

Midwest Diagnosis: Immigration Reform and the Healthcare Sector

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Executive summary

Healthcare is a critical part of the local economy, providing jobs for millions of Midwesterners and billions of dollars in wages across the 12-state region. However, the growing healthcare needs of the baby boomers as they age, coupled with acute shortages of healthcare workers, are straining the sector. Immigrants—foreign-born physicians, researchers, nurses, health aides, and hospital workers—are key to the future vitality of healthcare in the United States, and federal immigration reforms are urgently needed to ensure that the sector is able to maximize their contributions. However, legislation remains stalled in Congress, leaving Midwest healthcare to grapple with challenging issues:

- ▶ US-born medical school graduates are likely to pursue careers in lucrative specialties and relocate to coastal cities, causing severe shortages of critical primary care, pediatric, and family medicine physicians in the rural Midwest.
- ▶ Foreign-born healthcare professionals who have completed their training overseas face complicated, inconsistent reaccreditation processes in the United States, leaving many unable to practice in their fields.
- ▶ Undocumented immigrants, unable to access health insurance under current laws, are dependent on expensive, ineffective emergency room care to

address health issues or avoid receiving care altogether, compromising health outcomes.

- ▶ The linguistic and cultural assets of foreign-born healthcare workers are increasingly in demand given the growing diversity of the United States. Yet visa shortages and licensing issues complicate their hire.

A continued stalemate on immigration reform means these issues will only grow in urgency. Changes based on the following policy recommendations, developed with input from regional stakeholders from the healthcare sector, would not only remedy these issues in the Midwest but would ensure a vibrant healthcare sector across the country:

- ▶ Issue visas according to labor force demands.
- ▶ Remove quotas and caps on doctors and surgeons.
- ▶ Address credentialing challenges for foreign-born professionals.
- ▶ Allow undocumented individuals to access some forms of insurance.
- ▶ Train healthcare professionals to provide linguistically and culturally competent care to diverse populations.

It is vitally important that the region properly plan for the employment, economic, and healthcare needs of all residents, regardless of country of origin.

Introduction

The healthcare sector is fundamental to the development and sustainability of the Midwest economy. In states like Missouri, Nebraska, and North Dakota, the healthcare sector is the number one employer. In North Dakota alone, seven of the state's top 10 employers are in the healthcare sector. Hospitals throughout the region are responsible for employing nearly 1.3 million people, an average of more than 4 percent of each state's total employment (see figure 1A). In fact, the US Bureau of Labor Statistics calculates that the education and healthcare services sector provided nearly 5 million jobs—an average of 15 percent of total state employment across the 12-state region—and generated \$51 billion in wages (see figure 1B).¹

The vitality of the healthcare sector, however, depends on a functioning immigration system: foreign-born professionals accounted for 16 percent of all civilians employed in healthcare occupations and one-fourth of practicing physicians in 2010.²

But more workers are needed. The Midwest is particularly plagued by a physician shortage.³ Furthermore, labor-force issues will be exacerbated in the coming years as the healthcare needs of retiring baby boomers strain the system. Workforce gaps also extend to lower-skilled, lower-paid healthcare jobs, such as home healthcare aides and technicians, as US-born workers choose more-lucrative positions in other industries. While foreign-born healthcare workers are well-positioned to fill these gaps in the labor force (and have been doing so for years), the outdated federal immigration system, along with complicated state-level credentialing requirements, pose hurdles.

What's more, healthcare systems not only struggle to meet the needs of undocumented immigrants unable to access care under current policy, but they also lack the ability to capitalize on the foreign-born workers' linguistic and cultural assets, which are important to providing quality care for increasingly diverse communities.

The Midwest healthcare sector needs updated immigration laws that reflect today's economic and demographic realities and are poised to respond not only to the nation's but also the region's unique challenges. Until Congress enacts reforms to immigration policy that address these issues, the sector will continue to struggle with the challenges of providing quality care with limited personnel and resources. The

FIGURE 1A

Hospital Employment as a Percentage of the Midwest Economy

State	Hospital employment (Nov. 2015)	Percent of total employment (Nov. 2015)
Illinois	238,700	3.87%
Indiana	117,200	3.73%
Iowa	NA	NA
Kansas	48,100	3.33%
Michigan	202,900	4.49%
Minnesota	107,600	3.71%
Missouri	123,400	4.18%
Nebraska	44,300	4.51%
North Dakota	17,200	4.30%
Ohio	251,000	4.60%
South Dakota	24,300	5.51%
Wisconsin	111,100	3.74%
Total/Average	1,285,800	4.18%

Note: Percent of total employment calculated by dividing figures from November 2015 "Hospital Employment" from "State and Area Employment, Hours and Earnings" pages, www.bls.gov/sae/data.htm, by November 2015 total state employment from "Midwest Information Office-State Economies at a Glance" pages, <http://www.bls.gov/regions/midwest>.

Source: US Bureau of Labor Statistics, "State and Area Employment, Hours and Earnings" pages, "Hospital Employment" for November 2015, www.bls.gov/sae/data.htm.

region will also continue to miss out on productivity gains from a robust, fully functioning sector.

New strains on an old sector

The United States is experiencing an important demographic shift: growing numbers of baby boomers are reaching retirement age. Many regions, like the Mid-

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FIGURE 1B

Education and Health Services as a Percentage of the Midwest Economy

State	Education and health services employment (Oct. 2015)	Education and health services as a percentage of total employment (Oct. 2015)	Total wages earned in the education and health services industry (Q1 2015)
Illinois	906,500	14.70%	\$9,678,070,844
Indiana	458,200	14.65%	\$4,473,133,627
Iowa	139,700	8.49%	\$2,058,114,782
Kansas	192,900	13.49%	\$1,841,888,793
Michigan	665,300	14.78%	\$6,927,420,691
Minnesota	513,200	17.78%	\$5,579,467,538
Missouri	445,900	15.26%	\$4,408,317,860
Nebraska	155,400	15.85%	\$1,313,999,072
North Dakota	59,300	14.88%	\$673,228,145
Ohio	908,000	16.65%	\$8,935,677,945
South Dakota	70,800	16.11%	\$703,855,539
Wisconsin	447,400	15.14%	\$4,481,412,122
Total	4,962,600		\$51,074,586,958

Note: Education and health services as a percentage of total employment calculated by dividing the employment figures in column 1 by the total state employment for October 2015, <http://www.bls.gov/regions/midwest>.

