Conrad 30 State Totals from FY 2001 through FY 2010

State	FY 2001 10/00 to 9/01 20 slots			FY 2002 10/01 to 9/02 20+10 slots			FY 2003 10/02 to 9/03			FY 2004 10/03 to 9/04			FFY 2005 10/04 to 9/05					FFY 2006 10/05 to 9/06						FFY 2007 10/06 to 9/07						FFY 2008 10/07 to 9/08						FFY 2009 10/08 to 9/09						FFY 2010 10/09 to 9/10					
	01 PC	01 Sub	FY 01 Total	02 PC	02 Sub	FY 02 Total	03 PC	03 Sub	FY 03 GAO Total	Rural	Non-Rural	FY 04 GAO Total	05 PC	05 Sub	Rural	Non-rural	FY 05 GAO Total	06 PC	06 Sub	Rural	Non-Rural	Flex 5?	FY 06 Total	07 PC	07 Sub	Rural	Non-Rural	Flex 5?	FY 07 Total	08 PC	08 Sub	Rural	Non-Rural	Flex 5?	FY 08 Total	09 PC	09 Sub	Rural	Non-Rural	Flex 10?	FY 09 Total	10 PC	10 Sub	Rural	Non-Rural	Flex 10?	FY 10 Total
Alabama	4	0	4	5	1	6	8	10	18	19	0	19	14	10	14	10	24	2	13	2	13	0	15	6	6	4	8		12	3	12	8	7	0	15	1	12	10	3	0	13	2	8	1	0	0	10
Alaska	0	1	1	1	0	1	1	3	5	1	0	0	NO DATA PROVIDED				1	0	3	2	1	0	3	NO DATA PROVIDED						NO DATA PROVIDED						NO DATA PROVIDED						0	2	0	2	0	2
Arizona	15	4	19	25	5	30	20	10	30	13	17	30	23	7	12	18	30	21	9	10	20	0	30	24	6	14	16	0	30	26	4	9	21	0	30	23	7	13	17	0	30	8	10	5	13	0	16
Arkansas	0	0	0	6	24	30	7	23	30	15	15	30	4	24	20	8	29	3	11	3	11	0	14	NO DATA PROVIDED						3	15	10	6	2	18	NO DATA PROVIDED						NO DATA PROVIDED					
California	0	0	0	30	0	30	27	0	30	30	0	30	25	5	30	0	30	30	0	unk	unk	0	30	30	0	unk	unk	0	30	25	5	28	2	2	30	30	0	16	0	0	30	30	0	30	0	0	30
Colorado	0	0	0	0	0	0	7	4	11	2	1	3	1	4	4	1	5	6	3	5	4	1	9	6	3	6	3	0	9	1	6	2	5	0	7	8	5	6	7	5	13	2	3	1	4	3	5
Connecticut	20	0	20	20	0	20	27	0	27	2	28	30	NO DATA PROVIDED				26	8	13	0	21	0	21	4	16	0	20	0	20	NO DATA PROVIDED						19	3	0	22	0	22	17	12	0	29	0	29
Delaware	8	10	18	12	13	25	13	15	28	15	6	21	3	11	10	4	16	4	8	9	3	0	12	6	8	11	3	0	14	11	3	14	0	0	14	2	10	0	12	0	12	3	11	0	14	1	14
Dist. Of Col	9	0	9	7	0	7	7	4	3	0	8	9	3	1	4	0	3	1	1	0	2	1	2	2	0	0	2	0	2	1	3	0	4	0	4	2	3	0	5	0	5	1	2	0	2	1	3
Florida	17	0	17	25	0	25	30	0	30	7	23	30	21	9	8	22	30	13	16	9	20	0	29	23	6	4	25	1	29	24	5	4	25	1	30	15	15	5	25	3	30	17	13	6	24	2	30
Georgia	20	0	20	20	0	20	30	0	30	unk	unk	30	23	5	17	11	28	9	9	10	8	0	18	7	1	2	6	1	6	2	5	5	2	0	7	5	7	10	2	1	12	9	10	18	1	1	19
Hawaii	0	0	0	0	0	0	4	1	2	6	0	1	2	0	2	0	4	4	0	4	0	0	4	0	3	1	2	2	3	3	3	0	6	3	6	0	1	0	1	1	1	0	0	0	0	0	0
Idaho	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	1	0	0	0	0	1	0	0	0	0	0	0	1	0	1	0	0	1	1	0	1	0	0	1	0	0	0	0	0	0
Illinois	20	0	20	22	0	22	30	0	28	9	21	30	23	7	5	25	30	15	15	6	24	2	30	9	21	4	26	5	30	13	17	3	27	2	30	17	13	6	24	0	30	12	18	6	24	0	30
Indiana	15	3	18	23	5	28	19	11	27	20	10	30	14	16	5	25	30	20	9	10	19	4	29	8	6	0	14	1	14	6	10	4	14	4	18	15	14	12	17	7	29	14	16	unk	unk	1	30
Iowa	7	13	20	14	16	30	15	15	30	18	12	30			18	12	28	15	13	12	16		28	13	17	11	19	0	30	15	15	27	3	2	30	15	14	8	21	3	29	10	15	7	18	4	25
Kansas	0	0	0	4	0	4	6	6	14	8	22	26	7	10	14	3	17	7	10	9	8	0	17	1	13	8	6	0	14	3	13	8	8	0	16	4	9	9	4	0	13	6	10	6	10	0	16
Kentucky	20	0	20	26	4	30	24	6	30	24	6	30	17	13	22	8	30	14	16	unk	unk	3	30	13	17	21	9	5	30	14	16	20	10	5	30	14	16	15	15	10	30	16	14	17	13	9	30
Louisiana	0	0	0	13	2	15	12	3	15	7	6	13	NO DATA PROVIDED				10	10	5	8	7	3	18	9	13	11	11	5	22	11	11	11	11	4	22	8	7	12	3	4	15	14	11	6	19	7	25
Maine	11	1	12	8	12	20	11	18	29	7	11	18	10	13	9	14	25	5	13	9	9	2	18	13	12	10	15	0	25	15	8	9	14	3	23	2	7	3	6	5	9	unk	unk	unk	unk	unk	25
Maryland	2	4	6	4	5	9	13	3	15	14	8	22	22	8	unk	unk	29	14	10	4.5	19.5	0	24	5	11	1.5	14.5	5	16	9	9	12	6	1	18	14	7	10	5	6	21	6	12	8	10	5	16
Massachusetts	13	7	20	23	7	30	21	19	28	2	28	30	16	15	23	7	30	18	12	2	28	0	30	17	13	0	30	0	30	13	17	0	30	0	30	21	9	0	30	0	30	14	16	30	0	1	30
Michigan	20	0	20	30	0	30	30	0	30	15	15.5	30	18	12	17	13	30	18	12	10	20	5	30	14	16	10	20	0	30	10	20	12	18	3	30	10	20	9	21	1	30	8	22	12	18	1	30
Minnesota	14	0	14	20	3	23	25	5	30	8	7	15	8	10	6	12	21	5	12	8	9	5	17	NO DATA PROVIDED						5	18	9	14	5	23	8	7	5	10	5	15	11	10	12	8	7	21
Mississippi	10	4	14	6	7	13	7	9	19	19	0	17	14	5	19	0	18	5	3	7	1	1	9	4	5	9	0	5	9	2	5	1	6	0	7	2	1	1	2	1	3	4	3	4	3	2	7
Missouri	16	4	20	26	4	30	15	15	30	15	15	30	10	20	18	12	30	8	22	19	11	0	30	16	14	21	9	0	30	NO DATA PROVIDED						12	18	7	23	0	30	14	15	16	13	0	29
Montana	1	0	1	2	0	2	2	0	2	1	0	1	NO DATA PROVIDED				2	NO DATA PROVIDED					2	NO DATA PROVIDED						3	3	3	3	0	6	0	2	2	0	2	2	1	0	1	0	0	1
Nebraska	5	8	13	9	8	17	6	7	15	6	3	7	2	6	8	0	13	3	10	8	5	5	13	4	6	6	4	2	10	1	13	7	7	0	14	2	7	7	2	3	5	3	8	8	3	7	11
Nevada	20	3	20	20	12	20	26	8	26	6	12	18	11	1	4	8	13	11	0	3	8	0	11	9	0	1	8	0	9	9	2	1	10	1	11	9	0	3	6	2	8	0	2	0	2	0	2
New Hampshire	5	0	5	4	5	9	7	4	6	9	0	11	6	8	7	7	15	8	7	10	4	4	15	9	1	6	4	2	10	13	2	6	9	4	15	11	2	5	8	3	13	5	0	3	2	0	5
New Jersey	4	0	4	0	0	0	3	0	2	1	0	1	1	1	0	2	2	4	0	0	4	0	4	2	0	0	2	0	2	0	2	0	2	2	2	0	1	0	1	1	1	1	0	0	1	1	1
New Mexico	12	8	20	15	15	30	12	16	26	26	0	27	10	20	25	5	29	6	17	15	8	3	23	5	9	8	8	0	14	6	6	10	2	0	12	12	11	13	10	4	23	21	9	25	5	6	30
New York	14	6	20	27	3	30	20	10	30	10	20	30	5	25	9	21	30	10	20	4	26	4	30	15	15	8	22	2	30	16	14	7	23	4	30	12	18	8	22	2	30	18	12	7	23	1	30
North Carolina	8	0	8	14	0	14	9	1	10	11	0	11	10	3	11	2	16	13	1	11	3	1	14	NO DATA PROVIDED						NO DATA PROVIDED						10	2	12	0	2	12	6	5	6	5	5	11
North Dakota	5	2	7	6	4	10	9	3	11	6	5	13	1	3	1	5	10	2	5	2	5	5	7	4	5	3	6	5	9	1	5	1	5	0	6	0	9	0	9	0	9	0	10	0	10	10	10
Ohio	13	6	19	19	11	30	18	12	30	10	20	30	7	23	15	15	30	9	17	8	18	5	26	7	11	7	11	5	18	7	5	8	4	1	12	6	8	6	8	3	14	5	11	6	10	7	16
Oklahoma	4	1	5	0	0	0	0	0	0	8	9	17	3	9	3	9	12	4	3	3	4	1	7	NO DATA PROVIDED						3	6	4	5	5	9	6	4	3	7	2	10	3	4	2	5	0	7
Oregon	0	0	0	3	1	4	17	4	20	15	5	19	11	10	15	6	22	10	4	6	8	0	14	17	2	8	11	2	19	18	8	18	8	2	26	20	4	16	8	1	24	12	2	6	8	1	14
Pennsylvania	5	4	9	6	4	10	12	8	13	11	5.5	16	7	15	10	12	22	10	16	9	17	5	26	13	14	8	19	4	27	16	14	15	15	1	30	17	12	13	16	2	29	14	16	14	16	2	30
Rhode Island	17	3	20	22	8	30	21	9	30	unk	unk	30	NO DATA PROVIDED				30	NO DATA PROVIDED					30	8	12	0	20	0	20	NO DATA PROVIDED						4	15	0	19	0	19	NO DATA PROVIDED					
South Carolina	8	11	19	10	10	20	9	20	30	16	15	26	7	12	14	8	21	8	12	3	12	1	20	7	6	6	6	2	13	11	12	8	15	4	23	16	4	12	7	2	19	10	6	8	8	7	16
South Dakota	0	0	0	6	6	12	4	7	10	2	4	6	1	2	1	2	6	7	2	7	2	5	9	7	3	7	3	0	10	1	6	3	4	5	7	0	6	0	6	5	6	6	1	6	1	6	7
Tennessee	20	0	20	30	0	30	22	0	21	unk	unk	27	NO DATA PROVIDED				12	3	6	7	2	0	9	2	4	3	3	0	6	1	4	1	4	0	5	1	3	5	5	4	10	3	4	4	3	0	7
Texas	0	0	0	0	11	11	7	23	30	12	18	30	13	17	16	14	30	11	19	13	17	0	30	11	19	11	0	0	30	16	14	10	20	0	30	18	12	7	23	0	30	10	20	17	3	0	30
Utah	17	1	18	15	2	17	3	1	4	1	5	6	1	3	0	4	5	2	2	0	4	0	4	0	1	0	1	1	1	2	1	1	2	1	3	0	1	0	1	1	1	0	1	0	1	1	1
Vermont	0	1	1	0	1	1	0	0	0	0	0	1	3	0	3	0	2	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	0	0	0	0	0	0
Virginia	7	1	8	5	1	6	15	2	17	13	0	13	10	8	15	3	19	4	10	5	9	5	14	6	8	10	4	3	14	6	15	21	0	5	21	6	7	11	2	2	13	14	6	13	7	6	20
Washington	15	5	20	14	5	19	15	15	30	12	18	30	16	8	5	19	28	11	9	5	15	1	20	21	9	12	18	0	30	25	5	7	23	0	30	25	5	5	25	1	30	22	8	21	9	3	30
West Virginia	10	16	???	3	17	20	8	17	22	15	1	14	NO DATA PROVIDED				18	4	11	7	8	5	15	1	4	1	4	0	5	5	10	13	2	2	15	9	8	5	12	5	17	15	8	17	6	6	23
Wisconsin	20	0	20	21	0	21	29	0	29	unk	unk	23	11	1	2	10	12	11	5	6	10	2	16	16	4	15	5	3	20	14	7	9	12	4	21	3	16	7	12	5	19	7	4	9	2	2	11
Wyoming	1	0	1	1	0	1	0	1	3	3	1	3	1	4	2	3	4	0	4	0	4	4	4	3	0	3	0	0	3	3	3	2	4	4	6	1	5	1	5	6	6	2	3	2	3	3	5
Totals	452	127	550	622	220	842	663	350	982	471	400	964	415	286	444	347	864	407	419	297	468	83	859	397	340	282	425.5	61	737	395	377	352	420	62	773	435	374	306	439	116	809	306	373	360	368	119	794
Filled all slots			15			25			15			16					13						10						11						12						11						12
									(GAO)			(GAO)					(GAO)																														
Total State 30/ 10yrs: FFY 2001 to 2010																																														Total for 10 yrs = 8264	

