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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

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[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]

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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.

There have been some positive developments in the nursing workforce. A December 2011 study in *Health Affairs* found an increase in young people entering nursing after a decade of decline in the United States. (It is unclear to what extent the recent recession helped to cause this change.) "We may have reached a tipping point in the nursing shortage in the sense that we now, for the first time in more than a decade of research, are projecting growth in the total size of the registered nurse workforce," said Peter Buerhaus, one of the study's authors. "These early signs are positive, but we need to continually grow the supply of nurses to effectively match the expected growth in demand over the coming years."[9]

"The key issue is not just the overall number of nurses but their maldistribution geographically and need for specialty nurses," according to J. William DeVille, CEO, Health Carousel, based in Cincinnati, Ohio, a provider of both domestically and internationally-educated nurses and other medical personnel to hospitals and rehabilitation centers.[10]

The American Nurses Association (ANA) remains generally opposed to allowing foreign nurses to work in America, particularly on temporary visas. So certain is ANA that allowing more foreign nurses to work in America is a bad idea that it has not updated the section of its website dedicated to opposing foreign nurses since the year 2005.[11] On the website, the organization states its opposition to an old bill, the Rural and Urban Health Care Act of 2005.

It would be refreshing if the American Nurses Association stated it opposed the entry of foreign nurses on temporary visas, because, for example, such nurses may not join the union or that it might limit leverage when negotiating with employers. Instead, the American Nurses Association provides unconvincing, even contrived, reasons for opposing temporary visas for foreign nurses.

First, ANA argues that under H-1A visas "nurses were employed as lower-paid aides, were made to work unreasonable hours in unsafe conditions, and were mislead about the temporary nature of their visas."[12] While it is possible this happened in some individual instances, research indicates as a generalization this is untrue.

The United States used to allow foreign nurses to work in America on temporary visas similar to H-1B visas. But according to the Department of Homeland Security, "The H-1A classification for foreign nurses is no longer available. This was a program authorized by Congress in the Nursing Relief Act of 1989 for five years. The

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[9] Kathy Rivers, "Surge in New Nurses May Ease Looming Shortage," *Vanderbilt University Medical Center Reporter*, December 8, 2011.
[10] Interview with J. William DeVille.
[11] See "Immigration and the Nurse Workforce" at the ANA website at http://www.nursingworld.org/DocumentVault/GOVA/Federal/Federal-Issues/ImmigrationandWorkforce.aspx.
[12] Ibid.

program expired on September 1, 1995."[13] During that time, employers could petition for foreign nurses on H-1A visas.

Aside from the argument being out of date, it is also not supported by the facts. Economist Ruth Levine, who authored a Department of Labor-commissioned study on the impact of foreign nurses working on H-1A visas, testified before the U.S. Senate, "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."[14]

Second, ANA argues, "Over-reliance on foreign-educated nurses by the health care industry serves only to postpone efforts to address the needs of the U.S. nursing workforce."[15] The U.S. health care industry is not close to an "over-reliance" on foreign-educated nurses. U.S. Health and Human Services data show over 94 percent of the nurses in America have been "U.S.-educated."[16]

Third, ANA states, "There are serious ethical questions about recruiting nurses from other countries when there is a world-wide shortage of nurses. The removal of foreign-educated nurses from areas such as South Africa, India, and the Caribbean deprives their home countries of highly-trained health care practitioners upon whose skills and talents their countries heavily rely."[17] According to the U.S. Department of Health and Human Services, over 70 percent of nurses working in the United States who were educated internationally were born in the Philippines, United Kingdom, Canada and South Korea (see Table 2).

It seems unlikely that the American Nurses Association (or any other U.S.-based organization) cares more about the citizens of South Africa, India and the Philippines than the actual citizens of those countries who want to work in the United States as nurses. Remittances sent home from working abroad are a major boon to families and countries as a whole. The possibility to work abroad is often the primary reason a foreigner will study and train to become a nurse or other professional. Without such a possibility there would be far fewer people seeking to become nurses in the first place. There is no evidence on its website that the ANA regularly travels to the Philippines, South Africa or other countries to donate hours of service or provide money for hospitals or health care to help the poor in those nations.

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[13] http://www.uthouston.edu/dotAsset/11b9f020-cf59-4ec9-90f8-b4697f00f318.pdf.
[14] Testimony of Ruth E. Levine, in hearing on "Urban and Rural Health Care Needs," before the Senate Immigration Subcommittee, May 22, 2001.
[15] http://www.nursingworld.org/DocumentVault/GOVA/Federal/Federal-Issues/ImmigrationandWorkforce.aspx.
[16] Table 8-1, *The Registered Nurse Population, Findings from the 2008 National Sample Survey of Registered Nurses*, U.S. Department of Health and Human Services, Health Resources and Services Administration, September 2010. Figures are for 2008.
[17] http://www.nursingworld.org/DocumentVault/GOVA/Federal/Federal-Issues/ImmigrationandWorkforce.aspx.

In sum, the arguments offered against allowing in foreign nurses on temporary visas are unconvincing. Concerns about abuse could be addressed by such things as ensuring visas are portable enough to ensure the freedom to change employers. A sufficient supply of green cards that nurses could utilize would accomplish the same goal.

