The Intersection of National Immigration and Healthcare Policy

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Immigration policy and health care policy remain principal undertakings of the federal government. The two have recently been pursued independently in the judicial and legislative arenas. Unbeknownst to many policymakers, however, national immigration policy and health care policy are linked in ways that, if unattended, could undermine the well-being of a significant portion of the US population, specifically medically underserved rural and urban populations. Using current data from a workforce report of the Association of American Colleges and the published literature, we demonstrate the significant impact that contemporary immigration policy directives may have on the number and distribution of international medical graduates who currently provide—and by the year 2025 will provide—a significant portion of primary health care in the United States, especially in underserved small urban and rural communities. (J Am Board Fam Med 2018;31:163–165.)

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Immigration policy and health care policy remain principal undertakings of the federal government. The two have recently been pursued independently in the judicial and legislative arenas. Unbeknownst to many policymakers, however, national immigration policy and health care policy are linked in ways that, if unattended, could undermine the well-being of a significant portion of the US population, specifically medically underserved rural and urban populations.

Consider the actual projected growth of health care demands in an increasingly aging US population. The Association of American Medical Colleges released its physician workforce report, which projected that by year 2030 the physician shortage in the United States will reach between 40,800 and 104,000.[1] Moreover, despite increases in the number of American medical school graduates who will be eligible to fill these physician jobs after completing their residency training, by 2023 to 2024, 4,500 more physician residency training positions will remain available than American graduates from US medical schools who are able to fill them.[2] This is in part because of the shortage of graduates of US medical schools who are willing to enter residency training programs in medical specialties most needed in small cities and rural parts of the country. The latest data from The MATCH, the 2017 graduate residency training program matching system, shows that disciplines such as Internal Medicine, Family Medicine, and Pediatrics-primary were unable to recruit sufficient graduates from US medical schools to fill all their residency training slots: only 44.9%, 45.1%, and 67.5%, respectively, were filled by graduates of US medical schools.[3]

This shortage of US medical school graduates available to fill positions in such important primary care specialties has been compensated mostly by international (foreign) medical school graduates (IMGs), that is, individuals who receive their medical school education outside of the United States. In 2017, 68% of all IMGs admitted to the United States filled these much-needed primary care vacancies. Many of these IMGs are not born in the United States, and only a very small number of US-born students obtain medical school training

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abroad. Historically, among non-US-born IMGs, 45% originate from medical schools in the Middle East (16%) and Southeast Asia (29%), primarily India.[4] Remarkably, nearly 14,496 of currently active physicians in the United States were educated in Middle Eastern countries.[5] All IMGs must clear multiple rigid academic requirements and obtain certification by the Educational Commission for Foreign Medical Graduates before being able to apply to residency in the United States. Although initially some may not fare as well as their American counterparts on the US Medical Licensing Examination,[4] by the time they are out of their residency training and into general practice, IMGs provide high-quality care for the US population. In fact, recent studies show that patients whose care was provided by an IMG internist had survival as good as or better than those whose care was provided by US graduate internists.[6,7] Importantly, many IMGs fill much needed physician roles in underserved areas. They provide invaluable care in rural areas of the United States, filling the gaps in health care and physician shortage in those areas. In fact, IMGs provide nearly 20% to 25% of all care in chronically underserved parts of the country and constitute up to 52% of the primary care physician supply in some areas of the country, such as rural counties.[8] Similarly, in urban areas IMGs disproportionally provide care in the poorest neighborhoods within cities.[9]

It is estimated that if all primary care IMGs were suddenly removed, 1 of every 5 adequately served nonmetropolitan counties in the United States would become underserved, and that the percentage of nonmetropolitan counties with a physician shortage would increase from 30% to 44.4%.[10] On February 2, 2017, Thomas Nasca, MD, CEO of the Accreditation Council for Graduate Medical Education, issued a statement affirming that the recent White House Executive Order[11] regarding immigration from Middle Eastern countries would adversely affect over 10,000 licensed physicians in the United States who graduated from medical schools in 1 of the 7 countries named in the recent executive order—physicians who provide the care for more than 900,000 patients across the United States annually.[12] The executive order also has repercussions for the 1800 physicians who graduated from the 7 named countries and are currently enrolled in Accreditation Council for Graduate Medical Education–accredited residency and fellowship training programs. Retention of these graduates in the United States is integral because of their willingness to provide care in underserved areas. An interesting report from Washington State demonstrated that after concluding their commitment to their J-1 visa waiver employer, 74% of these doctors relocated to more urban centers within the state.[13] Many of these remained in their positions for an average of 34 months after fulfilling their obligation to their employer. Regretfully, 38% of these elected to relocate because their employer "should have shown them more respect."[13]

With the predicted future shortfall of US medical graduates who are willing and able to fill these positions in primary care and the increasing demand for health care in the United States, the role of IMGs in providing essential medical care in underserved urban and rural parts of the country will become more salient. To that end, we must see that our country's immigration policy does not aggravate these shortfalls and further widen the gaps in care for many US residents living in medically underserved areas of the county.

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References

1. IHS Inc. The complexities of physician supply and demand: projections from 2014 to 2025. Final report. Washington (DC): Association of American Colleges; 2015.
2. Mullan F, Salsberg E, Weider K. Why a GME squeeze is unlikely. New Engl J Med 2015;373:2397–9.
3. Results and data 2016 main residency match. Washington (DC): National Residency Matching Program; 2016.
4. Schenarts PJ, Love KM, Agle SC, Haisch CE. Comparison of surgical residency applicants from U.S. medical schools with U.S.-born and foreign-born international medical school graduates. J Surg Educ 2008;65:406–12.
5. Tekian A, Boulet J. A longitudinal study of the characteristics and performances of medical students and graduates from the Arab countries. BMC Med Educ 2015;15:200.
6. Tsugawa Y, Jena AB, Orav EJ, Jha AK. Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study. BMJ 2017;356:j273.
7. Norcini JJ, Boulet JR, Dauphinee WD, et al. Evaluating the quality of care provided by graduates of

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international medical schools. Health Aff (Millwood) 2010;29:1461–8.
8. Fordyce MA, Doescher MP, Chen FM, Hart LG. Osteopathic physicians and international medical graduates in the rural primary care physician workforce. Fam Med 2012;44:396–403.
9. Mick SS, Lee SY. International and US medical graduates in US cities. J Urban Health 1999;76:481–96.
10. Thompson MJ, Hagopian A, Fordyce M, Hart LG. Do international medical graduates (IMGs) "fill the gap" in rural primary care in the United States? A national study. J Rural Health 2009;25:124–34.
11. Executive order protecting the nation from foreign terrorist entry into the United States. Washington (DC): White House Office of the Press Secretary; 2017.
12. Nasca TJ. Letter to GME community on immigration policy, February 2, 2017. Chicago: Accreditation Council for Graduate Medical Education. Available from: https://www.acgme.org/Portals/0/PDFs/Nasca-Community/Nasca-Letter-Immigration-2–2-17.pdf. Accessed November 10, 2017.
13. Kahn TR, Hagopian A, Johnson K. Retention of J-1 visa waiver program physicians in Washington State's health professional shortage areas. Acad Med 2010;85:614–21.

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