Sources: US Bureau of Labor Statistics Midwest Office, "State Economy at a Glance" pages, Education and Health Services for October 2015, <http://www.bls.gov/regions/midwest>; US Bureau of Labor Statistics, "Quarterly Census of Employment and Wages," 2015 First Quarter, www.bls.gov/cew.

west, have experienced significant losses in their working-age population, causing challenging labor shortages across a variety of industries, including healthcare. The US Census Bureau projects a 36 percent growth in the number of Americans over age 65 in the next decade, with nearly one-third of all physicians retiring because they fall in that age demographic.⁴

At the same time, the number of individuals needing healthcare is increasing. Those 65 or older who are enrolled in Medicare make up more than 14 percent of the population.⁵ However, in less than 15 years, an estimated 20 percent of Americans will be 65 or older and on Medicare.⁶ Midwestern states have also seen

growing rosters of individuals enrolled in Medicaid due to the Patient Protection and Affordable Care Act (ACA) and Medicaid expansion.⁷ In Ohio, for example, 25 percent of residents are now covered under government-funded Medicaid and 18 percent under Medicare.⁸ And these individuals already live in a state ranked among the lowest in the country for total population health, meaning its residents are less healthy and need more care.⁹

As demand for healthcare services increases, the number of medical school students will also increase by 7,000 graduates every year for the next 10 years, according to the Association of American Medical

Colleges. Overall numbers of students enrolled in medical school is up 25 percent over 2002, to an all-time high of nearly 21,000 in 2015. Also encouraging is the fact that the field is growing more diverse, with Latino enrollees up 6.9 percent and African-American enrollees up 11.6 percent. The number of foreign-born students increased 9 percent between 2009 and 2015.¹⁰ However, unless the federal government approves funding to add 4,000 more physicians a year to the pipeline, demand cannot be met and access to healthcare will remain out of reach for many Americans throughout the Midwest.¹¹

As it stands, the United States will face a shortage of 46,100 to 90,400 physicians by 2025.¹² These shortages will be acutely felt in rural areas, like those in Wisconsin, which are home to 28 percent of the state's population but only 11 percent of its practicing physicians.¹³

Wisconsin is not alone in its struggles to provide quality care. Most of the Midwest faces similar circumstances. More than a quarter of the residents of Indiana, Iowa, Michigan, Minnesota, Missouri, and Nebraska live in a rural community. In South Dakota, the number is closer to one in two.¹⁴ There are simply not enough native-born healthcare workers to meet the growing demand and to do so in the geographic areas with the greatest need. The Midwest urgently needs a federal immigration policy that facilitates hiring more foreign-born workers, filling current job openings, and meeting local healthcare needs.

Immigrants already provide care

More than one-quarter of physicians and surgeons in the United States were foreign born in 2010. These statistics are consistent in the Midwest, where 25 percent of physicians and surgeons were born outside of the country. In Des Moines, Iowa, for example, 150 of the estimated 600 physicians employed by Mercy Medical Center were born outside the United States. According to administrators at Mercy, foreign-born doctors tend to be the system's "superstars," an essential part of the workforce. "Without the immigration of professionals to Iowa, healthcare would be in complete crisis," said one hospital administrator.¹⁵

The same is true at Presence Health, the largest Catholic healthcare system in Illinois, with more than 150 locations throughout the state. Administrators said that more than half the resident doctors at St. Francis

Hospital in Evanston are foreign born (48 of 84), as are 71 of the 79 internal-medicine and preliminary-year residents at Chicago's St. Joseph Hospital.¹⁶

Currently, at CoxHealth in Springfield, Missouri, 135 of the 450 physicians across the five-hospital system are foreign born. That's 30 percent of the system's doctors, which is more diverse than the surrounding community, indicating just how strong of an influence the immigrant community already has on the state's healthcare system.¹⁷

In addition to physicians, roughly one-fifth of nurses and home healthcare and psychiatric aides, and more than one-sixth of dentists, pharmacists, and clinical technicians in the United States were foreign

Box 1

Filling Gaps in Leadership and Research¹⁸

Italian-born Giovanni Piedimonte is physician-in-chief of Cleveland Clinic Children's Hospital and chair of the Cleveland Clinic Pediatric Institute. He came to the United States more than 25 years ago, conducting pediatric research and doing his residency in California before completing a fellowship in pulmonary medicine in North Carolina. He now has over 20 years of experience as a hospital administrator and has worked for the last three years at the prestigious Cleveland Clinic, one of the nation's top five hospitals. "I came from nothing, worked hard, and played by the rules," he said. "The United States was built with stories like this."

Piedimonte cites "huge personnel shortages" among his peers in hospital leadership positions, in addition to a dearth of primary care physicians and a shrinking supply of specialists in most pediatric subspecialties. These gaps need to be filled by qualified professionals, foreign born or US born. He adds that he would "be happy to hire American candidates, but sometimes there are no such applicants."

He has seen his Colombian-born wife, also a pediatrician and healthcare researcher, challenged by the US immigration system. "In order to get [research] funding from the National Institutes of Health, you need to be a permanent resident," he said, citing what is an obstacle for many foreign-born medical students in the United States on temporary visas.

"The United States gave me the opportunity to become who I am today," he said. "I'm a physician, not a politician, but I think others who want to come into this country and to contribute to its greatness should be able to do so."

born in 2010.¹⁹ It is easy to see that this growing population of foreign-born workers has become a cornerstone of healthcare in the Midwest.

Yet despite these significant cohorts of foreign-born workers across the sector, the immigration system curbs their contributions from entry point and educational training to long-term employment. For example, enrollment restrictions and visa requirements for medical and nursing school cohorts limit many immigrants' ability to come study in the United States, and outdated visa caps limit hospitals' ability to recruit these professionals once they finish their training. US immigration law also provides almost no opportunities for foreign paraprofessionals—such as healthcare aids or nursing assistants—to enter the country as either temporary workers or permanent residents, contributing to disparities in care that could be prevented by an updated immigration system that reflects current economic and demographic realities.

Overall, the United States' outdated federal immigration system presents several challenges to the healthcare sector: shortages of highly skilled workers, shortages of workers in entry-level jobs, limited access to care for immigrants, and meeting the linguistic and cultural needs of an increasingly diverse patient base.