International Medical Graduates and U.S. Immigration Policy
Myths and Realities

MYTH	REALITY
The Conrad IMG/MUA J waiver program costs taxpayers money.	Participating Conrad employers pay 100% of the salaries of the participating physicians. Unlike the National Health Service Corps or similar programs, no government funds are expended in loan repayment or any other compensation to participating physicians. Neither participating health facilities nor the physicians receive government funds as part of the program. In fact, some states receiving revenue in the form of filing fees, and the federal government receives between $1000 and $3,765 in filing fee revenues per case, between State Dept. fees and fees paid to USCIS.
U.S. citizens should be filling these physician positions	It would be fantastic if we could meet our nation's healthcare needs solely through the use of U.S. citizens and Lawful Permanent Residents. Unfortunately, by definition, very few U.S. MD's want to work in Medically Underserved Areas (MUAs). That is what makes the area underserved. Consider the following: • The Association of American Medical Colleges (AAMC) recently reported on a potential shortfall of 90,000 physicians in the U.S. over the next 10 years. https://www.aamc.org/newsroom/newsreleases/2011/268244/aamcreleases2011statephysicianworkforcedatabook.html • These shortages are predicted, in part, because despite increased enrollment in U.S. medical schools, federal funding for residency and fellowship training slots has remain frozen since 1997, making it impossible for graduate medical education programs to expand and accommodate the increased number of U.S. medical school graduates. The Resident Physician Shortage Reduction Act, if passed, would help correct this problem by increasing Medicare-funded graduate medical education training programs by 15% over a 5 year period. https://www.aamc.org/newsroom/newsreleases/2011/260830/110923.html • The physician shortage is particularly acute with regard to primary care physicians, with predictions of a shortage of over 45,000 primary care physicians by 2025.