The desire for protectionism in health care-related jobs is misplaced. The Bureau of Labor Statistics (BLS) projects there will be 711,900 new jobs for registered nurses between 2010 and 2020, the most of any occupation in America. "The projections further explain the need for 495,500 replacements in the nursing workforce bringing the total number of job openings for nurses due to growth and replacements to 1.2 million by 2020," notes the American Association of Colleges of Nursing.[18] According to BLS: "The healthcare and social assistance industry is projected to create about 28 percent of all new jobs created in the U.S. economy. This industry – which includes public and private hospitals, nursing and residential care facilities, and individual and family services – is expected to grow by 33 percent, or 5.7 million new jobs. Employment growth will be driven by an aging population and longer life expectancies, as well as new treatments and technologies."[19]

Physical therapy is among the fastest growing occupations in America. BLS 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*.[20]

U.S. News and World Report ranked both physical therapists and occupational therapists among the "Best Jobs" of 2012. "Growth in America's elderly population is expected to keep the job market for occupational therapists especially favorable," reported the magazine. "The Bureau of Labor Statistics projects occupational therapist employment growth of 33.5 percent between 2010 and 2020, adding 36,400 more professionals to the 108,800 already-existing jobs in this field."[21]

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[18] "Nursing Shortage Fact Sheet," updated August 6, 2012, American Association of Colleges of Nursing.
[19] *Projections Overview: Occupational Handbook Outlook*, U.S. Bureau of Labor Statistics, U.S. Department of Labor, March 29, 2012; http://www.bls.gov/ooh/about/print/projections-overview.htm.
[20] Janice L. Zimbelman, Stephen P. Juraschek, Xiaoming Zhang, and Vernon W. Lin, "Physical Therapy Workforce in the United States: Forecasting Nationwide Shortages," *American Academy of Physical Medicine and Rehabilitation, 2010; 2:1021-1029.*
[21] "Best Jobs 2012: Occupational Therapist," *U.S. News and World Report*, February 27, 2012.

For speech language pathologists, "employment is expected to grow by 23 percent from 2010 to 2020, faster than the average for all occupations," according to the Bureau of Labor Statistics. "As the large baby-boom population grows older, there will be more instances of health conditions that cause speech or language impairments, such as strokes, brain injuries, and hearing loss. This will result in increased demand for speech-language pathologists."[22]

Some may argue that more people would become nurses (or physical therapists, doctors, etc.) if wages grew more rapidly. However, financial constraints exist that limit salary increases, particularly for registered nurses. First, payroll costs represent a major part of hospital budgets. Wage increases for personnel that would create losses for a hospital would likely lead to cutbacks elsewhere in the hospital. Second, America does not have a free market in the provision of health care services. This has a major impact on the health care provider labor market, since hospitals are often constrained financially by reimbursements for care from Medicare and Medicaid. Discussing the H-1A visas in a Department of Labor-sponsored report, Ruth Levine noted, "[N]urse wages are not much affected by supply factors. Wages are much more affected by other forces in the market, including insurance reimbursement policy and the dynamics of the health care industry."[23] Third, if wages grew significantly for nurses, then hospitals would be tempted to decrease their demand for registered nurses. Research shows that employing an insufficient number of nurses harms patient health.

A major problem with attempting to increase the supply of nurses only domestically is finding qualified instructors for nursing schools. "Almost two-thirds of the nursing schools responding to the American Association of Colleges of Nursing (2011-12) survey pointed to faculty shortages as a reason for not accepting all qualified applicants into their programs."[24] Analysts have pointed to the low pay of faculty compared to the salary of nurses working in hospitals, particularly problematic since faculty may have incurred the time and expense of earning a graduate degree. "Unlike typical doctoral-prepared professors who begin their academic career in their early 30s, the average nurse educator with a doctoral degree doesn't begin teaching until she or he is almost 50. They also retire earlier, leaving a small cohort of graying professors to educate the country's new nurses," writes Laura Rodgers in the *Huffington Post*.[25]

[22] Bureau of Labor Statistics; http://www.bls.gov/ooh/Healthcare/Speech-language-pathologists.htm.
[23] Testimony of Ruth E. Levine, in hearing on "Urban and Rural Health Care Needs," before the Senate Immigration Subcommittee, May 22, 2001.
[24] "Nursing Shortage Fact Sheet," American Association of Colleges of Nursing.
[25] Laura Rodgers, "Nation Needs to Address Nursing Educator Shortage, Yesterday," *Huffington Post*, August 24, 2012.

U.S. IMMIGRATION LAWS MAKE NURSES HARD TO COME BY

The options for hospitals seeking to hire qualified foreign nurses are limited. This is the case even though a sufficient supply of nurses is essential for improving the health of patients. The options are so limited that hospitals today sponsor for immigration foreign nurses who are unlikely to begin work in the United States for five years or more, something unheard of in virtually any other profession.

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. Below is a review of the limited options under U.S. immigration law for employers seeking to hire a foreign nurse to work in America:

H-1C: The Nursing Relief for Disadvantaged Areas Act, which became law in 1999 and has since been reauthorized, allows no more than 25 foreign nurses per state annually for a maximum total of 500 on an H-1C visa. Due to the restrictive language, it is likely fewer than a dozen hospitals in the United States meet the law's criteria to be allowed to petition for a foreign nurse. "The number of H-1C visas approved by USCIS each year does not come close to the 500 visas allotted to the visa category," notes the Citizenship and Immigration Services Ombudsman. "According to USCIS, no H-1C visas were approved in FY 2006, 49 were approved in FY 2007, and approximately 110 were approved in FY 2008."[26]

TN: While more hospitals hire foreign nurses on TN visas than on H-1C, TN visas, through the North American Free Trade Agreement (NAFTA), are available only to nationals of Canada and Mexico. Nurses on TN visas can stay for up to three years initially but the visas can be renewed.[27] Attorneys point to two issues that limit TN visas as a widespread nurse supply solution. First, Mexican nurses generally do not receive their training in English, which means they might have difficulty passing English language requirements to work in the United States. Second, the relatively high wages in Canada limit the attractiveness of the U.S. market for Canadian nurses.