Shortages of highly skilled labor

In the Midwest, demand for high-skilled medical labor is far outpacing supply. The current shortage is no surprise, however, as it was predicted as far back as 1990, when the National Center on Education and the Economy issued a workforce report discussing future high-skilled labor needs.²⁰ With the supply of US-born medical professionals falling so far short of demand, it is unfortunate and irresponsible that current immigration policy still does not promote the inclusion of foreign-born professionals into communities most in need, especially rural areas. Nor does current policy encourage foreign-born medical practitioners to stay in those underserved regions once their educational and professional requirements have met federal standards.²¹

Native-born trend toward specialization

Despite an increasing healthcare demand that necessitates a greater number of general and primary care practitioners, the native-born population that completes medical school in the United States tends

FIGURE 2

Specialties Pursued by Native- and Foreign-Born Health Professionals in the United States for the 2010–11 Academic Year

	J-1 Visa Physicians (%)	US Medical Graduates (%)
Internal medicine	45.8	15.0
Pediatrics	11.0	7.4
Family medicine	7.9	5.8
General surgery	7.2	8.4
Psychiatry	5.2	3.8
Neurology	4.1	1.5
Obstetrics and gynecology	1.9	5.0
Orthopedic surgery	1.4	4.5
Diagnostic radiology	1.4	5.5
Anesthesiology	1.3	5.9
Other specialties/subspecialties	12.9	37.2
Total	100	100

Sources: Educational Commission for Foreign Medical Graduates, 2012 Annual Report, <http://www.ecfmg.org/resources/ECFMG-2012-annual-report.pdf>; Sarah E. Brotherton and Sylvia I. Etzel, "Graduate Medical Education, 2010–2011," January 2012, American Medical Association, <http://gsm.utmck.edu/medexp/documents/gme.pdf>.

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to specialize more than its foreign-born counterpart, owing partially to pay.²²

From 2000 to 2004, the median physician income for all primary care positions increased only 10 percent, compared to a 16 percent increase in the same time for all nonprimary care specialties. These increases come on top of an already skewed physician pay scale that compensates specialists up to 45 percent more than primary care physicians.²³

Native-born physicians are, therefore, choosing more lucrative specializations, such as dermatology, obstetrics, and orthopedics. This leaves generalist positions like family medicine, internal medicine, and pediatrics more likely to be filled by foreign-born practitioners (see figure 2).²⁴

Foreign-born medical professionals are, therefore, key in addressing the shortage of primary care physicians in the United States, particularly in underserved communities where there are fewer specialists and therefore a greater need for a broad range of medical skills. In fact, the American Academy of Family Physicians estimates that although family physicians make up less than 15 percent of the outpatient workforce, they perform about 42 percent of office visits in rural areas.²⁵

Challenges in rural communities

Rural care is a particularly urgent issue in the Midwest, whose combined 16 million rural residents account for 28 percent of the 12-state region's population.²⁶ The labor shortages affecting the nation as a whole translate to particularly compromised quality of care in rural communities.

For example, in Wisconsin's 104 federally designated primary care Health Professional Shortage Areas (HPSAs)—many of them rural communities—only 71 percent of primary healthcare demands are currently being met.²⁷ The Wisconsin Hospital Association projects that the state will show a shortfall of more than 2,000 physicians by 2030.²⁸ These disturbing trends come despite the fact that the Wisconsin Office of Rural Health is one of the country's oldest such bureaus, founded in 1979.

In addition to native-born medical students being more likely to pursue specialized fields, reports suggest they are also more likely to pursue work in coastal cities on graduation, a trend that particularly deepens physician shortages in the rural Midwest (see figure 3).²⁹ Foreign-born doctors, therefore, are increasingly key to filling labor gaps in these rural communities. Yet few programs incentivize them to fill those gaps.

The US Citizenship and Immigration Services' Conrad 30 J-1 Waiver Program allows foreign-born graduates from US medical schools to remain in the United States postresidency if they practice in an HPSA for no less than three years. However, with just 30 waivers allotted per state, the number of these physicians still falls far short of demand.³⁰ Midwestern

Box 2

Supporting Foreign-Born Doctors in Rural Communities³¹

Randy Munson, manager of the New Physicians for Wisconsin program of the Wisconsin Office of Rural Health, has been recruiting physicians—native born and foreign born—to work in Wisconsin for more than 25 years. "If doctors are from India or Indiana, they need support in a new environment," he said.

Turnover rates among foreign-born doctors can be especially high, given the isolating nature of work in rural communities. Munson encourages clinics, hospitals, and healthcare systems to "take visas on a case-by-case basis" and to understand the factors—such as marital status, connections to the community, previous experience living in the Midwest—that often bolster the retention of foreign-born professionals in rural areas.

He also coaches foreign-born doctors to become a part of the communities where they are working. "There's an onus on doctors to 'be seen' in town; living and working in the community will help their practice grow."

Even with challenges, "some foreign-born doctors stay 10 to 15 years in rural communities," he said, citing the case of an Indian-born doctor who worked at urban Cook County Hospital in Chicago before successfully transferring to a rural community in Wisconsin.

states like Iowa, for example, tend to fill its ratio of 30 waivers quickly, leaving administrators at Des Moines Mercy Medical Center to lament that they are "forced to pass on great candidates" every year. "The Conrad 30 needs to become the Conrad 50," they say.³²

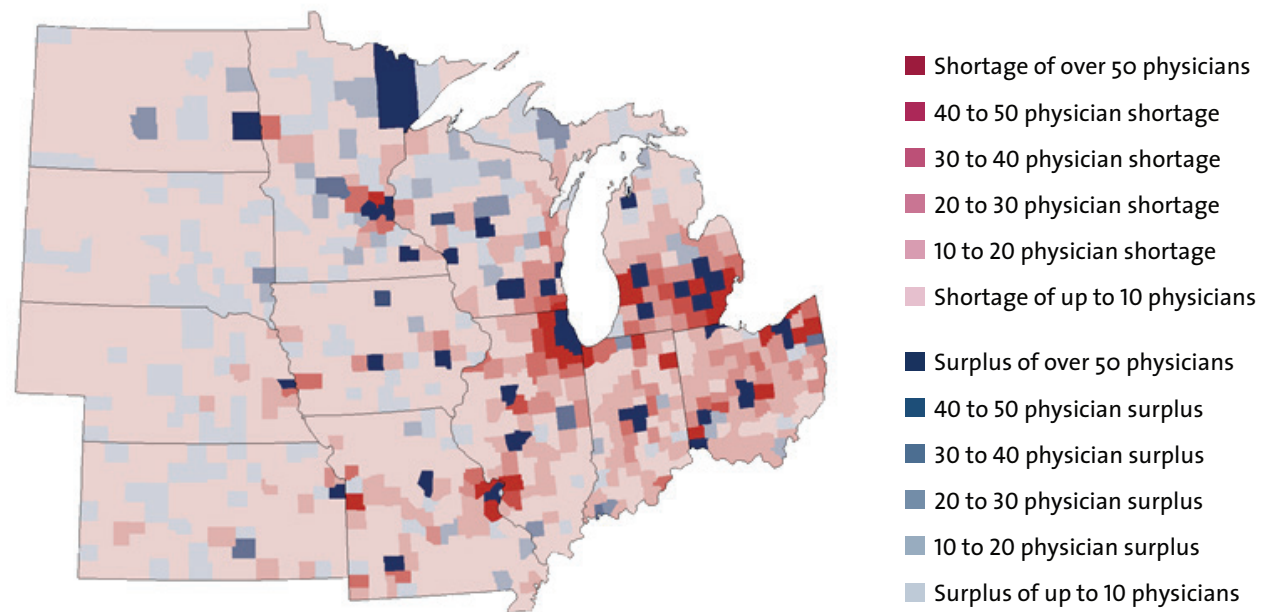
Hospitals and medical centers in rural regions of the Midwest often do not have the population density to sustain specialty and subspecialty facilities, nor the financial means to support such practices.³³ Therefore, they face challenges in meeting the accreditation requirements that would allow them to teach clinical education and train medical students. These factors lead some to fear that the healthcare pipeline for rural communities will dry up even faster than in other geographic areas.