	http://www.ama-assn.org/amednews/2010/04/12/prl10412.htm • The American Medical Association has reported that International medical graduates are more likely than U.S. medical graduates to fill primary care positions. http://www.ama-assn.org/ama1/pub/upload/mm/18/img-workforce-paper.pdf • International medical graduates are more likely than U.S. medical graduates to practice in medically underserved areas and to treat racially and ethnically diverse patient populations. http://www.ama-assn.org/ama1/pub/upload/mm/18/img-workforce-paper.pdf
Immigrants in general hurt our economy, especially in a recession or slow economic times	High skilled immigrants in general consistently create more jobs than they take, creating new businesses, driving technological advances and innovation, and raising wages. • A 2010 study published by the Federal Reserve Bank of San Francisco concludes that: "Statistical analysis of state-level data shows that immigrants expand the economy's productive capacity by stimulating investment and promoting specialization. This produces efficiency gains and boosts income per worker. At the same time, evidence is scant that immigrants diminish the employment opportunities of U.S.-born workers." http://www.frbsf.org/publications/economics/letter/2010/el2010-26.html; • Factcheck.org research found that: "Study after study has shown that immigrants grow the economy, expanding demand for goods and services that the foreign-born workers and their families consume, and thereby creating jobs. There is even broad agreement among economists that while immigrants may push down wages for some, the overall effect is to increase average wages for American-born workers." http://www.factcheck.org/2010/05/does-immigration-cost-jobs/ • Bernard Baumohl, Executive Director of the research organization, Economic Outlook Group, has been quoted by CNN as arguing that: 'Immigration is actually critical. . . It allows the U.S. economy to grow more rapidly without higher

	inflation pressures." http://money.cnn.com/2006/05/01/news/economy/immigration_economy/index.htm; • *The Economist* warns the U.S. that it turns away immigrant labor at its peril: "Immigration is, on the whole, good for economies; and right now, rich countries can do with all the economic help they can get. Rather than sending immigrants home, with their skills, energy, ideas and willingness to work, governments should be encouraging them to come. If they don't, governments elsewhere will.' http://www.economist.com/node/21526893 IMG's in particular consistently fill areas of chronic medical shortage, creating the framework for growth, along with new support services, RNs, administrative staffing, medical technicians, etc.
IMG MD's are not as good as U.S. MD's	We attract the cream of the crop from other countries. A recent study shows that patients of IMG's have significantly lower mortality rates (9%) than patients of U.S. citizen MD's. http://content.healthaffairs.org/content/29/8/1461.abstract.

Bloomberg

Doctors Educated Outside U.S. Outperform Home-Grown Physicians

By Pat Wechsler - Aug 3, 2010

U.S. patients of doctors who went to medical school outside the country and weren't American citizens had a 9 percent lower death rate on average than those whose doctors trained at home, a study showed.

The report, published today in the August issue of Health Affairs, tracked the performance of primary-care doctors, internists and cardiologists in 244,153 hospitalizations involving congestive heart failure or heart attacks.

Economics may help explain the gap in patient outcomes, said John Norcini, co-author of the study. Internal medicine and primary care have failed to attract the best U.S. students because of lower pay, relative to other specialties, he said.

"Primary care may not be getting the best and the brightest from U.S. medical schools," said Norcini, chief executive officer of the Foundation for Advancement of International Medical Education and Research, a Philadelphia-based nonprofit. "Foreign students see primary care as a gap that they can fill and a way to practice medicine here."

Primary-care doctors, including internists and family practice physicians, earn on average from $175,000 to $200,000 annually, while orthopedic surgeons make $519,000; radiologists, $417,000; and anesthesiologists $331,000, according to a survey released in June by the national physician search firm Merritt Hawkins, based in Irving, Texas.

U.S. medical schools don't produce enough graduates to supply all the postgraduate training slots available, and the void has been filled by graduates from institutions in other countries, Norcini said. These international-schooled doctors make up a quarter of practicing physicians in the U.S., and are especially important in the area of primary care, he said.

'Cream of the Crop'

"We have been blessed with the cream of the crop" from other countries, said Norcini. "The ones who make it through to become doctors are highly desirable and highly motivated."

Before being eligible to apply for a post-graduate residency slot in the U.S., graduates of non-U.S. medical

schools must go through a two-step process that tests a graduate's clinical knowledge and skills. Over the past five years, more than 10,000 certificates have been awarded annually by the Educational Commission for Foreign Medical Graduates, the group that created Norcini's foundation.

The authors of the Health Affairs study said their results, based on data from 2003 to 2006 in Pennsylvania, mark a shift from the early 1990s when research showed international medical graduates underperforming U.S.-trained doctors on licensing examinations, specialty board certifications and other metrics.

'Well Written'

"I am somewhat surprised by the results of the study," said John Prescott, chief academic officer of the American Association of Medical Colleges in Washington. "But the paper was well-written and the authors went out of their way to address any issues people might raise."

Not all international medical graduates had good results. U.S. citizens who attended medical schools abroad underperformed graduates of U.S. medical schools and citizens from other countries who went to school outside the U.S. Internationally trained foreign doctors had a 16 percent lower mortality rate than Americans schooled overseas, according to the Health Affairs article.

"Whenever you have a study like this, it says perhaps we need to look a little more closely," AAMC's Prescott said.

Issues Raised

Harlan Krumholz, a professor at Yale School of Medicine and director of Yale-New Haven Hospital Center for Outcomes Research and Evaluation, raised issues with the methodology and conclusions of the study.

"In reality there is a team of doctors for every patient and it is difficult to know the role that any one individual played," he said in an e-mail. He also questioned why the article didn't distinguish where the international medical graduates went to school.

"This can only be considered an exploratory result," he said.

Even though foreign medical graduates produced good patient outcomes, according to this study, they may find it harder to get a post-graduate residency as U.S. medical schools have increased their class sizes while the federal government has failed to raise the number of training spots available. The number was capped in 1997 as a way to control spending on Medicare, the U.S. health plan for the elderly and disabled. Medicare helps fund post-graduate positions.

The study also found that doctors who have been certified by a medical specialty board -- typically after completing post-graduate training -- have lower mortality rates than those who haven't been, regardless of nationality, Norcini said. The further a doctor gets from medical training the worse their patients fare as well,

making an argument for the need for continuing education and post-certification testing, he said.

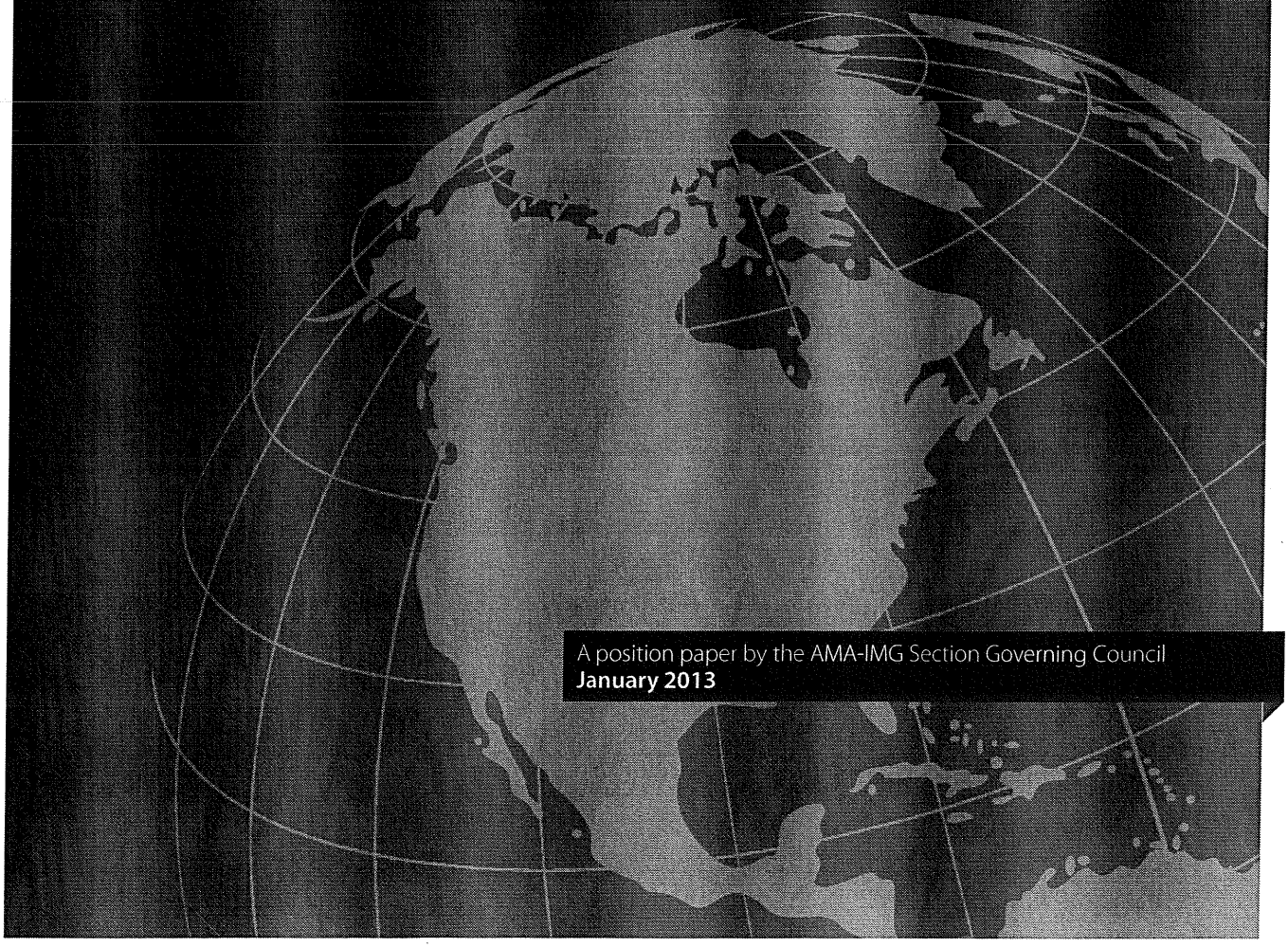
"People don't need to pay so much attention to whether their doctor is a graduate of an international school but they should pay more attention to whether or not the doctor has been board certified," Norcini said.