H-1B: Only registered nurses able to qualify as a member of a "specialty occupation" where the employer shows the specific job and the industry standards for the job require a bachelor's degree or higher can utilize an H-1B visa. "In effect, the vast majority of RNs cannot qualify for an H-1B visa because most of them do not meet the requirements set forth by statute. Stakeholders reported to the CIS Ombudsman that the H-1B process is not a viable route for nurses as most employers do not require a bachelor's degree or the equivalent for a RN position.

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[26] *Improving the Processing of "Schedule A" Nurse Visas*, Office of the Citizenship and Immigration Services Ombudsman, U.S. Department of Homeland Security, December 5, 2008, pp. 5-6.
[27] Ibid., p. 6.

The few RNs who qualify for an H-1B visa typically hold a supervisory or very specialized nurse position."[28] Immigration attorneys say U.S. Citizenship and Immigration Services has issued guidance in the past supporting the entry of specialty nurses on H-1B visas but, in practice, adjudicators approve relatively few cases.

Employment-Based Green Cards: "The most common route for foreign nurses, the green card option, is hampered by a limited number of immigrant visas and long wait times," notes the immigration service's Ombudsman.[29] The employment-based third preference (EB-3) is the category most normally used by employers sponsoring a foreign nurse. The wait times in those categories can run many years. An analysis by the National Foundation for American Policy estimated a foreign national from India or China in the EB-3 category could wait a decade or possibly even decades if sponsored today. For individuals from countries other than India and China the wait in the third preference category has been about 5 to 6 years. For example, as of the November 2012 Visa Bulletin, employers petitioning for nurses from the Philippines must have filed their cases by August 8, 2006 for the nurses to obtain their green cards in the third employment-based preference (EB-3). A new case sponsored today from the Philippines could potentially take longer than 5 or 6 years.

Table 1
Current Waiting/Processing Times for Employment-Based Green Cards

Employment-Based Immigrant Categories	China	India	Philippines	Mexico and the Rest of the World
EB-1 (First Preference)	Current	Current	Current	Current
EB-2 (Second Preference)	Processing cases filed before September 10, 2007	Processing cases filed before September 1, 2004	Current	Current
EB-3 (Third Preference)	Processing cases filed before April 15, 2006	Processing cases filed before October 22, 2002	Processing cases filed before August 8, 2006	Processing cases filed before November 22, 2006

Source: Visa Bulletin, November 2012, U.S. Department of State

The reason for the difference in waiting time by country is the "per country" limit on employment-based immigrants, which generally limits the admission of a national from one country to approximately 10,000 a year.[30] A bill in Congress, H.R. 3012, which passed the U.S. House of Representatives, would phase out the per country limit for employment-based immigrants over a three-year period. That would eventually move green card

[28] Ibid., pp. 6-7.
[29] Ibid., p. 8.
[30] The per country limit can be exceeded if employment-based green cards would otherwise go unused in a category.

processing to a first come, first served basis without regard to country of origin. In practice, absent other changes in Congress, the legislation would eventually equalize waiting times in the employment-based third preference category.

H.R. 3012 would mean shorter waits for would-be immigrants from China and India but longer waits for foreign nationals from other countries. While India is a source of nurses for U.S. employers, more arrive to the United States from the Philippines (see Table 2), which means passage of H.R. 3012 could mean longer waits for the majority of foreign nurses sponsored for green cards, who are sponsored primarily in the employment-based third preference (EB-3). Similarly, in the employment-based second preference (EB-2), physicians, physical therapists and other medical personnel from India or China would have shorter waits if H.R. 3012 became law. Many physicians from India have been waiting several years in the EB-2 backlog. However, medical professionals from other countries would see increased waiting times in the EB-2 category.[31] Some have argued in favor of eliminating the per country limit but changing the transition formula in the bill.[32] Others argue against changing the legislation further.[33] It is unclear at this time whether H.R. 3012 will, in fact, become law. It is important to note that changes in the law that increased the numbers available for employment-based green cards overall would mitigate the short-term impact from eliminating the per country limit.

Table 2
Country of Origin of Internationally Educated Nurses Working in the United States

COUNTRY OF ORIGIN	PERCENTAGE AMONG FOREIGN NURSES IN U.S.
Philippines	50.1 percent
Canada	11.9 percent
India	9.6 percent
United Kingdom	6.0 percent
S. Korea	2.6 percent
Nigeria	2.1 percent
Other	17.8 percent

Source: Figure 8-1, *The Registered Nurse Population, Findings from the 2008 National Sample Survey of Registered Nurses*, U.S. Department of Health and Human Services, Health Resources and Services Administration, September 2010. Figures are for 2008.

[31] For more detail on the impact of various legislative changes see *Waiting and More Waiting: America's Family and Employment-Based Immigration System*, NFAP Policy Brief, National Foundation for American Policy, October 2011.
[32] See for example http://www.musillo.com/2012/07/a-better-phase-in-plan-for-hr-3012.html.
[33] http://www.prweb.com/releases/2012/8/prweb9823392.htm.

It is a testament to the dire 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. 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 will wait overseas. Perhaps the only advantage available to foreign nurses is that the U.S. Department of Labor lists nursing on Schedule A as a shortage occupation. That means employers do not need to endure the time and expense of "labor certification" when sponsoring a foreign nurse for a green card. In 2005, legislation allocated 50,000 employment-based green cards that had previously gone unused to foreign nationals in occupations under Schedule A, which primarily benefitted nurses.[34] Despite that one-time infusion of green cards, the long wait times for foreign nurses continue.