Other obstacles for foreign-born professionals

Across the employment spectrum, foreign-born professionals face unique obstacles. In rural areas, the challenges are even more acute. Factors like integration issues, connecting with patient populations, and

FIGURE 3

Shortage and Surplus of Primary Care Physicians in Midwestern States



Source: Connor Ryan, “Doc Shortage or Maldistribution?,” American Action Forum, August 14, 2014, <http://americanactionforum.org/weekly-checkup/doc-shortage-or-maldistribution>.

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low pay often cause high turnover among foreign-born doctors in rural areas, prompting some state and hospital human resources departments to resist hiring them in the first place.³⁴

The Wisconsin Office of Rural Health conducted a study over a five-year period that showed how integration challenges can influence the retention rate of physicians on J-1 visas compared to their US-born-and-trained counterparts. While retention of US-born-and-trained physicians was close to 90 percent after five years of practice, the retention rate for international medical graduate physicians who were originally on J-1 visas was notably lower. A full 30 percent of these physicians did not complete three years of service in their assigned HSPA.³⁵

Foreign-born healthcare professionals who completed their education overseas, known as International Medical Graduates (IMGs), face even more complicated accreditation and licensure processes. While many IMGs are fully authorized to work in the United States, they cannot always practice in the healthcare field.³⁶ To maintain US standards, IMGs seeking to practice as physicians may need to return

to school for training and education, compete for residency, and retake examinations—all after having completed similar requirements in their home countries.³⁷

In some cases, because of intense competition for limited residency slots—native-born candidates or foreign-born graduates of US medical schools may have

Box 3

Undocumented, MD-PhD

According to Cesar Montelongo, an undocumented student in Illinois, it was easier for him to gain admission to a highly competitive MD-PhD program than to get his US visa to practice medicine. “I am one of the first undocumented immigrant students to have been accepted into an MD-PhD program,” he said.

According to his estimates, of the 731,000 applications to US medical schools in 2014, just 20,343—less than 3 percent—were accepted. The number admitted to MD-PhD programs was just 626. Despite his beating these odds and having lived in the United States for 20 years, and the overwhelming shortage of healthcare professionals with his skill set, Montelongo is still unable to obtain legal status.³⁸

established networks that may give them an advantage—relocation may be required for IMGs. On being asked if he would consider relocating to Boise, Idaho, from Chicago, one IMG told a nonprofit caseworker that he would “take a residency on Mars if it would mean that I could practice as a doctor.”³⁹

Indeed, IMGs may be willing to accept the rural or remote posts passed up by their peers, offering a solution to the acute physician shortages in these communities. However, given the significant personal, professional, and financial burdens involved in re-credentialing, many IMGs opt for employment in other fields or are underemployed in lower-paying jobs.

Rigorous accreditation requirements are essential to ensuring a high standard of professional quality in the US healthcare system, but they vary widely from state to state and may create situations where states compete against each other for IMGs, raising the possibility of further losses for regions like the Midwest. For example, Midwestern states like Nebraska, Missouri, and North Dakota require foreign graduates to complete two more years of postgraduate training than their native-born counterparts, making these states less appealing to those who attended school outside the United States, despite the vast number of jobs in the sector.⁴⁰

Carmen Velasquez, founder of Alivio Medical Center in Chicago, cites examples of foreign-born nurses moving as far away as Texas for licensure after being turned away in Illinois, where accreditation practices by the state were more restrictive.⁴¹ Licensure issues also pose challenges in Kansas, where cardiovascular providers from Kansas City sometimes drive up to four hours into rural areas of their state to compensate for the lack of local providers. Sometimes those same providers have to go into Missouri and Nebraska to see patients, as licensure requirements have exacerbated shortages in those states and reciprocity policies allow Midwestern doctors to cross certain state boundaries because of need.⁴²

Innovative national nonprofits such as Upwardly Global and the Welcome Back Initiative help foreign-born healthcare professionals navigate complicated licensing requirements and also provide support services such as career coaching, resume writing, and professional networking.⁴³ Similarly, the Women’s Initiative for Self Empowerment, located in Minnesota, coordinates a Foreign Trained Professional Recertification Program for refugees who have lived

Box 4

Midwestern Legislation Tackles International Medical Credentialing

Facing severe gaps in their local healthcare workforces, Midwestern legislators are embracing the talents of foreign-born professionals trained overseas.