To contact the reporters on this story: Pat Wechsler in New York at pwechsler@bloomberg.net

AMA
AMERICAN MEDICAL ASSOCIATION

International medical graduates in American medicine:

Contemporary challenges and opportunities



A position paper by the AMA-IMG Section Governing Council
January 2013

Table of contents

Acknowledgements . . . 3
Introduction . . . 4
Historical context of medical education and migration . . . 5
Early American medicine . . . 6
State of medical education . . . 7
Flexner Report and aftermath . . . 7
The evolution of American medicine: Three-legged stool of teaching, patient care and research . . . 7
Creation of modern GME . . . 7
Flexner's impact on U.S. medical schools . . . 8
IMGs: The work force dynamics . . . 8
The profile of IMGs in 2011 . . . 11
U.S. citizens pursuing ECFMG certification . . . 12
Post-residency IMGs . . . 13
The Educational Commission for Foreign Medical Graduates and IMGs . . . 16
IMGs in the context of physician shortage in the United States . . . 21
Impact of health care reform on physician work force . . . 21
Council on Graduate Medical Education findings . . . 22
Health Resources and Services Administration . . . 23
Association of Academic Health Centers . . . 23
Recommendations . . . 24
Graduate medical education (GME) . . . 26
Selecting residency programs . . . 26
ECFMG certification . . . 26
Applying to graduate medical education programs . . . 26
Obtaining a residency position in the United States . . . 32
International medical schools . . . 33
Observerships . . . 34
Immigration and visas . . . 35
Foreign national IMGs and graduate medical education . . . 35
Legal permanent residence or "green card" status . . . 36
USIMGs . . . 38
Dynamics of migration: Brain drain . . . 40
A historical review of IMG contributions to physician work force: Safety-net and primary care . . . 44
Gap-filling or safety-net role . . . 44
IMGs in primary care . . . 47
IMGs in academic medicine and research . . . 49
Trends among IMG faculty at U.S. medical schools: 1981–2000 . . . 50
Immigration . . . 50
IMGs in organized medicine . . . 51
2012–2013 AMA-IMG Section Governing Council . . . 51
State medical societies with IMG sections . . . 51
Recommendations . . . 52
Conclusion . . . 54

IMGs: The work force dynamics

While these far-reaching and fundamental changes were occurring in America, the countries that would later become significant sources of IMGs to the United States (India, Pakistan and the Philippines) were undergoing major struggles for independence from their colonial rulers. For these countries, one of the beneficial effects of their colonial past had been their facility with the English language and the education systems of their former colonial powers. In medicine, this translated into the Western practices and education systems being inherited to form a medical education system that produced physicians in large number who were ill-suited to practice their Western-influenced skills and knowledge in their native lands. There was considerable dissonance between the real world and the curriculum in the medical school for these young physicians. The physicians who came out of this system were greeted by a social reality that lacked the financial wherewithal to utilize their skills, and emigration became a way out for many aspiring doctors in these emerging post-colonial societies. Today, rulers of these donor countries tacitly encourage emigration of their talented physicians for multiple reasons, and there has been an outcry in the west against the ethics of wealthy nations taking advantage of more vulnerable, developing nations.

The presence of IMGs has ebbed and flowed during the past 70 years. These fluctuations have been influenced by major economic, immigration and social priorities of the United States. It has been noted by work force researcher Steven Mick that IMG presence usually diminishes in response to an ECFMG certification or immigration-related policy change aimed at restricting IMGs' entry into the United States. Subsequently, as IMGs find a way around the new policy due to structural weakness in the economy and the vast health care system, their numbers tend to increase. While the 1950s and 1960s were marked by the migration of European and Latin American physicians, the 1970s and subsequent decades were marked by Asian physician dominance in the IMG work force. The turning point came when U.S. immigration priority was changed from family reunion to preference for high-skilled professionals. In addition, the advent of Medicare, which resulted in the expansion of health care coverage to seniors, the disabled and the poor, required employment of a large number of physicians. This opened the doors widely to the IMGs. On the other hand, in the 1980s and early 1990s, the influence of managed care resulted in the contraction of clinical services with fewer physicians needed to run those services.

Around this period, there were significant concerns that the United States had a physician surplus and that IMGs' entry should be curtailed. This coincided with the failed Clintonian health care reform effort. Simultaneously, many professional organizations offered remedies to curtail physician surplus like the 110 percent solution, which addressed the work force surplus by capping the number of GME positions at 110 percent of the number of U.S. medical graduates. However, not much came out of these recommendations, and the number of IMGs continued to rise unabated in the 2000s. Even the introduction of the Clinical Skills Assessment (CSA) exam by ECFMG—to be held only in the United States—had only a temporary impact on the number of IMGs who entered the U.S. work force.

The tragedy of 9/11 and its aftermath did, however, adversely affect the climate for immigrants in general and IMGs as part of that population. Yet, the movement towards Obama's health care act, which has impacted 37 million more Americans as well as 15 million more Medicare recipients due to the aging of baby-boomers, has increased the demand for physicians. (This massive expansion is similar to the expansion that occurred following the introduction of Medicare in 1965.) The United States has responded to this demand by increasing its domestic output of physicians while taking an ambiguous approach to the presence of IMGs in American medicine. However, the increase in the number of undergraduate medical education (UME) positions is not matched in a correlative increase in the number of GME positions. The disconnect between UME and GME has resulted in the likelihood of IMGs being removed from GME positions due to a 1997 cap imposed on expanding the number of GME positions. Thus, the tool that was used to curtail the number of IMGs entering U.S. GME is now restricting any increase in Medicare financing of GME for U.S. graduates.

Parenthetically, one must mention that there has been a large number of IMGs who entered the United States legally but have not succeeded in obtaining GME positions, in spite of possessing all the requisite ECFMG certificates. The flow-chart demonstrates clearly various paths IMGs traverse to obtain residency positions, details of which can be found in the chapter on immigration in this publication. The plight of these individuals (20 percent per year) is becoming known across the IMG world. It is aided by the perception amongst IMGs in major source countries that the United States is not as welcoming as originally thought and that going to the United States can be a very frustrating exercise. Consequently, the number of IMGs in the United States is beginning to fall.

The role of IMGS in the work force

IMGs total 25.8 percent of all post-residency physicians and 26.3 percent of residency physicians in the United States. Their strengths are in patient care (75.5 percent), but they are less represented in research, medical teaching and administration[9] (see table below)

Number of physicians in United States	985,375
Number of IMG physicians in United States	254,396
% IMG physicians in United States	25.8
% IMGs in residency programs	26.3*
% IMGs in patient care	75.5
% IMGs on full-time staff	29.9
% IMGs in research	19.9
% IMGS in medical teaching	16.7*
% IMGs in administration	12.0

*Percentages exclude residents/fellows unless otherwise noted.

IMGs have been a part of American health care for the last 75 years.[10] They have played a critical role in caring for underserved populations and a corrective role in physician maldistribution and in the survival of specialties such as pathology and nuclear medicine. The heterogeneity among IMGs may be an asset in a multicultural society with an expanding minority population that will eventually outstrip the current racial majority.

Relative to the preceding point, it should be noted that the percentage of U.S. minorities entering medical schools in the United States has remained constant for a long period of time despite concerted efforts to increase their presence in the physician work force. It must be noted, further, that foreign medical education is the preferred route to becoming a physician for U.S. minority students.

In these times of budget deficits and uninsured individuals who will enter the health care system, the IMGs, as physicians who are ready and eligible to enter U.S. GME, may play an important role in serving our country's patients. Simple arithmetic confirms that without either doubling the output of U.S. medical graduates or keeping IMGs as part of the solution, the physician work force shortage will not be resolved. Following are some IMG-focused strategies to address the work force shortage.

