texas), with 15 states reporting that they would recommend in excess of 30 additional slots. Interest in additional Conrad slots was expressed not merely by the largest states in the country, like California, New York and Texas, but also Arkansas, Iowa, Kentucky, New Mexico and others.[17] In other words, for many states the 30 physicians available annually via the Conrad program are insufficient.

The Conrad program presents an interesting mix of federal and state responsibilities that in some ways parallels the overall process of legal immigration. That is, the overall number of Conrad physicians is set by Washington, but the initiation of requests and the burden of policy implementation fall to a great extent on local entities, in this case the states. Successfully managing and implementing Conrad waivers requires states to certify that doctors are serving the populations and geographic areas they are required to serve. Yet no federal funds are provided to states to conduct these activities, which can be time consuming.

States have therefore used a variety of methods to fund their compliance programs. Texas, for example, charges a $2,000 application fee for Conrad waivers, while Michigan charges only an initial $50 fee and then levies additional fees at other stages of the program. In Texas, the $2,000-per-application fee generates sufficient revenue to fund a full-time state employee. Texas also sets aside Conrad funds in a special account within the state treasury. This avoids the common situation in state government where fee revenue is placed in a general fund and then "disappears," leaving agencies to fight each year for appropriations even if their services are generating sufficient revenue in the first place.

Immigration Policies and Nurses

Given the serious shortage of qualified nurses in the United States, one might expect policymakers to design programs that facilitate the entry of nurses into underserved areas. Indeed, nurses trained abroad are able to enter the country in a variety of ways, yet the overall numbers admitted are low and fail to meet the nation's nursing needs. Furthermore, the methods by

which qualified nursing personnel can enter the United States actually have been limited in recent years, further exacerbating shortages.

In 1989, the Nursing Relief Act created a pilot program of H-1A temporary worker visas for foreign-trained nurses. By 1995, the last year in which employers could petition for H-1A nurses, some 6,512 had been admitted to the United States. But Congress allowed the H-1A program to expire and there has been no comparable replacement program specifically designed to facilitate the entry of nurses. In 1999, a new nonimmigrant visa category known as H-1C was created for nurses, but these visas are only available to nurses sponsored by hospitals in health professional shortage areas. In addition, only 500 visas can be issued each fiscal year and there are additional caps on individual states.[18] Given that only a handful of hospitals have received permission from HHS to apply for H-1C workers, the H-1C classification is not a viable option for most employers seeking to recruit foreign nurses. Moreover, the program is scheduled to end on June 13, 2005.

The bottleneck restricting the availability of temporary visas for nurses was also tightened by the Immigration Act of 1990, which added the requirement that applicants in nearly all occupations eligible for H-1B visas needed a four-year college degree. While an exception was made for fashion models, nurses became largely ineligible for H-1B visas as a result of the legislation. Nursing certification does not require a bachelor's degree in 49 of the 50 states, so relatively few nursing positions can be filled via the H-1B visa.[19]

A look at the delays and complications affecting the entry of qualified foreign-trained nurses reveals an immigration system that has been limited in its ability to provide adequate numbers of nurses to the health care industry. Section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) requires that the credentials of certain foreign health care professionals be certified and evaluated prior to those individuals being able to work in the United States. This process includes a review of the health care worker's

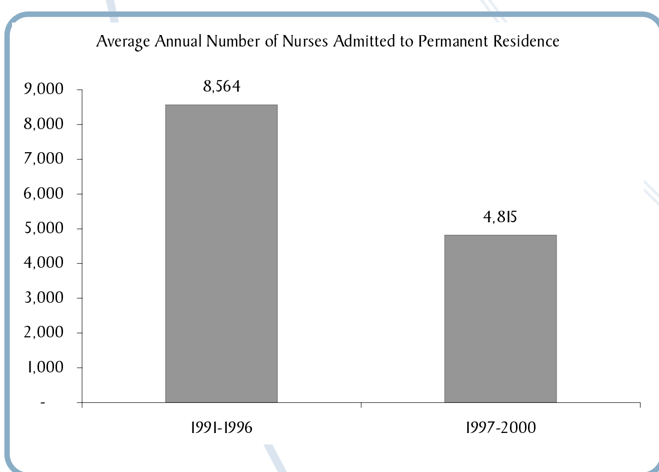
education and licensure, a test of his or her English ability and, for nurses, a predictive examination. Currently, this review process is available only through the Commission on Graduates of Foreign Nursing Schools (CGFNS).[20]

Requiring foreign-trained nurses to prove that they have the requisite skills to perform their job is important. However, the process of fulfilling these requirements under U.S. immigration law is duplicative, slow and expensive. Since foreign nurses must possess either a nursing license in the state of intended employment or have passed a test administered by the CGFNS, the additional certification and evaluation requirements imposed by IIRIRA duplicate requirements already imposed by state licensing authorities. Moreover, the exam of nursing skills is available only in the United States and its territories. Thus applicants have to travel to this country or locations like Guam to take the nursing test, an arrangement that constrains participation in the process. Prior to 1996, nurses had to pass an English test, but the standards were raised by IIRIRA. Typically, nurses take this test in a large room listening to an audio tape of two Americans having a conversation. The atmosphere of the test can be chaotic, and there is reportedly a failure rate of over 50 percent. The high failure rate in combination with the $200 fee required of test takers discourages potential applicants.