Table 3
U.S.-Educated and Internationally Educated Nurses Employed in United States

U.S.-Educated Registered Nurses	2,450,502	94.4 percent
Internationally Educated Registered Nurses	146,097	5.6 percent

Source: Table 8-1, *The Registered Nurse Population, Findings from the 2008 National Sample Survey of Registered Nurses*, U.S. Department of Health and Human Services, Health Resources and Services Administration, September 2010. Figures are for 2008.

PHYSICIANS: OVERCOMING YEARS OF BAD POLICY

Once a bad policy becomes enshrined in law it is difficult to undo the damage – even 35 years later. Prior to 1977, the U.S. immigration system generally permitted the entry and permanent residence of foreign-born physicians. "The law provided permanent residence visa opportunities to IMGs (International Medical Graduates) and facilitated their entry into permanent resident status, with preferences reflecting requirements that were easily met and adjudications that were lightening quick when compared to today's immigration system," writes George S. Newman, a partner in Stinson Morrison Hecker LLP.[35]

The relatively liberalized treatment of doctors did not last. "All of this changed with the passage of the HPEAA (Health Professions Education Assistance Act), which took effect on January 10, 1977," notes Newman. "International Medical Graduates were now subjected to two requirements that dramatically interrupted the free flow of medical talent into the United States."[36]

[34] Public Law No. 109-13.
[35] George S. Newman, "Overview: So How Did We Get Here . . . ?," in ed. Margaret A. Catillaz, *Immigration Options for Physicians*, Third Edition, AILA, Washington, DC, 2009, p. 29.
[36] Ibid., p. 30.

First, new credentialing rules made it difficult for International Medical Graduates by requiring testing on material the physician likely studied several years before. Second, prohibitions on using other temporary visa categories in the new law "had the net effect of forcing virtually every IMG coming to the United States for graduate medical education into the J-1 visa category, which meant that all of these individuals became subject to the two-year home residence requirement of INA Section 212(e)."[37]

A foreign national seeking to practice medicine in the United States must demonstrate knowledge of English and earn a state medical license. To be granted such a license an International Medical Graduate must complete a program of graduate medical education in America. To do so, a foreign national generally must enter the United States on a J-1 exchange visitor visa to enroll in such a program, although it has been possible to use H-1B visas (when available). As attorneys Robert D. Aronson and Dinesh P. Shenoy write, "For the vast majority of International Medical Graduates, the J-1 exchange visitor program provides the only immigration vehicle for engaging in a program of residency or clinical fellowship training, which in turn makes the individual eligible to obtain a state medical license. This credentialing requirement effectively eliminates most IMGs from H-1B eligibility, instead forcing them to apply for J-1 visas and creating a major barrier to entering the physician workforce."[38]

The key limitation of the J-1 visas is "[A]ll J-1 physicians engaged in clinical programs are subject to the two-year home residence obligation, regardless of their country of nationality or last residence."[39] While there are ways to overcome this obligation without leaving the country, the number of people who can do so annually is limited.

Under the law, an Interested Government Agency could issue a waiver and the International Medical Graduate would be eligible to work in the United States, usually in a geographic location deemed "underserved." In 1994, with a limited number of government agencies willing to issue waivers and the process convoluted, Senator Kent Conrad (D-ND) authored an important legislative measure. He explained the need for a change in the law: "Because of the difficulty of [the] process [of working with the various federal agencies to find a sponsor for a waiver], one facility in North Dakota was forced to use the Coast Guard as an interested Federal agency . . . [W]hen the Coast Guard has to be the agency to declare an area of North Dakota in need of a physician, something needs to change."[40]

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[37] Ibid., p. 30.
[38] Robert D. Aronson and Dinesh P. Shenoy, "From Draconian to Protean: Home Residence Obligations for Physicians Under INS Section 212(e)," in ed. Margaret A. Catillaz, *Immigration Options for Physicians*, Third Edition, AILA, Washington, DC, 2009, p. 22.
[39] Ibid., p. 17.
[40] Ibid., p. 23.

Senator Conrad's original legislation allowed each state to let its health department or other state agency act as an Interested Government Agency and issue up to 20 waivers annually. In 2002, Senator Conrad helped pass an extension of the program and expanded the number of waivers per state to 30. In September 2012, Congress extended the Conrad 30 program until September 30, 2015. "Over the years, this program has enabled the state departments of health to place roughly 1,000 J-1 physicians per year in either designated medically underserved areas or in practice positions providing critically needed services to at-risk populations."[41]

While attorneys recommend several technical improvements to the Conrad 30 program, several of which were included in S. 1979 in the most recent Congress, the main problem with the Conrad 30 program is that 30 J-1 physician waivers per state is too small a number. The largest states, such as Texas, New York and California generally use the 30 slots within days, according to Greg Siskind, partner, Siskind Susser, P.C.[42] In addition, up to 10 of those 30 slots are often reserved for large regional facilities and academic institutions, such as hospitals and research institutions affiliated with large universities.

Unlike the entry of foreign nurses, which the American Nurses Association has generally opposed, there does not appear to be any organized opposition to admitting more foreign doctors. Sometimes one will hear a generalized concern about a "brain drain," but prohibiting foreign physicians from practicing in the United States under such a premise amounts to controlling the lives of ambitious people without due cause.