Recommendations

1. Fund more graduate medical education positions. If the number of graduate medical education slots were determined by the needs of the system, the physician shortage could more realistically be addressed. The graphic on pageXX illustrates the interrelationships among the four major groups in the U.S. residency work force. With the total number of U.S. medical graduates slated to grow by 30 percent by 2014, it is highly unlikely that IMGs will find space in residency training, or their numbers will be so diminished due to the residency cap imposed by Medicare. The best solution would be to lift the cap and see how the market forces would correct the demand for physicians. If this change is not made, most likely there will be an impact on care for the underserved and in primary care because of the central role IMGs play in those areas. See the table on page XX.

2. Redesign immigration visa categories by permitting dual intent for individuals with temporary visas or by doing away with temporary visas altogether: A new visa type similar to category O (a temporary visa for "aliens of extraordinary ability") should be created for physicians to allow flexibility during the various phases of their training and careers.

3. Plan for the long term—if the current physician shortage is not addressed by the measures suggested, the following long-range solutions should be considered:

   a) Undertake active recruitment of foreign physicians. This idea is a radical one that would allow IMGs with postgraduate degrees from certain English-speaking countries to enter the United States and start practicing right away. (The requirement would be that any foreign physician, no matter how senior, who wishes to obtain a license to practice medicine in the United States, must complete a residency program here.) Active recruitment was used by the United Kingdom to recruit a large number of senior physicians from India and South Africa to run its National Health Service. [11,9] However, one important point that must be remembered is that it is unethical for the recruiter to rescind these physicians' employment when the native physician supply improves.

9. Smart DR. Physician Characteristics and Distribution in the U.S. 2011 ed. Chicago, IL: American Medical Association; 2011

10. Rao NR. "A Little More than Kin, and Less than Kind": U.S. Immigration Policy on International Medical Graduates. Virtual Mentor. 2012;14(4):329-37.

11. Overseas doctors and the UK's National Health Service. Lancet. 2007;370(9583):194.

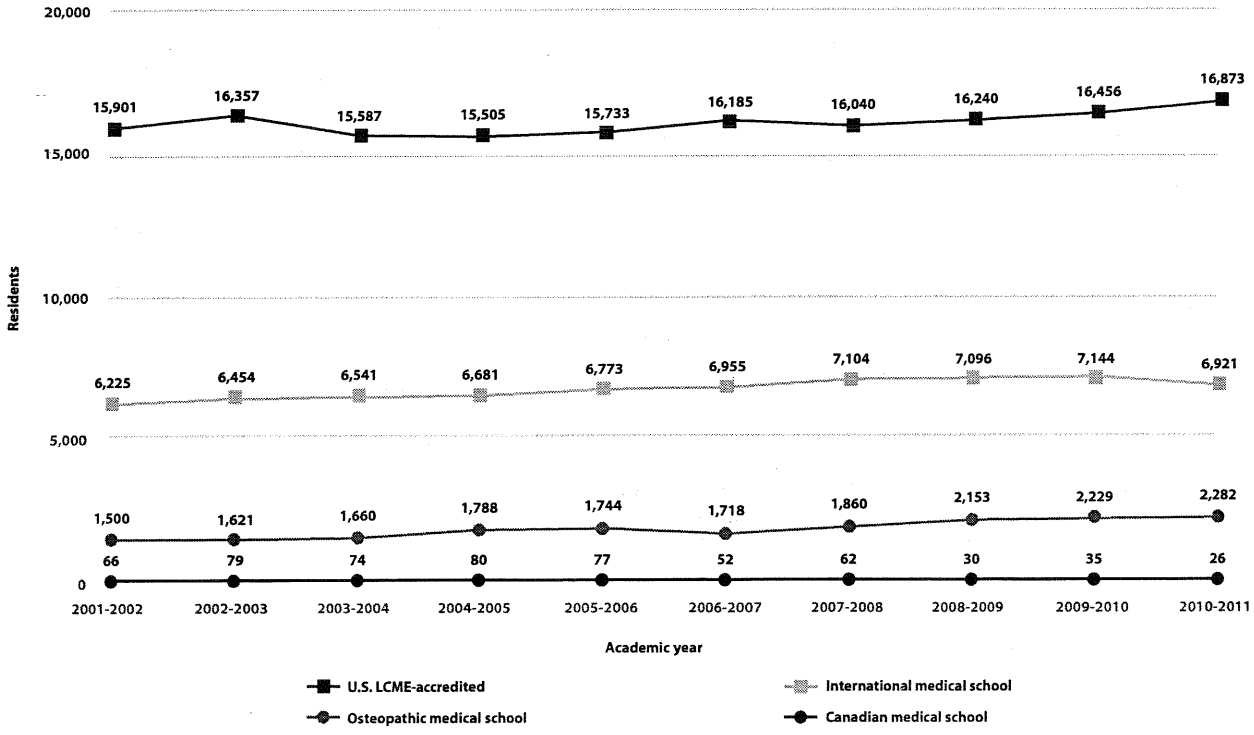
b) Develop a truly global medical education system in which the undergraduate and graduate medical education standards of the United States shape medical education abroad. This development would allow professionals to move back and forth between the United States and their countries of origin, as individuals are able to do within countries and between Eurozone countries. Recently, the Accreditation Council for Graduate Medical Education accredited Singapore's graduate medical education program, and many U.S. medical schools have established satellite campuses abroad. The Educational Commission for Foreign Medical Graduates (ECFMG) will require international accreditation of foreign medical schools starting in 2023.[12]

With the exception of the AAMC, which calls for continued entry of IMGs with the J-1 visa, none of the major organizations have explicitly addressed the relevance of IMGs in correcting the physician shortfall. Not addressing the role of IMGs in the work force shortage is a cause for concern. Reports from the ECFMG mention a double-digit reduction in first-time registrants from India and other South Asian countries.

In conclusion, we have discussed the problem of physician shortage and its causes and have highlighted the role of IMGs in relation to this issue. A balanced physician work force is critically needed due to the cultural and economic changes occurring in the United States. A partial solution will make the current problem worse, and the country will have to then turn to more expensive solutions or to solutions involving less well-trained individuals—an outcome not supported by any party at this time.

12. ECFMG (2012) 2011 Annual Report: Available at: www.ecfmg.org/resources/ECFMG-2011-annual-report.pdf. Accessed Jan. 10, 2013.

Number of residents entering the pipeline, by medical school type and academic year



ACGME (2012) Data Resource Book: Academic Year 2010-2011

Recommendations

The American Medical Association International Medical Graduates (IMG) Section Governing Council proposes the following recommendations:

Work force

1. The United States is in the throws of an acute physician shortage caused by demographic changes, changes in physician work effort, increased demand for physician services caused by health care reform, among other reasons. One way to address this shortage is to permit an increase in graduate medical education (GME) positions by lifting the cap on their expansion. The IMG section strongly endorses the stated positions by the AMA and the AAMC on this issue.

2. The mechanism being used to address the shortage of physicians is to increase domestic output of physicians. Given the fixed number of GME positions, solely depending on domestic increases will exclude IMGs from GME, which will have an adverse impact on patient populations that traditionally depend on IMGs. It is imperative that the AMA and the AAMC lobby for the removal of GME caps and expand GME positions by creating alternative funding mechanisms, reallocating GME positions and stipends.

3. Explore accrediting and recognizing international GME programs outside the United States/Canada in order for IMGs to enter and exit residencies more efficiently.

4. Launch a strategic grassroots campaign to inform members of Congress and the U.S. Senate in IMG-rich states (power states) about the physician shortage, IMG contributions and visa issues that will affect their constituencies both positively and negatively.

5. Work with the Council on Medical Education on work force and IMG issues.

6. Create a new societal obligation for ALL medical students and residents to serve in a shortage area or underserved community for two years.

Licensure parity

7. Continue to collaborate with and support the Federation of State Medical Boards (FSMB) efforts to develop guidelines for uniform licensure requirements for USMGs and IMGs alike to be applied by individual state medical boards.

8. Encourage IMGs to use the Federation Credentials Verification Service (FCVS) as a standard, primary source verification for their medical education to facilitate their ability to obtain a medical license from state medical boards.

9. Encourage all state medical licensing boards to utilize the International Medical Education Directory (IMED) to verify medical school credentials and avoid creating arbitrary lists of approved and unapproved medical schools.

10. Establish state medical license portability across the United States as a top priority for all physicians. If medical licenses were portable, the physician work force could redistribute itself more efficiently, especially in times of disasters.

11. Encourage state medical boards to collect practice data information from physicians during the licensure renewal process. This data will be helpful in accurate work force planning and policies.

12. Promote the Education Commission for Foreign Medical Graduates' (ECFMG's) Electronic Repository of International Credentials (EPIC) program in 2013.