Completion of the testing and certification requirements can take an entire year, and therein lies the problem with using this immigration route to satisfy nursing shortages. Hospitals and nursing homes need to fill nursing slots immediately, and a year-long process of hiring is obviously an inefficient and unattractive mechanism for obtaining personnel.

U.S. hospitals and other institutions in desperate need of nursing personnel can hire foreign-trained nurses as temporary workers with H-1B visas. In fact, if the employer or applicant pays $1,000, their case can be expedited and receive a decision in 15 days. Unfortunately, the great majority of unfilled nursing positions in the United States do not meet the requirements of the H-1B visa, which is reserved almost exclusively for occupations that require a four-year college degree.

Data from USCIS illustrate the combined effect of the disappearance of the H-1A program and the new requirements imposed on foreign-trained nurses by IIRIRA. During 1991-1996, a period which ends with the passage of IIRIRA, the average annual number of nurses admitted to the United States as legal immigrants was 8,564. By the latter half of the decade, however, that number had fallen to just 4,815. Furthermore, the 1997-2000 average includes about 2,100 former H-1A nurses who adjusted to permanent residence. The absence of this program means that declining numbers of these adjustments can be expected in ensuing years, tending to further lower the numbers of nurses getting permanent residence.



The ongoing need for physicians and nurses necessitates the continued and enhanced use of immigration policy to help fill the gaps.

Some Considerations on the Economic Impact of Foreign-Trained Medical Professionals

The ongoing debate over the role of immigration in American society has many facets, but one of the most contentious is the economic impact of immigrant workers on the native-born workforce. Some observers of the role that immigrant doctors and nurses play in delivering health care question whether these workers lower the wages and salaries of U.S. health workers by increasing the overall supply of workers.

However, interviews with health care workers and their employers, as well as consideration of the regional and occupational nature of health worker shortages, suggest that such concerns are largely unfounded. For instance, immigrant doctors adjusting from J-1 exchange visitor status are obtaining employment precisely because there are not enough native workers in the areas where they are hired.

The shortage of 126,000 nurses nationally and the high wages that many hospitals are paying to fill those shortages lay to rest any concern about native-born nurses being frozen out of positions by the presence of foreign-trained professionals. We are very far from a situation in which a native-born nurse would have difficulty in finding a job. The number of native-born nurses may be limited by too few slots in nursing schools, and by low high school graduation rates among groups that might be interested in nursing, which is one of the few well-paid occupations that does not require a four-year college degree. However, neither of these problems is attributable to immigration, and neither can be solved soon.

Conclusion

American immigration policies explicitly recognize the critical role played by immigrant workers. Special categories of immigrant visas are reserved for foreign-born workers, tens of thousands of whom are allowed to enter the United States each year on temporary visas. The need for immigrant professionals is clearly evident in the field of health care. Immigrant doctors who entered the United States with J-1 exchange visitor visas are currently treating thousands of persons in underserved areas of the nation where native-born doctors are in short supply. Some 70,000 foreign-trained nurses received U.S. permanent residence in the 1990s and helped alleviate a dramatic national shortfall of nursing professionals, even while in recent years our nation has restricted the influx of these workers.

The ongoing need for physicians and nurses necessitates the continued and enhanced use of immigration policy to help fill the gaps. With regard to J-1 physicians seeking permission to stay in the United States and practice medicine, the low numbers of J-1 waivers recommended to date by HHS – and the increased restrictions applied to the program by that agency – raise concerns about whether the program will ever process significant numbers of waivers. Recent revisions to the HHS program restrict its availability to only the neediest communities, thereby eliminating about 86 percent of previously qualifying areas.

Given that about a third of state requests for Conrad doctors involve medical sub-specialists such as surgeons, there is good reason to permit sub-specialist applications in all federal waiver programs as well.[21] An increase in state allotments under the Conrad program may be advisable as well given that states' increasing use of waivers for sub-specialists cuts into the number of primary care physicians they can request. The current limit of 30 doctors per state has few parallels in immigration policy. H-1B professionals, for example, are not allotted on a state-by-state basis.