In 2014, Missouri’s state legislature created a new licensure classification for “assistant physicians,” designed for work-authorized immigrants who have passed required sections of the U.S. Medical Licensing Examination but have not completed postgraduate residency in the United States. While rule making for the legislation is still in process, assistant physicians will eventually be able to practice in Missouri, helping alleviate workforce gaps in the state.⁴⁴

Minnesota’s International Medical Graduates Assistance Program, launched in 2015, helps foreign-born physicians in navigating the complex process of credentialing and licensing in the United States.⁴⁵ The bill (S.F. 1049) includes financial provisions to support up to five foreign-born physicians in residency each year and accept private support for additional slots. With over 300 immigrant physicians living in the state—two-thirds of whom are estimated to be general practitioners—this initiative could be an invaluable source for quality care.⁴⁶

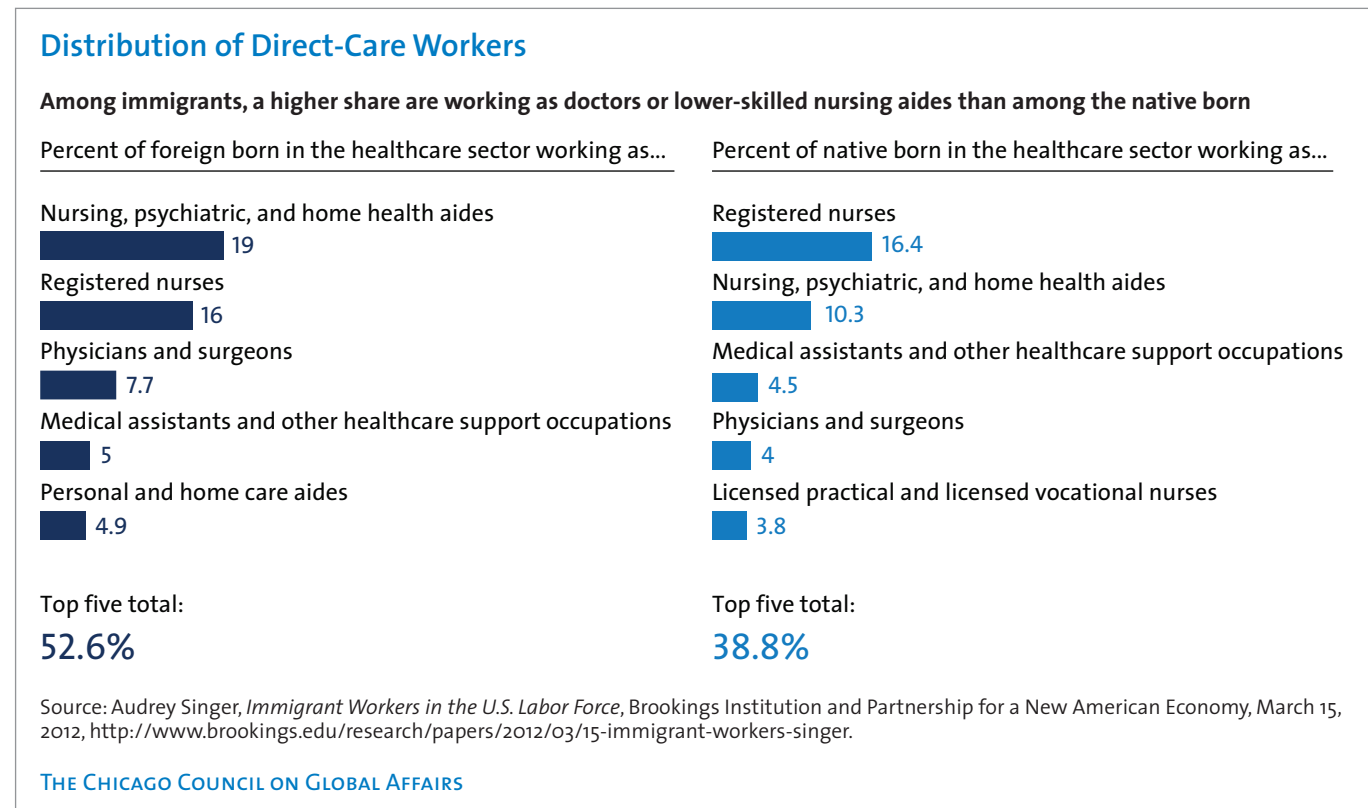
in the United States for less than five years. The program provides information, education, mentorship, resources, and advocacy to support foreign-trained healthcare professionals who must be recertified to practice in the United States.⁴⁷ While the reach of these organizations is still fairly limited—Upwardly Global has offices in Chicago and Detroit and is expanding throughout the Midwest—taking on accreditation challenges is no longer a solo endeavor for many high-skilled individuals.⁴⁸

Demand for entry-level healthcare jobs

In addition to depending on high-skilled foreign-born workers to fill doctor and physician shortages, the healthcare system also relies on low-skilled foreign-born workers to fill other roles. Many positions require less education but are equally important to the overall functioning of the Midwest’s healthcare ecosystem and communities.

Today, a wide range of jobs, from home health aides to housekeeping staff to data-entry technicians, are more likely to be filled by foreign-born healthcare workers than their native-born counterparts (see fig-

FIGURE 4



ure 4). This trend is partially attributed to the low pay and service-oriented nature of these jobs, as many US-born workers have the mobility and language skills to move to more-lucrative professions. It can also be attributed to the fact that many low-skilled healthcare positions require less than a high school education. Only 76 percent of foreign-born workers 25 or older have completed high school, compared to 95 percent of US-born citizens, often making these roles a good fit for their limited US standardized educational background.⁴⁹

Distribution of direct-care workers

As the US baby boomer population continues to age, the demand for long-term home healthcare by professionals trained to provide personal care and services for the elderly and chronically and terminally ill is growing. Yet the annual salaries for these demanding jobs, which typically require less than a high school degree, was as low as \$20,820 in 2012, with minimal increases projected.⁵⁰ Native-born workers, even those with low levels of education, tend to pass up these jobs, which are often physically demanding, tedious, and poor paying, for more-lucrative, less-demanding

positions, leaving the healthcare sector increasingly reliant on immigrants to fill gaps.⁵¹

As with high-skilled gaps in the healthcare workforce, labor shortages persist in entry-level healthcare jobs, despite foreign-born workers' increasingly filling them. In some areas of the Midwest, filling entry- and even middle-level positions is such a pressing need that hospitals and healthcare systems are partnering with trade schools and community colleges, as well as starting their own instruction series to educate and train a new workforce. These various programs cater to young adults, immigrants, and others, depending on the community need and program focus.

In an effort close gaps caused by the 800 job vacancies throughout its system, administrators at Missouri's CoxHealth have developed a scholarship program with Ozarks Technical Community College to build a pipeline of healthcare aides, nursing assistants, and therapists.⁵² The hospital system has also created Cox College, which offers a variety of programs ranging from certifications to graduate degrees, training local workers as young as 16 for futures in healthcare careers. Still, administrators report, "there just aren't people to fill the jobs."⁵³ Representatives from the

Box 5

Definitions of Visas

J-1 Visa (also known as J Waiver): A temporary visa administered by the US Department of State that allows participants to work in "exchange program"-style jobs, ranging from au pair to scientist to student to physician. In most cases, the participant is expected to return to his or her home country for at least two years after completion of the program.