Visa issues

13. Lobby relevant governmental agencies to streamline the visa issuance process to avoid unnecessary delays affecting the timely entry of IMGs in graduate medical education programs.

14. Congress should increase the number of J-1 visa waiver positions (currently 30 per state) especially in states with the greatest projected shortages.

15. Lobby for the creation of an "MD visa" as a separate visa classification for physicians.

Graduate medical education

16. Advocate for equal consideration for IMG and USMG residency acceptance. Residency programs must consider IMG applications equivalent to the USMG applications by using the same evaluation criteria. It is imperative to have transparency and nondiscrimination in the selection process.

17. Study the National Resident Match Program (NRMP) All-In Policy's impact on IMGs.

18. Increase the number of GME positions so that ECFMG-certified IMGs who are waiting for residency positions can enter the physician work force immediately. One alternative funding mechanism suggestion is to reevaluate residents' stipends and length of training.

19. Increase IMG representation on national and regional medical boards, regulatory bodies and organizational administrative positions responsible for regulation and policymaking. For IMG concerns to be heard, they must be voiced and addressed. Boards such as ECFMG, and most recently NRMP, which have included IMG representation, have benefited greatly.

20. Continuously study challenges and issues pertinent to IMGs because these issues are evolving as our country's health system is changing. The federal government should fund studies through the National Institutes of Health, for example, to review issues and experiences encountered by IMGs and the patients they serve.

21. Recent data revealed that IMGs commonly have higher USMLE scores and provide quality medical care on par with that of their USMG colleagues. Encourage and incentivize GME program directors and residents/fellows to provide a more welcoming and appreciative culture towards IMGs and minorities. Diversity within a GME program is a mark of excellence for the profession and the diverse patient population it serves.

22. Explore research funding as one way to fund GME positions.

23. Acculturation programs and resident/fellow orientations should be created by local medical societies and GME program directors. The AMA-IMG Section and the ECFMG (via ECHO) should serve as a clearinghouse for these resources.

24. Reach out to USIMGs to present a uniform voice and messaging about GME.

25. Shift some of our GME programs to other countries.

Scholarly research

26. Sponsor a research competition for IMG studies and offer substantial prize money.

Observerships

27. Create more observerships or job shadowing opportunities for IMG physicians to work in clinical settings under the supervision of a licensed physician with privileges. This will enable IMGs to familiarize themselves with the American system of health care delivery and provide them with the experience they need to enter into a residency program. Also, these types of programs will keep the IMG in touch with clinical medicine and assist them in sharpening their communication skills. The AMA-IMG Section's Observership Guide at ama-assn.org/go/observership can be used as a resource.

28. Create positions in hospitals and use unemployed, qualified IMGs who are awaiting residency to help hospitals with performance improvement and safety projects that can improve the overall quality of hospital care.

Global physician migration

29. Encourage more study and analysis on global physician migration patterns before we can offer any recommendations or analysis on this topic. It is premature to make a determination on the effects of the global physician migration. The current debate regarding "brain drain" has been biased and inconclusive. The money and transfer of medical knowledge between donor and recipient countries has not been quantified nor studied sufficiently.

30. Explore collaborations with host countries in order to create partnerships on undergraduate and graduate medical education.

Conclusion

In this discussion paper, the AMA-IMG Section Governing Council has examined numerous aspects concerning the presence of IMGs in the U.S. physician work force. The IMG story—including the challenges IMGs have faced and continue to face—has been outlined. While the presence of IMGs is beset with controversies, biases and misconceptions, we feel we have presented data to clarify and address many of these issues.

Historically, IMGs have served patients in the United States in the highest professional manner, making up one-quarter (25.3 percent) of the physician work force and more than one-quarter (27.8 percent) of resident physicians. IMGs often serve in the neediest communities and are over-represented in primary care specialties.

The AMA-IMG Section Governing Council has presented data to illustrate the following points:

- IMGs are more likely to serve in medically underserved areas
- IMGs comprise more than 30 percent of the work force in primary care specialties
- IMGs comprise close to 40 percent of the physician work force in inner-city areas in large metropolitan cities
- IMGs comprise a significant portion of critical care physicians in this country
- IMGs have participated in mainstream medical organizations and are increasingly being appointed/elected to leadership positions
- IMGs are undoubtedly an integral part of health care delivery in this country
- IMGs generally go through a unique set of challenges in getting a residency position, securing legal immigration and finding the right job

We will continue to monitor and study IMG issues, as well as revise this discussion paper every other year. Please send an email to img@ama-assn.org with any comments or questions.

Thank you for your interest.

NATIONAL FOUNDATION FOR AMERICAN POLICY

NFAP POLICY BRIEF » NOVEMBER 2012

U.S. GOVERNMENT, HEAL THYSELF: IMMIGRATION RESTRICTIONS AND AMERICA'S GROWING HEALTH CARE NEEDS

BY STUART ANDERSON

EXECUTIVE SUMMARY

The U.S. Congress and the executive branch have failed to establish immigration policies that would allow a sufficient number of foreign-born doctors, nurses and other medical personnel to work in the United States. At a time of tremendous need in health care, the United States is saddled with an immigration system designed to prevent, not facilitate, the entry of highly skilled physicians, nurses, physical therapists and other foreign-born medical personnel. The aging U.S. population, the demands of the Affordable Care Act (ACA) and the potential benefits brought by medical advances and increased specialization mean America must tap the global talent pool in health care or see its citizens suffer the consequences.

This report makes four broad policy recommendations:

1) Expand the number of employment-based green cards so the wait times for skilled immigrants, including nurses, physicians, and physical/occupational therapists, can be measured in weeks or months, rather than in years or decades.

2) Establish a temporary visa that facilitates the entry of foreign nurses. Current temporary visas do not work for the vast majority of foreign nurses and their potential employers.

3) To aid patients in underserved areas and enable more U.S.-trained doctors to pursue specialized medical fields expand the Conrad 30 program to include many more physicians per state and in the country as a whole. Also, we should consider policies to overcome the limitations on medical residency slots in the U.S. by developing guidelines to allow foreign-trained doctors to practice in the United States if they can demonstrate a high level of expertise. Congress logically should include physicians and medical researchers in biology and chemistry in the definition of Science Technology Engineering and Mathematics (STEM) for exemption from employment-based green card quotas in future legislation.

4) Streamline state licensing and other procedures for foreign medical personnel, including physical therapists and occupational therapists, to help with the nation's long-term health needs.

Given the tremendous demand for health care services in the coming years it is not possible for America to meet those needs through purely domestic means. In general, a "shortage" normally does not last for a long time in a labor market. However, government actions, such as current immigration restrictions, can lead to an undersupply

of specialized labor and leave employers with choices that may not be in the best interests of consumers. In other words, "shortages" of doctors and nurses in the United States will appear in the form of longer waits for appointments and subpar medical care for Americans, not empty hospital rooms or vacant medical office buildings.

Physicians

The U.S. immigration process sets up significant obstacles for foreign-born doctors. To be granted a license to work as a physician in the United States a foreign national must complete a graduate medical education, which usually means entering on a J-1 visa or an H-1B visa. However, a J-1 visa requires an individual to return to his or her home country unless a waiver is received. J-1 waivers often require a foreign doctor to work in an underserved area in the United States. J-1 waivers can be issued through a government agency and/or via the Conrad 30 program. Under the law, Conrad program J-1 waivers are limited to 30 per state, which means in large states the waivers can be exhausted in a matter of days.

"Finding a doctor will get increasingly difficult, waits for appointments will grow longer, and more sick people will turn to crowded emergency rooms," according to Ted Epperly, of the American Academy of Family Physicians. "The Association of American Medical Colleges estimates that in 2015 the country will have 62,900 fewer doctors than needed," reported the *New York Times* in discussing the impact of President Obama's health care legislation. "And that number will more than double by 2025, as the expansion of insurance coverage and the aging of baby boomers drive up demand for care." Analysts agree that individuals with health insurance are more likely to use medical services and the Congressional Budget Office estimates the Affordable Care Act could insure 30 million people who previously lacked health coverage.

"Severe physician shortages have already hit children," according to Mark Wietecha, President and Chief Executive of the Children's Hospital Association, which represents more than 220 children's hospitals. "Children are struggling to get timely medical care, with some waiting almost four months for subspecialist appointments even in communities served by a children's hospital." The association's survey found, "In the most affected specialties, children can wait nearly 15 weeks for appointments in developmental-behavioral medicine and 9 weeks in neurology."