"There is a certain amount of arrogance in any discussion of the brain drain," writes Greg Siskind. "The physicians who choose to leave a country are not just leaving for better opportunities abroad. They are also voting with their feet to leave a country. In many cases, the country a doctor is leaving needs to look inward. Is it unreasonable for a doctor to flee dictatorships, civil wars, corrupt political systems and the litany of other conditions that have always motivated immigrants? . . . Furthermore, the brain drain argument for tightening immigration rules also assumes doctors only have the choice of the United States or their home country. But there are physician shortages around the world and plenty of other countries aren't wringing their hands worried about recruiting these physicians."[43]

As noted earlier, Congress has enacted exceptions to the 1977 law, seeking to overcome the law's premise that foreign-born doctors are neither needed nor welcomed. Of course, such physicians are particularly needed in areas of the country that find it difficult to attract doctors. One such community that would welcome skilled physicians, including general surgeons, regardless of their place of birth, is Nassawadox, Virginia. "Having a surgeon is vital to keeping open the doors of Shore Memorial and thousands of other small hospitals like it,"

[41] Ibid., p. 24.
[42] Interview with Greg Siskind.
[43] Greg Siskind, unpublished letter to the *New York Times*, September 14, 2012.

reports *USA Today*. "But as local doctors have moved away from this community or retired during the past 10 years, the ranks have fallen from seven full-time surgeons to two. There are also only two anesthesiologists; one is nearing retirement."[44]

To earn permanent residence an International Medical Graduate generally must agree to work three or five years in an underserved area or Veterans Administration (VA) facility. The requirement is three years if going through the labor certification process and then being sponsored for a green card. It is five years if the physician uses a "national interest waiver."

Some physicians attempt to use H-1B visas to avoid the two-year home residency and/or the uncertain waiver process of the J-1 visa. But the H-1B process carries its own pitfalls for physicians. For example, if a foreign national pursues a specialty, then the medical training may run beyond the 6 years typically permitted for the duration of H-1B status. Also, the H-1B visa process can be more expensive and uncertain for employers.

U.S. Citizenship and Immigration Services promulgated regulations in 2007 that practitioners agree meet the intent of the National Interest Waiver for foreign physicians. "In essence, so long as the physician agrees to work for a total of five years as a clinician at a facility that is either physically located in a federally underserved area, or at a VA facility, and either a federal agency or a state department of health agrees that the work is in the public interest, USCIS must permit the physician to adjust status or apply for an immigrant visa on that basis," writes attorney Jennifer Minear.[45]

Back in 1977, supporters of the restrictive Health Professions Education Assistance Act, which took effect in 1977, argued foreign doctors were inferior to U.S.-educated physicians.[46] If that was ever the case, recent research shows that it is not true today. A study in *Health Affairs* concluded, "The quality of care provided by doctors educated abroad has been the subject of ongoing concern. Our analysis of 244,153 hospitalizations in Pennsylvania found that patients of doctors who graduated from international medical schools and were not U.S. citizens at the time they entered medical school had *significantly lower mortality rates* than patients cared for by doctors who graduated from U.S. medical schools or who were U.S. citizens and received their degrees abroad. The patient population consisted of those with congestive heart failure or acute myocardial infarction. We found no significant mortality difference when comparing all international medical graduates with all U.S. medical school

[44] Robert Davis, "Shortage of surgeons pinches U.S. hospitals," *USA Today*, February 26, 2008.
[45] Jennifer Minear, "Getting the Green Card on the Five-Year Plan: National Interest Waivers for Clinical Physicians," in ed. Margaret A. Catillaz, *Immigration Options for Physicians*, Third Edition, AILA, Washington, DC, 2009, p. 220.
[46] George S. Newman, "Overview: So How Did We Get Here . . . ?."

graduates." The study noted, "One-quarter of practicing physicians in the United States are graduates of international medical schools."[47]

The results cited above may reflect "self-selection" in the immigration process, which means capable and enterprising individuals are the people most likely to take a chance on working in and/or immigrating to another country. "These findings bring attention to foreign-trained doctors and the valuable role they have played in responding to the nation's physician shortage," said lead author John J. Norcini. "U.S. medical schools are doing their part by expanding for the first time in thirty years, but the number of graduate training programs has not increased proportionately. If this continues, the current physician shortages will persist and the numbers of foreign-trained doctors will likely decrease significantly."[48]

PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS AND OTHER MEDICAL PERSONNEL

One would think with a rapidly aging population and the demand for physical therapy expected to skyrocket the United States would make it relatively easy for foreign physical therapists to work in America. That is not the case. J. William DeVille of Health Carousel estimates it typically takes three to four years for a foreign physical therapist to complete the various licensing and related requirements to start working in America (longer if a visa is not available).[49]

Foreign physical therapists need to run a gauntlet of tests and procedures before even confronting the lack of an H-1B visa or green card. These steps include passing an English language proficiency exam. A foreign physical therapist first needs to pass the Test of English as a Foreign Language (TOEFL) exam to demonstrate proficiency in English. In addition, a physical therapy board for the state in which the individual hopes to work must evaluate a foreign physical therapist's credentials and education. It may often tell a foreign physical therapist he or she needs to take additional classes or training if wishing to practice physical therapy in the state. A health care worker's credentials certification from an agency designated by U.S. Citizenship and Immigration Services is required, commonly the VisaScreen certificate issued by CGFNS International. Before taking a state's physical therapy exam, he or she must obtain a visitor visa (not a given by any means, note attorneys). The final step would be to file for an H-1B visa or a green card. As noted earlier, an H-1B visa or green card may not be available.

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[47] John J. Norcini, John, R. Boulet, W. Dale Dauphinee, Amy Opalek, Ian D. Krantz and Suzanne T. Anderson, "Evaluating the Quality of Care Provided by Graduates of International Medical Schools," *Health Affairs*, August 2010 vol. 29 no. 8 1461-1468. Emphasis added.
[48] Chris Fleming, "Foreign-Trained and U.S-Trained Doctors Provide Same Quality of Care," *Health Affairs Blog*, August 4, 2012.
[49] Interview with J. William DeVille.