H-1B Visas: A temporary visa, awarded via lottery, for high-skilled workers in specialty occupations. H-1B holders may work only for their sponsoring employer. Requirements include a minimum of a four-year university degree or equivalent and pay at the "prevailing wage."

EB-2 Visa: A permanent visa for a foreign national with an "exceptional ability" to offer the US labor force. Applicants will typically hold an advanced degree or its equivalent.

system also remark on the irony that the Springfield metro area is among the least diverse in the nation yet it has a strong immigrant workforce in healthcare. However, this foreign-born population is still not enough to fill the community's health-related needs.

As with higher-skilled positions, certification for these lower-skilled healthcare services is handled by each state, often creating confusing barriers to entry.⁵⁴ However, across all states, becoming a certified nursing assistant or home healthcare aide requires less than two weeks training and is not subject to federal regulations.⁵⁵ Because this training is so cost effective in plugging labor gaps, some large corporations are being accused of trying to abuse systems—like the H-1B business visa lottery (see box 5)—so they can hire more immigrant workers at lower cost.⁵⁶ If this trend continues, the federal government will need to change immigration laws and businesses practices.

Baby boomers change demand

Given the aging population of baby boomers in the United States, one healthcare field that has seen a substantial—and necessary—influx of low-skilled and entry-level workers is long-term care. With at least one-fifth of Americans projected to be 65 or older by 2030, Medicare will face mounting costs for individuals who live longer, use more care, and have multiple health concerns. In fact, an estimated 75 percent of the

45 million Americans 65 or older already have two or more chronic conditions that require ongoing medical attention or limit activities of daily living and require medical assistance.⁵⁷

In 2012, about 58,500 long-term-care service providers—including adult day service centers, home healthcare agencies, hospices, nursing homes, and assisted living facilities—served approximately 8 million people in the United States.⁵⁸ The number of people receiving care is expected to grow more than 230 percent—to 27 million—by 2050.⁵⁹ These trends not only mean there will be more job openings in the long-term care industry but also a need for workers with the skills to address the increasingly complicated health demands of the elderly as they age.⁶⁰

In fact, day-to-day care for this population has already begun to create financial and human-resource challenges for the country (care averages \$10,082 a year for each person older than 65, compared to \$3,931 for those younger than 65) and intensify costly workforce gaps.⁶¹ Nevertheless, even though there are not enough US-born workers to meet current demand, the country has yet to update its immigration system in a way that maximizes the contributions of immigrant workers in this sector, especially as they pertain to low-skilled caregivers.

Immigrants' access to care

In addition to growing workforce gaps across the healthcare sector, the outdated US immigration system presents other hurdles to clinics, hospitals, and healthcare-service providers across the country.

Perhaps most urgent is the issue of immigrants' unequal—or often nonexistent—access to healthcare services and insurance benefits, despite recent improvements in overall rates of insurance coverage resulting from the ACA. With few options to access care outside of emergency room treatment, uninsured immigrants—both undocumented and authorized populations—often forgo necessary preventive screenings, resulting in delayed disease detection and worsening of chronic conditions. Insurance payment gaps also leave hospitals struggling to finance expensive emergency room care and to meet the level of demand, especially from immigrants.

Providing access to adequate healthcare services for uninsured immigrants adds a layer of complexity to existing challenges in caring for increasingly

diverse populations. In particular, cultural differences and access disparities mean that foreign-born and native-born populations often interact with their local healthcare systems very differently, leaving already short-staffed hospitals struggling to provide appropriate linguistic and culturally competent care for communities with a greater number of immigrants.

The challenges of Medicaid and charity care

Immigration policy intersects with healthcare policy in the long-debated issue of providing care to uninsured immigrants. In 2014, noncitizens were more than three times as likely as their native-born counterparts to be uninsured (31 percent and 9 percent, respectively), although they represented only 20 percent of the total US uninsured population.⁶² A 2014 Kaiser Family Foundation survey of low-income Americans revealed that seven percent of respondents were uninsured because of their immigration status (see figure 5).

From 2013 to 2014, health insurance coverage rates increased for all groups because of mandates and opportunities of the ACA. In fact, the foreign-born population, including both naturalized citizens and noncitizens, experienced a larger increase in health insurance coverage rates than did the native-born population (6.4 percentage points for the foreign born and 2.4 percentage points for the native born).⁶³ Illinois, Iowa, and Nebraska felt the impact of those insurance increases most dramatically among the 12 Midwest states, as their immigrant populations increased the most over the last two decades.⁶⁴

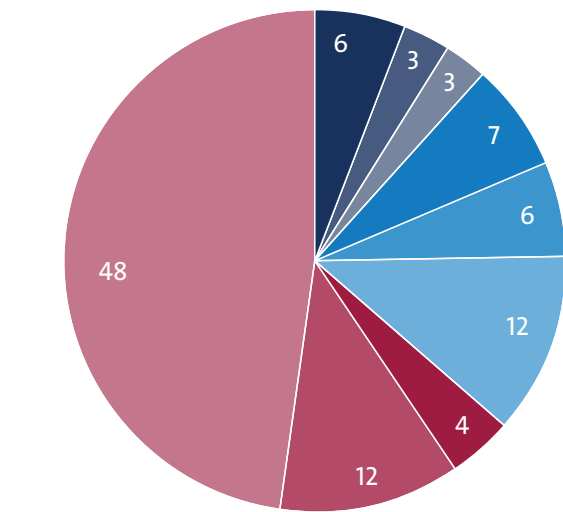
Further, undocumented immigrants are blocked from purchasing benefits on public exchanges in the Midwest despite overall improvements in insurance rates for the previously uninsured. Given the informal nature of many jobs held by unauthorized workers—one-half of low-income noncitizens are employed in agriculture, construction, or service industries—they are not able to purchase insurance through employers, as these three industries are historically the least likely in the United States to offer employer-sponsored insurance.⁶⁵ Additionally, even those who are newly insured often do not get the same quality of care as those who have had long-term access, mostly because of their location, historic and continued lack of resources, and limited knowledge about where to receive the best care.⁶⁶

Authorized immigrants face many of the same challenges as the undocumented when accessing

FIGURE 5

Reasons for Being Uninsured among Uninsured Adults, Fall 2014

When asked, the remaining uninsured said that the main reason they were without insurance was... (%)



- Don't need it
- Opposed to the ACA/prefer to pay penalty
- Don't know how to get it
- Immigration status
- Told they were ineligible
- Unemployed/work doesn't offer/not eligible at work
- Don't know/refused
- Other reason
- Too expensive

Source: Kaiser Family Foundation, "Key Facts about the Uninsured Population," October 2015, <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

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healthcare. Per the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, immigrants face a five-year ban on Medicaid participation even after naturalization.⁶⁷ This means that no matter their legal status, many immigrants do not have access to the same quality of care as their native counterparts.