Nurses

The need for registered nurses (RNs) may surpass that of doctors. According to a 2012 "United States Registered Nurse Workforce Report Card and Shortage Forecast," published in the *American Journal of Medical Quality,* "With an aging U.S. population, health care demand is growing at an unprecedented pace . . . The number of states receiving a grade of "D" or "F" for their RN shortage ratio will increase from 5 in 2009 to 30 by 2030, for a

total national deficit of 918,232 RN jobs. There will be significant RN workforce shortages throughout the country in 2030; the western region will have the largest shortage ratio of 389 RN jobs per 100,000."

A major problem with attempting to increase the supply of nurses only domestically is finding qualified instructors for nursing schools. But hiring a foreign nurse on a temporary visa is daunting and potentially not even possible, depending on the job requirements and the country of origin. That leaves primarily green cards as the only viable path for most foreign nurses, but the wait for employment-based green cards is currently 5 years or more from most countries. One argument made by critics is the H-1A temporary visas available in the early 1990s resulted in poor treatment of foreign nurses. However, economist Ruth Levine authored a Department of Labor-commissioned study and concluded, "There was no evidence that the increased access to foreign labor under the law had negative short-term effects on the wages, benefits or working conditions in area hospitals. . . . In addition, and contrary to common beliefs, we found that foreign nurses were not paid less than U.S. nurses and were not exposed to worse working conditions."

Unlike other foreign nationals who can work in the United States in H-1B status while waiting for their green cards, typically a foreign nurse must wait overseas. It is a testament to the need for foreign nurses that employers would endure the cost and the wait of at least 5 years until a foreign nurse could begin working in the United States. The problem is not simply overall numbers but the distribution of nurses geographically and the need for specialty nurses, note experts in the field.

As economists explain, there is no such thing as a free lunch. The cost of policies that permit too few nurses to work in America is paid for by a greater rate of infection and increased patient mortality. In *Medical Care* (April 2011), Mary A. Blegen and other researchers found higher nursing care staff hours were associated with lower rates of dying from congestive heart failure, infections, and prolonged lengths of stay. The conclusion: "Higher nurse staffing protected patients from poor outcomes." According to a study published In the *New England Journal of Medicine* (March 2011), "Staffing of RNs (registered nurses) below target levels was associated with increased mortality, which reinforces the need to match staffing with patients' needs for nursing care."

A *Journal of the American Medical Association* study found that increasing a nurse's workload from 4 to 8 patients would be accompanied by a 31 percent increase in patient mortality. "These effects imply that, all else being equal, substantial decreases in mortality rates could result from increasing registered nurse staffing, especially for patients who develop complications." The authors concluded, "Our major point is that there are detectable differences in risk-adjusted mortality and failure-to-rescue rates across hospitals with different registered nurse staffing ratios."

Physical Therapists

Physical therapists are among the fastest growing occupations in America. The Bureau of Labor Statistics projects the number of physical therapist jobs to grow by 39 percent (or 77,400) between 2010 and 2020. "On the basis of current trends, demand for PT services will outpace the supply of PTs within the United States. Shortages are expected to increase for all 50 states through 2030. By 2030, the number of states receiving below-average grades for their PT shortages will increase from 12 to 48. States in the Northeast are projected to have the smallest shortages, whereas states in the south and west are projected to have the largest shortages," according to research published in the *American Academy of Physical Medicine and Rehabilitation.*

Despite this, licensing and immigration procedures can often take three to four years to complete before foreign-born physical therapists can become eligible to work in America. Even then, foreign physical therapists may find an H-1B visa is unavailable or the wait for a green card could take years, particularly for nationals of India and China. U.S. organizations have pushed to move the minimum degree requirement for entry in the physical therapy field up to the level of Ph.D. by 2020. This new standard, combined with U.S. immigration restrictions, is likely to make it far more difficult for Americans, particularly seniors, to find physical therapists in a timely manner in the coming years.

The argument against allowing foreign doctors and nurses to enter the United States because it may create a "brain drain" in other countries is a red herring. It is usually promoted by people or organizations opposed to high skill immigration for reasons that have nothing to do with concern for people in other countries. There is no evidence that proponents of the "brain drain" argument perform considerable (or any) charitable works to help foreigners or care more about people in particular foreign nations than those who grow up and educate themselves in those nations hoping to work abroad and send money home to their families. Foreign doctors and nurses have many choices besides coming to the United States, since the demand for their services is widespread in industrialized nations. That means blocking the entry of skilled foreign professionals hurts U.S. patients and serves only to divert these professionals to other Western nations.

There are now over 100 million Americans age 50 or older and approximately 3.5 million Baby Boomers turn 55 every year. In another 20 years, over 20 percent of the U.S. population is expected to be 65 or older, according to United Nations estimates. While Americans are living longer, they would be living better with a sufficient supply of doctors, nurses and other medical personnel. U.S. patients and hospitals have waited decades for Congress to reform the immigration system for professionals in the health care system. The need is evident and the reforms are straightforward. Americans will continue to suffer the medical consequences unless Congress and the executive branch act on such reforms.

BACKGROUND: TOO FEW DOCTORS, NURSES AND PHYSICAL AND OCCUPATIONAL THERAPISTS

Economists Adam Smith and Frederic Bastiat explained that the purpose of sound economic policy is to benefit the consumer, not the producer. Bastiat wrote, "Treat all economic questions from the viewpoint of the consumer, for the interests of the consumer are the interests of the human race."[1] In medicine, another name for the consumer is "the patient." U.S. immigration policy in the health care field has placed the needs of patients far behind those of special interests and others who mistakenly argue the market for labor is solely domestic, rather than global. That is the case even though blocking the entry of foreign nurses and other medical professionals harms both U.S. patients and the well being of U.S.-born nurses and doctors.

In general, a "shortage" normally does not last for a long time in a labor market. However, government actions can lead to an undersupply of specialized labor and leave employers with choices that may not be in the best interests of consumers. "Finding a doctor will get increasingly difficult, waits for appointments will grow longer, and more sick people will turn to crowded emergency rooms," according to Ted Epperly, of the American Academy of Family Physicians, which includes more than 90,000 doctors.[2]

In other words, "shortages" of doctors and nurses in the United States will appear in the form of longer waits for appointments and subpar medical care for Americans, not empty hospital rooms or vacant medical office buildings. "The Association of American Medical Colleges estimates that in 2015 the country will have 62,900 fewer doctors than needed," recently reported the *New York Times*. "And that number will more than double by 2025, as the expansion of insurance coverage and the aging of baby boomers drive up demand for care. Even without the health care law, the shortfall of doctors in 2025 would still exceed 100,000."[3]

Dean Baker, co-founder of the Center for Economic and Policy Research, noted the *New York Times* article contained no discussion of relaxing U.S. immigration laws to address the lack of doctors: "If the government were to set up mechanisms that could fast track the certification of doctors from other countries so that they could quickly establish that they have been trained to U.S. standards and then would be free to come to practice in the United States just as any native-born doctor, it is likely hundreds of thousands of doctors from around the world would quickly take advantage of the opportunity."[4] As noted later in this analysis, the U.S. government currently

---

[1] As cited in "Quote of the Day," Carpe Diem, January 22, 2012. http://www.aei-ideas.org/2012/01/quote-of-the-day-from-frederic-bastiat/. Thank you to economist Mark Perry for his insights on the term "labor shortage."
[2] Janice Lloyd, "Doctor Shortage: Primary Care Losing Its Prestige," *USA Today*, August 18, 2009.
[3] Ann Lowrey and Robert Pear, "Doctor Shortage Likely to Worsen with Health Law," *New York Times*, July 28, 2012.
[4] Dean Baker, "Doctor Shortage? NYT Has Never Heard of 'Immigration,'" *Business Insider*, July 29, 2012. Baker mentions helping developing countries train additional doctors. It is preferable to help developing countries in this way, possibly with the

makes it difficult for foreign physicians to practice in America. Cuts in federal subsidies to teaching hospitals could mean fewer residency spots for both foreign and U.S. doctors, note attorneys.

Estimates vary, but no analysts believe the United States will have enough doctors or nurses to meet patient needs in the coming years. "According to Richard "Buz" Cooper, MD and Linda Aiken, PhD, RN, co-chairs of the newly created Council on Physician and Nurse Supply, the U.S. may lack as many as 200,000 physicians and 800,000 nurses by the year 2020."[5] Analysts point to a connection between doctors and nurses, since patients without available doctors may have no choice but to see a nurse or nurse practitioner. However, as nurses are compelled to fill new or additional roles it will mean fewer nurses available to perform their traditional or primary duties.