"Generally, the main hurdle for overseas physical therapy applicants to overcome is the state license requirement," notes attorney Lynne R. Feldman. "In most cases, consulates will not issue a visa if the PT (physical therapy) client is not yet licensed to practice in his or her intended state of employment. And likewise, most states will not issue a license to a physical therapy applicant without an SSN (Social Security Number), or without an immigrant visa."[50]

In theory, foreign physical therapists and occupational therapists possess more options to enter and work in the United States than do foreign nurses and physicians. For example, physical therapists, occupational therapists, speech language pathologists, pharmacists, and (generally) medical technologists are eligible to receive an H-1B visa, while many registered nurses are not eligible. Yet, in practice, in every fiscal year for the past decade, the H-1B quota (65,000 plus 20,000 for recipients of a masters degree or higher from a U.S. university) has been exhausted. For FY 2013, the quota was reached in June 2012. That means no foreign national can start work on a new H-1B visa until October 1, 2013, the start of FY 2014.

This lack of availability of H-1B visas presents a major problem for employers of all types, including in the health care industry. Only nationals of Canada and Mexico can receive TN visas, and only a national of Australia can receive an E-3 visa, while a national of Chile or Singapore can obtain an H-1B1. The choice for health care employers wishing to hire medical personnel born in countries other than Canada, Mexico, Chile or Singapore is to wait months for the availability of H-1B visas, or wait potentially years for green cards. Physical therapists are listed under Schedule A, which means their employers do not need to obtain labor certification as part of the green card process. However, if a green card is unavailable, as in the case of nurses, there is no alternative but to wait in line.

THE HEALTH IMPLICATIONS OF TOO FEW DOCTORS, NURSES AND PHYSICAL AND OCCUPATIONAL THERAPISTS

Americans, on balance, are living longer but research shows they would be living better with a sufficient supply of doctors, nurses and other medical personnel. In short, 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 and improve the health of Americans.

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[50] Lynne R. Feldman, "Immigration Options for Physical Therapists," in ed. James David Acoba, *Immigration Options for Nurses and Allied Health Care Professionals*, second edition, American Immigation Lawyers Association, Washington, DC, 2009, pp. 54, 57. Information on the requirements for entering the United States as a nurse, physical therapist and some other medical professional fields is available on the website of the CGFNS International at http://www.cgfns.org/.

The research literature on the negative impact of insufficient care providers is the most extensive on nurses but it is logical to expect negative health effects when too few of other types of medical professionals are available to serve patients.

In *Medical Care* (April 2011), Mary A. Blegen and other researchers attempted "[t]o determine the relationship between nurse staffing in general and intensive care units and patient outcomes and determine whether safety net status affects this relationship." They utilized data from over 1 million adult patients and examined staffing at 54 hospitals in 872 patient care units. The research found higher nursing care staff hours were associated with lower rates of dying from congestive heart failure, infections, and prolonged lengths of stay. The overriding conclusion: "Higher nurse staffing protected patients from poor outcomes."[51]

A study published in the *New England Journal of Medicine* (March 2011), examined nursing shifts and patient admissions, including "the association between mortality and high patient turnover owing to admissions, transfers, and discharges." The researchers found, "There was a significant association between increased mortality and increased exposure to unit shifts during which staffing by RNs was 8 hours or more below the target level . . . The association between increased mortality and high patient turnover was also significant." The bottom line: "Staffing of RNs below target levels was associated with increased mortality, which reinforces the need to match staffing with patients' needs for nursing care."[52]

Research published in the *Journal of the American Medical Association* (2002) explained, "Registered nurses constitute an around-the-clock surveillance system in hospitals for early detection and prompt intervention when patients' conditions deteriorate. The effectiveness of nurse surveillance is influenced by the number of registered nurses available to assess patients on an ongoing basis. Thus, it is not surprising that we found nurse staffing ratios to be important in explaining variation in hospital mortality."[53]

Similar to the other research cited above, the *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."[54] The authors concluded,

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[51] Mary A. Blegen, Colleen J. Goode, Joanne Spetz, Thomas Vaughn, and Shin Hye Park, *Medical Care*, April 2011, 49(4): 406-414.
[52] Jack Needleman, Peter Buerhaus, V. Shane Pankratz, Cynthia L. Leibson, Susanna R. Stevens, and Marcelline Harris, "Nursing Staffing and Inpatient Hospital Mortality," *New England Journal of Medicine*, March 2011; 364:1037-45.
[53] Linda H. Aiken, Sean P. Clarke, Douglas M. Sloane, Julie Sochalski and Jeffrey H. Silber, (2002). "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," *JAMA*, 2002, 288: 1987-1993.
[54] Ibid. See also Stuart Anderson, *Deadly Consequences: The Hidden Impact of America's Nursing Shortage*, National Foundation for American Policy, September 2007.