Box 6

Hispanic Health Paradoxes

"Immigrants come to this country with health advantages," said Fernando DeMaio, an associate professor of sociology and co-director of the Center for Community Health Equity at DePaul University in Chicago. "The challenge is that this advantage, on average, is lost over time," leading to an irony known as the Hispanic Health Paradox.⁶⁸

Hispanic immigrants in the United States have better health and live longer than their non-Hispanic white counterparts despite being poorer and having harsher, more dangerous jobs and less access to healthcare and education.⁶⁹ According to the Population Reference Bureau, "fatal chronic diseases—heart disease, cancer, chronic lung disease, and stroke—are much less prevalent among older Hispanics than among other racial and ethnic groups."

Experts agree that Hispanics' relative youth, along with lower rates of smoking and higher rates of community involvement, contribute to better mental and overall health outcomes than for other groups.⁷⁰ The challenge comes in extending positive health outcomes to second or third generations, as Hispanics face higher risks of cardiovascular disease than Americans overall, which is linked to high rates of obesity, diabetes, and high blood pressure.⁷¹

The uninsured are most often left with the emergency room as one of their only options when they require care. The Emergency Medical Treatment and Labor Act, passed in 1986, stipulated that no one can be turned away from an emergency department (ED) regardless of immigration status. Thus, the emergency room has become the most utilized source of care for this population, even though ED care is the most costly.⁷² What's more, emergency care is far less effective than regular preventative care in the long run, further driving up costs for follow-up treatment. The expenditures for this type of care for the uninsured—called charity care—dramatically affect the bottom line of hospitals and clinics across the Midwest.

Challenges in providing charity care play out differently for urban and rural healthcare systems. For example, Chicago-based Presence Health estimates it sees 5 to 10 undocumented immigrants daily in each of its urban hospitals, although the number could be higher owing to challenges in identifying legal status. Estimating an average of eight cases of uninsured patients per day, these undocumented immigrants account for a large share of the \$65 million in

financial assistance costs to the Presence Health system in 2014.⁷³

Healthcare systems in smaller cities, like Des Moines, are also challenged by costs related to the uninsured. At Mercy Medical Center, charity care costs the system an estimated \$10 million per year. To a smaller system, this can be just as debilitating to the bottom line as \$65 million can be to a larger system.⁷⁴

Further, reliance on emergency departments complicates health outcomes in rural hospitals, which see many of the Midwest's 57,000 migrant agriculture workers present in hospital EDs with injuries caused by farming equipment.⁷⁵ In these situations, accessing emergency care often requires traveling long distances, which worsens the acute nature of these traumas.

For hospitals that serve uninsured patients, known as safety-net hospitals, charity care costs will continue to grow as congressional budget cuts mount in the coming years. Between growing Medicare and Medicaid rosters, federal budget cuts, and increasing healthcare costs, the financial burden may prove to be prohibitive for some healthcare providers.⁷⁶

Cultural understanding and competency in high demand

Providing linguistically and culturally competent care for an increasingly diverse immigrant population is a

Box 7

Expanding Health Insurance Access in Illinois

Presence Health and other Illinois-based healthcare providers, along with nonprofit organizations, civic leaders, and law-enforcement officials, are part of the steering committee of Healthy Illinois, a campaign committed to expanding health insurance options, including those for undocumented immigrants.⁷⁷ "This country can't afford not to have universal access to healthcare. It will cost us more in the long run," said Carmen Velasquez, founder of Alivio Medical Center in Chicago and a member of the steering committee.⁷⁸

Illinois' undocumented immigrants pay more than \$560 million in state and local taxes annually but are typically excluded from access to affordable, comprehensive health insurance.⁷⁹ Citing healthcare benefits to patients and fiscal benefits to Illinois taxpayers, the campaign aims to expand coverage options and promote better policy making in the future.⁸⁰

multifaceted challenge that policy alone cannot solve. Those born outside the United States do not utilize healthcare systems the same way as their native-born peers do, suggesting that cross-cultural competency is an increasingly core part of providing effective, quality care.

It is good business practice for any healthcare provider to foster access to competent, quality care, reducing the frequency and severity of healthcare visits. Healthcare systems that know how to provide superior care to diverse patients—often those that prioritize the hiring of foreign-born healthcare professionals and individuals who speak multiple languages—will have a competitive advantage in today’s global economy.

Nearly 40 million people in the United States spoke Spanish in 2011, making it the second-most-common language in the country after English.⁸¹ Yet fewer than 4 percent of healthcare providers are proficient in Spanish, let alone other less-common languages.⁸² These linguistic barriers limit trust and engagement with healthcare systems, forcing immigrants to look beyond healthcare providers—often to in-language television and radio—for health and wellness information.⁸³

Foreign-born healthcare professionals, whether trained in the United States or abroad, can consequently be the bridge for language and trust gaps within the system. Like Upwardly Global, the Welcome Back Initiative, and the Women’s Initiative for Self-Empowerment, Chicago’s Bilingual Nurse Consortium is an example of a growing group of programs in the region that assists underemployed immigrants, many of whom were healthcare professionals in their home countries, in re-credentialing in the United States and finding sustainable employment. The program not only fills gaps in the Midwest labor sector but also builds a linguistically and culturally skilled workforce.⁸⁴

Trust is another key factor in providing effective healthcare. Through its community partners, Presence Health has heard of undocumented immigrants being afraid to engage with the healthcare system for fear that hospital records could be shared with immigration authorities.⁸⁵ Administrators have made efforts to educate the community that hospitals are safe havens for all, regardless of immigration status, but history and lack of resources in the broader community have made this messaging difficult for many hospitals.

Chicago’s St. Anthony Hospital has built trust within its community by prioritizing the hiring of diverse staff and making them visible in the neighborhood. Community health promoters conduct workshops and clinics at churches and other community organizations, which in turn provide referrals to the hospital. The hospital has also expanded the ways it works with the uninsured to pay for services, offering cash, credit, and sliding scale payment options. The fiscal value of this trust is not lost on hospital leaders, who are proud to be able to operate in the black while never turning anyone away. But administrators recognize the limitations of expanding community programs under the current immigration system. According to a staff member, “without comprehensive immigration reform, we can’t do this long term.”⁸⁶

No solutions in sight

Current federal immigration policy hinders the economic development and stability of the Midwest’s healthcare sector and also compromises the health and well-being of immigrant communities.