"Severe physician shortages have already hit children," according to Mark Wietecha, President and Chief Executive of the Children's Hospital Association, which represents more than 220 children's hospitals. "Children are struggling to get timely medical care, with some waiting almost four months for subspecialist appointments even in communities served by a children's hospital. These wait times, documented in a recent survey by the Children's Hospital Association, are a result of vacancies of 12 months or longer among key pediatric specialties. Shortages of specialists affect the ability of families to obtain timely medical care for children in communities across the country."[6] The association's survey found, "In the most affected specialties, children can wait nearly 15 weeks for appointments in developmental-behavioral medicine and 9 weeks in neurology." The association cites the longer training periods needed for pediatric specialty care and low Medicaid reimbursements for discouraging doctors from filling the need for pediatric specialists.[7]

The need for registered nurses may surpass that of doctors. According to a 2012 "United States Registered Nurse Workforce Report Card and Shortage Forecast," published in the *American Journal of Medical Quality,* "With an aging U.S. population, health care demand is growing at an unprecedented pace . . . The number of states receiving a grade of "D" or "F" for their RN shortage ratio will increase from 5 in 2009 to 30 by 2030, for a total national deficit of 918,232 RN jobs. There will be significant RN workforce shortages throughout the country in 2030; the western region will have the largest shortage ratio of 389 RN jobs per 100,000."[8]

---

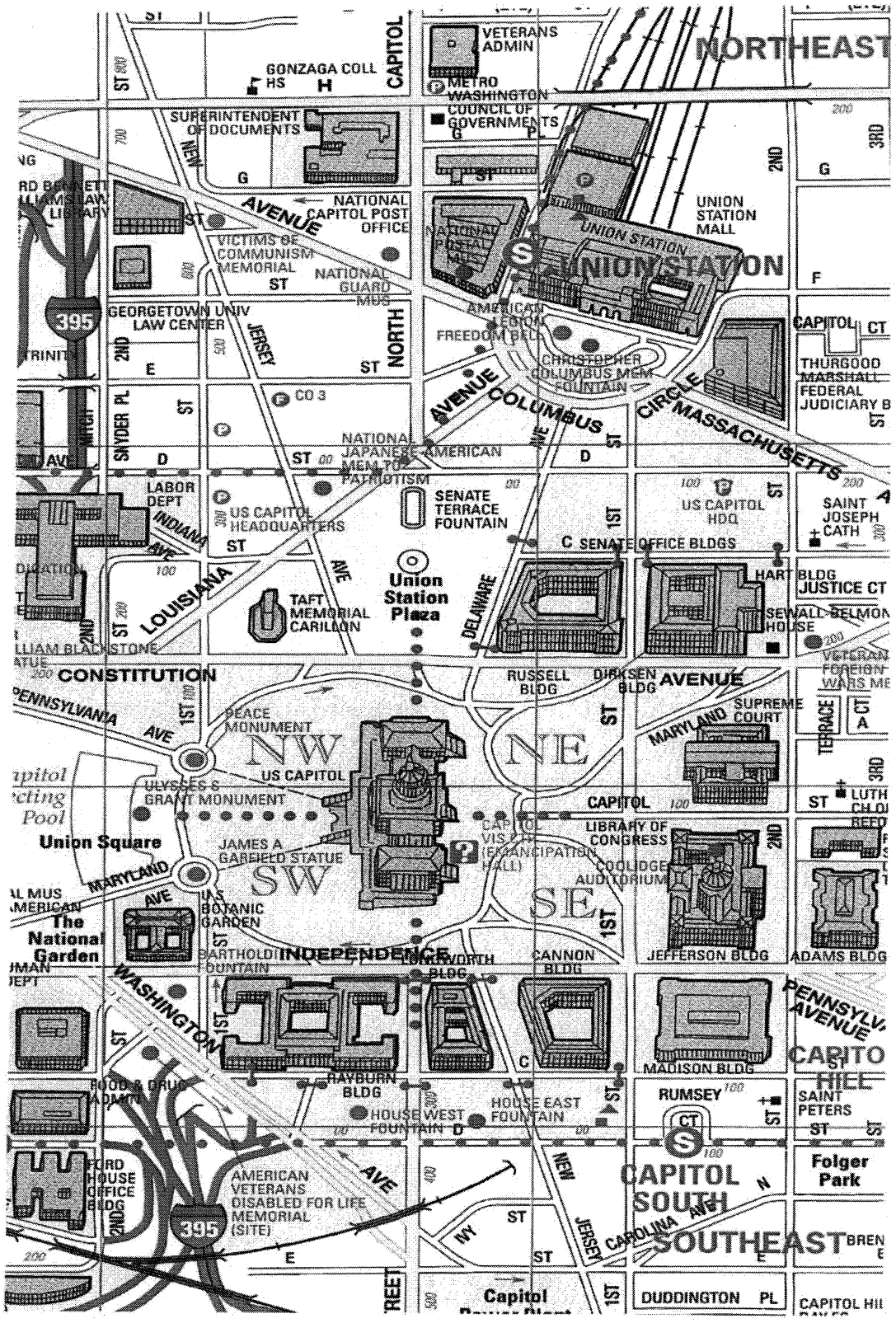
assistance of foundations, than to attempt to limit the aspirations of foreign-born doctors to emigrate. One obvious problem with attempting to prevent such a "brain drain" is that the United States is not the only potential destination for such physicians.

[5] http://www.physiciannursesupply.com/Articles/council-press-release.pdf.

[6] Mark Wietecha, Letter to the Editor, "A Doctor Shortage and the Health Law," *New York Times*, August 1, 2012.

[7] *Pediatric Specialist Physician Shortages Affect Access to Care*, survey, Children's Hospital Association, August 2012, and "Pediatric Shortages, Long Wait Times Reinforce Need for Improved Access to Health Care for Children," News Release, Children's Hospital Association, July 23, 2012.

[8] Stephen P. Juraschek, Xiaoming Zhang, Vinoth K. Ranganathan and Vernon W. Lin, "United States Registered Nurse Workforce Report Card and Shortage Forecast," *American Journal of Medical Quality, 2012,* 27(3), p. 241.


NORTHEAST
SOUTHEAST
NW
NE
SW
SE
CAPITOL
GONZAGA COLL HS
VETERANS ADMIN
METRO WASHINGTON COUNCIL OF GOVERNMENTS
SUPERINTENDENT OF DOCUMENTS
NEW JERSEY AVENUE
NATIONAL CAPITOL POST OFFICE
VICTIMS OF COMMUNISM MEMORIAL
NATIONAL GUARD MUS
UNION STATION MALL
UNION STATION
AMERICAN LEGION FREEDOM BELL
CHRISTOPHER COLUMBUS MEM FOUNTAIN
GEORGETOWN UNIV LAW CENTER
395
CO 3
NATIONAL JAPANESE AMERICAN MEM TO PATRIOTISM
CAPITOL CT
THURGOOD MARSHALL FEDERAL JUDICIARY B
MASSACHUSETTS AVE
COLUMBUS CIR
LABOR DEPT
US CAPITOL HEADQUARTERS
SENATE TERRACE FOUNTAIN
US CAPITOL HDQ
SAINT JOSEPH CATH
C SENATE OFFICE BLDGS
HART BLDG
JUSTICE CT
SEWALL BELMON
TAFT MEMORIAL CARILLON
Union Station Plaza
DELAWARE AVE
LOUISIANA AVE
CONSTITUTION AVENUE
PENNSYLVANIA AVE
RUSSELL BLDG
DIRKSEN BLDG
SUPREME COURT
PEACE MONUMENT
US CAPITOL
ULYSSES S GRANT MONUMENT
CAPITOL
LIBRARY OF CONGRESS
JAMES A GARFIELD STATUE
CAPITOL VIS CTR (EMANCIPATION HALL)
COOLIDGE AUDITORIUM
Union Square
MARYLAND AVE
US BOTANIC GARDEN
The National Garden
BARTHOLDI FOUNTAIN
INDEPENDENCE AVE
LONGWORTH BLDG
CANNON BLDG
JEFFERSON BLDG
ADAMS BLDG
WASHINGTON
RAYBURN BLDG
MADISON BLDG
PENNSYLVANIA AVENUE
CAPITOL HILL
HOUSE WEST FOUNTAIN
HOUSE EAST FOUNTAIN
RUMSEY
SAINT PETERS
Folger Park
FORD HOUSE OFFICE BLDG
AMERICAN VETERANS DISABLED FOR LIFE MEMORIAL (SITE)
CAPITOL SOUTH
NEW JERSEY AVE SE
CAROLINA AVE SE
Capitol Power Plant
DUDDINGTON PL
CAPITOL HILL