"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."[55]

According to the Minnesota Evidence-based Practice Center, in a report prepared for U.S. Health and Human Services, "Higher registered nurse staffing was associated with less hospital-related mortality, failure to rescue, cardiac arrest, hospital acquired pneumonia, and other adverse events. The effect of increased registered nurse staffing on patients safety was strong and consistent in intensive care units and in surgical patients. Greater registered nurse hours spent on direct patient care were associated with decreased risk of hospital-related death and shorter lengths of stay."[56]

Infections can lead to infant deaths. Research in the *Archives of Pediatrics and Adolescent Medicine* has linked nurse staffing and infections in infants at New York hospitals. "Our findings suggest that registered nurse staffing is associated with the risk of bloodstream infection among infants," concluded the study's authors. "We hypothesize that inadequate nurse staffing and increased nurse workload in a critical care environment results in poor hand hygiene compliance, breaks in aseptic technique, or compromises in practice that might increase the risk of transmitting infection." One suggestion of the findings is that "increasing registered nurse staffing by 1 full-time equivalent could possibly reduce the risk of bloodstream infection by 11 percent."[57]

The evidence of an association between proper nursing staff levels and a patient's health outcomes can be also be found in research performed in other countries. A Canadian study found a 10 percent increase in registered nurse staff caring for acute medical patients was associated with 5 fewer deaths in 1000 discharged patients.[58] Research in Belgium concluded, "Increased nurse staffing in postoperative general nursing units was significantly associated with decreased mortality."[59]

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[55] Linda H. Aiken and others, "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction."

[56] Robert L. Kane, M.D., Tatyana Shamliyan, M.D., M.S., Christine Mueller, Ph.D., R.N.
Sue Duval, Ph.D., Timothy J. Wilt, M.D., M.P.H., "Nurse Staffing and Quality of Patient Care," Prepared for Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Evidence Report/Technology Assessment, Number 151, AHRQ Publication No. 07-E005, March 2007. The analysis pointed out it was not possible to definitively show a "causal" relationship.

[57] Jeannie P. Cimiotti, DNS, RN, Janet Haas, MS, Lisa Saiman, MD, MPH, and Elaine L. Larson, PhD, "Impact of Staffing on Bloodstream Infections in the Neonatal Intensive Care Unit," *Archives of Pediatrics and Adolescent Medicine*, 2006, 160, p. 835.

[58] As cited in A. E. Tourangeau, L.A. Cranley, and L. Jeffs, "Impact of Nursing on Hospital Patient Mortality: A Focused Review and Related Policy Implications," *Quality and Safety in Health Care,* 2006; 15:4-8.

[59] Koen Van den Heede (and others), "The Relationship Between Inpatient Cardiac Mortality and Nurse Numbers and Educational Level: Analysis of Administrative Data," *International Journal of Nursing Studies*, June 2009, Vol. 46, Issue 6, pp. 796-803.

Many other studies have reached similar conclusions to the research cited here. Additional studies can be found at the website of the American Association of Colleges of Nursing.[60] The bottom line: 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.

TOO FEW MEDICAL PERSONNEL: ALSO BAD FOR U.S. DOCTORS AND NURSES

Conventional wisdom holds that limiting competition, in this case foreign-born competition, is good for U.S.-born doctors and nurses. As is often the case, the conventional wisdom is wrong. A study in the *Journal of the American Medical Association* concluded, "[N] nurses in hospitals with the highest patient-to-nurse ratios are more than twice as likely to experience job-related burnout and almost twice as likely to be dissatisfied with their jobs compared with nurses in the hospitals with the lowest ratios."[61] In other words, the lack of nurses can lead to job dissatisfaction and potentially to nurses even choosing to leave the profession.[62]

In her study of nurses conducted for the U.S. Department of Labor, Ruth E. Levine found the foreign nurses admitted in the early 1990s benefitted U.S. nurses: "In the in-depth interviews, most respondents said that hiring foreign nurses actually increased the ability of hospitals to respond to the needs of a diverse patient community. And fellow U.S. nurses consistently recognized that having some extra 'hands on deck' made their lives better. It is, after all, nurses themselves who suffer most when there is a critical shortage."[63]

U.S.-educated physicians also benefit from the entry of foreign professionals, in this case International Medical Graduates. One of the main benefits is foreign doctors can serve in areas in need of primary care physicians. The entry of such doctors helps U.S. doctors who wish to enter specialties. Entering specialty fields is desirable for many American-born physicians and improves health outcomes for U.S. patients.

Imagine back to the fictional world of *Dr. Quinn Medicine Woman*. Dr. Quinn was a generalist who tried to serve patients in rural Colorado in the years after the Civil War. It is not possible for any doctor back then or today, given all the advances in medicine, to be an expert in every field of medicine, including surgical procedures. On the other hand, American patients would suffer if it had nothing but specialists. Admitting foreign-educated doctors has encouraged the specialization that has benefitted Americans in treating cancer, AIDS, diabetes and other diseases. Many foreign-educated physicians also pursue specialties. But the conclusion is clear: The more

[60] http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf.
[61] Linda H. Aiken, "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction." .
[62] Additional studies on this theme can be found at http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf.
[63] Testimony of Ruth E. Levine, in hearing on "Urban and Rural Health Care Needs," before the Senate Immigration Subcommittee, May 22, 2001.

International Medical Graduates allowed to enter the United States and become primary care physicians, the easier it will be to meet the aspirations of U.S.-educated doctors who wish to pursue specialty fields in medicine.

AMERICA'S AGING POPULATION AND THE AFFORDABLE CARE ACT

In March 2011, President Barack Obama signed into law the Affordable Care Act, which is designed to expand coverage to many individuals who do not possess health insurance coverage.[64] Without delving into the details of the legislation or the controversies surrounding it, critics and supporters can agree on one thing – when you provide an individual with health insurance coverage he or she is more likely to consume medical services. Given this reality, past analyses on the demand for nurses, doctors and other medical professionals likely underestimate the future use of medical care

If the law is even partly successful in achieving its main goal, the Affordable Care Act will result in millions, potentially tens of millions, of U.S. residents utilizing the services of more doctors, nurses, and physical and occupational therapists than if the bill had never become law. The Congressional Budget Office estimated more than 30 million more people would be insured under the law.[65] That means it is incumbent for the U.S. government to enact immigration policies and other measures to ensure that medical personnel are available to serve these patients.

