CAH/FLEX
National Tracking Project

FINDINGS FROM THE FIELD

Volume 3, Number 1
June 20, 2003

The Role of International Medical Graduates in America's Small Rural "Critical Access" Hospitals

Background

Almost one-fourth (23.3%) of the nation's 772,000 practicing physicians are graduates of non-U.S. medical schools (known as international medical graduates, or IMGs). One in five medical residents is on a J-1 student visa.[a] One of the requirements of the J-1 visa is that recipients return to their home country following residency training for at least two years before applying for permanent residency status. A "J-1 visa waiver," granted by the Bureau of Citizenship and Immigration Services (formerly Immigration and Naturalization Service), waives this two-year return-home requirement if IMGs find employment in health professional shortage areas (HPSAs)[b] and agree to three to five years of service in those jobs. About 75% of the IMGs who receive the waiver eventually become U.S. permanent residents.

Administrators from 167 (44.8%) of the CAHs reported they currently had IMGs admitting patients to their hospital. About one in four (24%) of the physicians admitting to all CAHs were reported to be IMGs.

Federal government agencies that help foreign-born physicians find positions in HPSAs include the Appalachian Regional Commission (ARC), and the U.S. Department of Health and Human Services (DHHS). A state health department can recommend up to 30 annual J-1 visa waivers, for any rural or urban HPSA in its state. The state authority was created in 1994 in legislation sponsored by Senator Kent Conrad (D-ND), originally for 20 waivers per state and expanded to 30 waivers per state in 2002.

Of the 53 hospitals in non-metropolitan counties classified as persistently poor, 33 (62%) had one or more IMGs. Of the 335 hospitals in non-metropolitan counties not classified as persistently poor, 141 (42%) had one or more IMGs.

A Report on a Survey of Critical Access Hospitals

The University of Minnesota's Rural Health Research Center coordinated the development and administration of a survey of Critical Access Hospital (CAH) administrators in the winter of 2002. A total of 388 CEOs responded from 39 states (for a response rate of 96%). We report here on the findings of that survey as it pertains to IMGs.

International Medical Graduates

The Numbers

Administrators from 167 (44.8%) of the CAHs reported they currently had IMGs admitting patients to their hospital. About one in four (24%) of the physicians admitting to all CAHs were reported to be IMGs, a similar number to the U.S. average of IMGs as a percent of practicing physicians. Almost half (48%) of the CAHs with an IMG admitting to the hospital reported having only one IMG, while 11% had four or more. For 16% of CAHs, at least half their admitting physicians were IMGs, and for another 10%, the portion of IMGs on the physician staff was 75% or more.

For towns with fewer than five physicians admitting to the hospital, 27% of those physicians were IMGs. This compares to towns with more than five physicians admitting to the hospital, where only 17% were IMGs.

IMGs were found in significantly greater numbers in hospitals that reported physician recruitment as a "major problem" (48.5% of hospitals with IMGs reported a major problem with recruitment, but only 36.2% of those without IMGs reported a major problem, $p = .037$).

We also found hospitals in "persistently poor" counties were significantly more likely to have IMGs. Of the 388 hospitals in our study, 53 (14%) were located in persistent poverty non-metropolitan counties as defined by the USDA's Economic Research Service. Of these, 33 (62%) had one or more IMGs, compared to 141 (42%) of the 335 hospitals in non-metropolitan counties that are not classified as persistently poor ($p = .007$).

Geographical Distribution

CAHs in the mid-Atlantic region[c] were much more likely to have IMGs than those in the Pacific Northwest region[d] (83% vs. 12%). Among the states that had at least five responding CAHs in our study, we found the proportion of hospitals with IMGs to be highest in North Carolina, Kentucky, New York, West Virginia, Illinois, Indiana, and Georgia (70% or more of the hospitals in those states had one or more IMGs).

Specialties and Origins

The majority of IMGs admitting patients to CAHs were internists (59%). Another 26% were family practitioners, with less than 6% each working as surgeons or pediatricians. Obstetric services were significantly less likely to be found in hospitals with one or more IMGs (79% vs. 21%).

The majority of IMGs (61%) in CAHs received their medical training in India, the Philippines, or Pakistan—the same three countries that supply the bulk of the U.S.'s IMGs.[e]

While a third of IMGs from the Philippines and 22% of Indian IMGs were family practitioners, very few (only two) of the IMGs from Pakistan were family physicians. The longest-tenured IMGs were largely from the Philippines and India, while IMGs of Pakistani origins tended to be more recent arrivals.

Quality

Using a five-point scale, where poor = 1 and excellent = 5, hospital administrators ranked IMG clinical skills an average of 4.35 and interpersonal skills at 4.02. We also asked administrators to tell us about their experiences with IMGs using an open-ended question. When categorized, we found 50% of the 115 administrators who commented had unreservedly positive comments about the IMGs in their communities, 27% gave their IMGs mixed reviews, and 23% had predominantly negative comments.

Conclusion

CAHs in counties that have difficulty sustaining physician practices are more reliant on IMGs than are more stable CAHs. CAHs are significantly more likely to have one or more IMGs when CAHs are located in a persistent poverty county, when CAH administrators reported recruitment or retention of physicians is a major problem, and/or when the number of admitting physicians is very small.

The presence of fellow nationals likely contributes to a continually increasing number of immigrants in some locations. As one administrator explained, "I recruited the first few IMGs; after that, they recruited each other." Despite greater numbers of IMGs in CAHs east of the Mississippi, and a high concentration in the mid-Atlantic and Great Lakes regions, there was still a considerably wide distribution of IMG experience across the states.

In the communities where it is working well, administrators reported IMGs have been accepted because they have adapted well socially, have good English skills, and are willing to work hard (some of the comments suggested perhaps IMGs are expected to work even harder than U.S.-trained physicians in the same settings). Not all communities have been welcoming, however, and in some places where the administrators expressed concern, it seemed the community was not adapting to the idea of a non-U.S. medical graduate.[f]

Congress has elected to expand the Conrad Program to 30 slots per state, perhaps signaling a continued reliance on IMGs to help solve the U.S. physician mal-distribution problem. The December 2002 decision by Secretary of Health Tommy Thompson to involve DHHS in facilitating placement of IMGs further signals support for a pro-IMG policy. These new IMG policy changes seem somewhat at odds with recent harsher overall immigration policies, but U.S. policy has historically been friendlier to highly educated immigrants than others.

Where can I get more information?

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About this project: Check out our website: http://www.rupri.org/rhfp-track/

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Notes

[a]Graduate medical education tables, Appendix II, Table 6. *JAMA.* 2002;288:1159.

[b]Health professional shortage areas (HPSAs) are designated by the U.S. Bureau of Health Professions. A web site provides a listing of all HPSAs: <http://www.bphc.hrsa.dhhs.gov/databases/newhpsa/newhpsa.cfm> (July 4, 2002).

[c]The mid-Atlantic region includes New York, Pennsylvania, New Jersey, Delaware, Maryland, and Washington, DC.

[d]The Pacific Northwest region includes Washington, Oregon, Idaho, Montana, Wyoming, Alaska, and Hawaii.

[e]The AMA reports India supplies 20% of IMGs, Pakistan 12%, and the Philippines 9%. <http://www.ama-assn.org/ama/pub/printcat/1550.html> May 13, 2002.

[f]One hundred fifteen administrators responded in this survey to an open-ended request for comments about their experience with IMGs.

Background

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

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