The national shortage of 126,000 or more nurses at a time of declining admissions of foreign-trained nurses clearly requires a rethinking of immigration policy. Even a doubling of current admissions (which averaged about 7,000 per year in the 1990s) would not significantly alleviate nursing shortages nor create undue competition for graduates of American nursing schools. Achieving increased arrivals of foreign-trained nurses would probably require reestablishment of an H-1A program that allows nurses to enter the United States without the lengthy wait times of the existing process.

Few would disagree with the argument that our immigration system should serve to complement the U.S.-born workforce, and that federal policymakers have a duty to facilitate the entry of native-born workers into occupations experiencing labor shortages. One way to address the need for medical professionals would be to provide further incentives for U.S.-born physicians to work in underserved rural and inner-city areas. The National Health Service Corp represents one effort in this direction, but its existence has not obviated the need to permit immigrants to work in health shortage areas. Scholarships and loan waivers could raise the numbers of new U.S.-trained nurses, but these programs would take years to establish. Ultimately, incentives to increase enrollment in nursing schools would require deep investment in the K-12 educational system, where students need to acquire skills and interests that both increase high school graduation rates and prepare them for technical careers. The shortages of physicians and nurses, however, are not problems that can await a solution years or decades in the future, given the immediate implications that lack of adequate health care has for American families, workers and the economy.

Few would disagree with the argument that our immigration system should serve to complement the U.S.-born workforce, and that federal policymakers have a duty to facilitate the entry of native-born workers into occupations experiencing labor shortages.

Endnotes

[1] These statistics refer to persons who are "foreign born" regardless of where they received their training.

[2] Census data do not distinguish between practicing physicians and research physicians, though the great majority of foreign-born physicians are likely to be practicing doctors.

[3] *Selected Statistics on Health Professional Shortage Areas* 2003 Washington: National Center for Health Workforce Analysis.

[4] Cooper, Getzen, McKee and Laud 2002 "Economic and Demographic Trends Signal an Impending Physician Shortage" in *Health Affairs* Vol. 21, No. 1.

[5] ibid.

[6] *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis* 2002 Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations.

[7] The 1990 Immigration Act, for example, created new employment-based immigrant categories for persons of exceptional skill, for persons likely to create businesses employing large numbers of Americans, and for certain other categories of skilled workers.

[8] J-1 exchange visitors are defined in the Immigration and Nationality Act of 1952, Pub. L. No. 82-414, 66 Stat. 163 (codified as amended at 8 USC 11-01 *et seq.*).

[9] For a brief period of time in the mid-1990s, the Department of Housing and Urban Development (HUD) also had a program to process waivers for physicians.

[10] Source: Texas Primary Care Office.

[11] These HPSAs did not have to be located in rural areas.

[12] Siskind, Gregory "DHHS Does Not Address Physician Shortages" in February 3, 2004 ILW.com.

[13] Immigration and Nationality Technical Corrections Act of 1994, Pub. L. No. 103416, 108 Stat. 4305.

[14] Agencies interviewed include the Department of State, Department of Agriculture, Department of Health and Human Services, Appalachian Regional Commission, and Delta Regional Authority.

[15] This number excludes 200 medical researchers recommended by HHS.

[16] 220 of 1,072.

[17] The states expressing interest in additional Conrad slots were Arizona, Arkansas, California, Delaware, Florida, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, New Mexico, New York, Ohio, Texas and Washington.

[18] In 1999 President Clinton signed into law the Nursing Relief for Disadvantaged Areas Act, which created a new nonimmigrant category for nurses who work in Health Professional Shortage Areas designated by the U.S. Department of Health and Human Services. The number of visas available under this program is restricted to 500 annually, and the program is scheduled to terminate after four years of operation.

[19] Nurses who can receive H-1B visas are limited to nursing categories found on a list maintained by the U.S. Department of Labor, and include specialized positions such as emergency room nurses, operating room nurses, oncology nurses, pediatric nurses, clinical nurse specialists, nurse midwives, nurse anesthesiologists, and nurse managers, with the latter subject to extra scrutiny by the U.S. DOL.

[20] Pendergrast 2003 "VisaScreen™: Visa Credentials Assessment" in ILW.com.

[21] Under current State Department regulations, the Veterans Administration is the only federal agency permitted to request J-1 waivers for sub-specialists.

ABOUT THE FOUNDATION...

The American Immigration Law Foundation is a 501(c)(3) non-profit organization dedicated to increasing public understanding of immigration law and policy and the value of immigration to American society; to promoting public service and excellence in the practice of immigration law; and to advancing fundamental fairness and due process under the law for immigrants.

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