The United States was already facing an aging population that would increase the demand for medical services. In the United States, life expectancy rose to 57 years by 1928. And today the life expectancy at birth for someone born in America is nearly 80 years.[66] "This dramatic increase in life expectancy is not accidental. Its substantial and pleasing rise results from infectious disease control, public health initiatives, and new surgical and rehabilitation techniques," notes the organization Transgenerational.[67]

There are now over 100 million Americans age 50 or older and about 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. Between 2000 and 2010, "those aged 45 to 64 rose by 31 percent to 81.5 million." People in that age range "make up 26 percent of the U.S. population" today.[68]

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[64] http://www.healthcare.gov/law/timeline/.
[65] "How the Number of Uninsured May Change With and Without the Health Care Law," *New York Times*, June 27, 2012.
[66] Sonia Arrison, *100 Plus*, Basic Books (New York, NY, 2011), pp. 21-23.
[67] http://www.transgenerational.org/aging/demographics.htm.
[68] Ibid.

The U.S. Census Bureau reports, "Between 2010 and 2050, the United States is projected to experience rapid growth in its older population. In 2050, the number of Americans aged 65 and older is projected to be 88.5 million, more than double its projected population of 40.2 million in 2010."[69]

The advancements are such that *100-Plus*, a book by Sonia Arrison, makes what many would find a startling prediction. She writes, "Humanity is on the cusp of an exciting longevity revolution. The first person to live to 150 years has probably already been born."[70]

First, Arrison points out that people today considered "old" are in better shape than ever before in human history. She points to a master's track championship held in 2010 that had hundreds of participants over age 75." She writes, "It is possible to stay healthier longer not only because of better nutrition and living conditions, but also because medical technology has advanced beyond simply fighting infectious diseases. The old are no longer quite as old as they used to be."[71]

She points out that not only are chronic diseases striking people at later ages than in the past but when surveyed people in their 60s and 70s often report that they don't feel old. And this is an important goal of extending life. "Dr. David Sinclair of Harvard University has said, 'The goal is not just to make people live longer. It's to see eventually that an 80-year-old feels like a 50-year-old does today.'"[72]

CONCLUSION

Despite the increased demands for medical services due to health care legislation and the aging U.S. population, U.S. immigration policy has not kept up with the demands of modern American society and its citizens' health care needs.

To maintain current restrictive immigration policies on medical professionals puts patients lives at risk. Given other government interventions in the health marketplace, including reimbursements for services under Medicare and Medicaid, and the limited slots to train new doctors and nurses, U.S. policies cannot achieve anything close to domestic "self-sufficiency" in medical care, nor is self-sufficiency even a reasonable goal considering the number of talented and dedicated foreign-born individuals who would like to work in America in the medical field.

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[69] Ibid., and U.S. Census Bureau, *The Next Four Decades: The Older Population in the United States: 2010 to 2050*, May 2010, p. 1.
[70] Sonia Arrison, *100 Plus*.
[71] Ibid.
[72] Ibid.

Employers, their organizations and others directly involved in the health care field, as well as immigration attorneys, have specific recommendations that should be considered in reforming our immigration system. But when examining the issue more broadly several policy recommendations come to mind that should be apparent to policymakers who care about the health of Americans:

- 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 years or decades.

- 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.

- At minimum, vastly expand the Conrad 30 program to include many more physicians per state and in the country as a whole. This will aid patients in underserved areas and enable more U.S.-trained doctors to pursue specialized medical fields. 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.

- Also, consider methods 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.

- Streamline state licensing procedures for foreign medical personnel, including physical therapists and occupational therapists.

A recent survey of U.S. doctors found that 6 in 10 would retire today if they "had the ability to do so."[73] Many cannot retire. "But even if only a small percentage follow through on any of that it could be worrisome to the workforce," according Walker Ray, MD, vice president, the Physicians Foundation. "We have 75 million Baby Boomers transitioning to Medicare starting last year over the next 12 or so years. We have a growing population. We have 32 million people who may be gaining health insurance and yet we have the same number of doctors. We have a bottleneck for training. We are training 25,000 or so doctors a year and the fact that we are finally

[73] *A Survey of America's Physicians: Practice Patterns and Perspectives*, The Physicians Foundation, September 2012, p. 115.

building some new medical schools is not going to increase the doctor supply because the residency level is fixed at 25,000 or 26,000 positions."[74]

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 suffer the medical consequences unless Congress and the executive branch act on such reforms.

[74] John Commins, "6 in 10 Physicians Would Quit Today," HealthLeaders Media, September 26, 2012.

ABOUT THE AUTHOR

Stuart Anderson is Executive Director of the National Foundation for American Policy, a non-profit, non-partisan public policy research organization in Arlington, Va. Stuart served as Executive Associate Commissioner for Policy and Planning and Counselor to the Commissioner at the Immigration and Naturalization Service from August 2001 to January 2003. He spent four and a half years on Capitol Hill on the Senate Immigration Subcommittee, first for Senator Spencer Abraham and then as Staff Director of the subcommittee for Senator Sam Brownback. Prior to that, Stuart was Director of Trade and Immigration Studies at the Cato Institute in Washington, D.C., where he produced reports on the military contributions of immigrants and the role of immigrants in high technology. He has an M.A. from Georgetown University and a B.A. in Political Science from Drew University. Stuart has published articles in the *Wall Street Journal*, *New York Times*, *Los Angeles Times*, and other publications. He is the author of the book *Immigration* (Greenwood, 2010).

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