Historically, the system did not interfere with medical practices of foreign-born healthcare professionals. Before 1977, US immigration policies allowed the entry and permanent residence of foreign-born, internationally trained doctors. However, in 1976, the Health Professions Educational Assistance Act began to subject international medical graduates to new criteria and standards—credentialing requirements and temporary visas like the Conrad 30 program—that still limit their entry and citizenship some 40 years later.⁸⁷

The Resident Physician Shortage Reduction Act of 2015, introduced by US Representatives Joseph Crowley, D-NY, and Charles Boustan Jr., R-LA, who is a medical doctor, aims to address some of the shortages created by the 1976 law.⁸⁸ The bill (H.R. 2124) proposes the addition of 15,000 residency slots nationwide by 2019. However, the likelihood of this legislation passing in time to meet demand is slim given the current political stalemate in Washington, and even if it passes, it does not address wider immigration policy challenges such as permanent residency and the future pipeline of providers.

Another approach on Capitol Hill has been to revisit H-1B visas, which allow employers to sponsor temporary visas for healthcare professionals but are subject to competitive caps and a lottery (see box 5). While

nonprofit, research, and teaching hospitals are exempt from caps, for-profit providers must compete with other industries to secure limited numbers of visas, which are dominated by global outsourcing companies.⁸⁹ While the bipartisan Immigration Innovation (I-Squared) Act (S. 153), introduced in the Senate in January 2015, would essentially double the number of H-1B visas extended to those working in science, technology, engineering, and math, the legislation does not change the competitive lottery system.⁹⁰ The bill has not moved past its submission to the Committee on the Judiciary last January.

Even with expansion, the caps on H-1B visas—in 2015, a record high number of 233,000 workers applied for just 65,000 visa slots—severely limit the foreign-born professionals allowed to be trained and practice healthcare services in the Midwest.⁹¹

Unlike the I-Squared Act, the Conrad State 30 and Physician Access Act (introduced in 2013 as S. 616 and reintroduced in 2015 as S. 1189) proposes an update to the limited Conrad 30 program but does not include provisions to expand the number of available slots. Instead, the legislation would provide an EB-2 visa (see Box 5) to a provider who agrees to serve in a medically underserved area or Veteran Affairs facility for five years, three of which can be under the Conrad 30 program.⁹² Legislation would also make participating physicians exempt from worldwide caps, which cause long wait times for applicants from countries with high volumes of petitions, such as India and China. The bill is under consideration in the Senate but has not been deliberated on by a committee since May 2015 and is not yet slated for 2016.

Introduced in June 2015, the Professional’s Access to Health Workforce Integration Act (H.R. 2709) would support internationally trained healthcare professionals in “entering into and advancing in” the American healthcare workforce. The bill directs the Department of Health and Human Services, through the National Institute on Minority Health and Health Disparities, to award grants to organizations that assist immigrants with legal work authorization and international healthcare credentials by providing evaluation of foreign credentials and access to English as a Second Language courses.⁹³ Since June 2015, the proposal has sat in the Subcommittee on Health of the House Energy and Commerce Committee.⁹⁴

These legislative proposals do not address immigrants’ limited access to health insurance and

Medicaid. But the Healthy America Act of 2015, proposed by US Representative Luis Gutierrez (D-IL) in September 2015, takes a small step in expanding insurance access for individuals. The bill proposes that legal status not be considered in allowing access to the healthcare exchange and that all state residents should be insured under the ACA.⁹⁵ The bill has not moved past the introductory phase of the legislative process because of proposed alterations to the IRS code and strong political opposition to expanded insurance coverage.⁹⁶

Passing these various proposals would represent a step forward in updating the federal immigration system, bringing it into sync with the current demands on the Midwest healthcare sector. However, many of these stand-alone bills are currently stuck in Congress, victims of a longtime political stalemate on immigration that is not likely to be resolved until after the 2016 election.⁹⁷ Indeed, a legislative tracking website predicts that the I-Squared Act and Conrad 30 legislation have a 1 percent and 0 percent chance, respectively, of being enacted.⁹⁸

Yet even if piecemeal legislation were passed, larger-scale, more-comprehensive reforms are still needed to address the overall shortcomings of current immigration policy for the Midwest and the entire country. Even as current elected officials and presidential candidates have called for reform, US Speaker of the House Paul Ryan has maintained that his chamber will not take up the broader issue of immigration reform until at least 2017.⁹⁹

Meeting healthcare labor needs in the twenty-first century

Immigration reform is urgently needed for a robust healthcare sector across the country and especially in the Midwest. The following policy recommendations, developed with feedback from regional hospital administrators, physicians, healthcare professionals, and community leaders, should help shape those reforms. While some of the Midwest healthcare sector’s stake in the current immigration debate is unique, the recommendations outlined below would not only meet the needs of the regional sector but also address labor shortages, visa issues, and other immigration-related challenges to the healthcare systems across the country, helping keep the region and the nation more globally competitive.

Issue J-1 visas according to labor force demands

By reallocating Conrad 30 slots to reflect demand—versus simply assigning a standard 30 slots to each state—local healthcare systems can make hires based on actual need. While some states need to increase the number of slots, others may opt to reduce their allocated number of waivers. Randy Munson of the Wisconsin Office of Rural Health said “several Midwestern states traditionally use their entire allocation of waivers every year, whereas Wisconsin in recent years has not.”¹⁰⁰ Given these disparities in demand, the program should be updated to include an expansion and flexibility in the number of available positions based on state need. The application process should also be streamlined, with prioritization of federal medical centers over local hospital systems. Such updates would allow states to follow more-flexible models like those employed by Wisconsin, which has adapted the Conrad 30 to allow slotting for nonshortage areas and certain specialties.

Remove quotas and caps on doctors and surgeons

Doctors and surgeons are essential, not just to the healthcare sector but also to the health—physical and economic—of the Midwest. With current limitations removed from hospitals and healthcare systems hiring of foreign-born physicians, the entire healthcare system would see more provider options and increases in primary care and general practitioner availability, and be better positioned to meet growing demand. A general expansion of the number of available H-1B visas, or, alternatively, the creation of a specific allocation of H-1B visas for healthcare professionals, would help for-profit hospitals fill critical workforce gaps. The hiring of vital healthcare professionals should not be constrained by the same limited criteria and quotas as, for example, accountants and data analysts.

Address credentialing for foreign-born professionals

Current credentialing and licensing policies, along with intense competition for US residency slots, limit opportunity for many IMGs who wish to practice in the United States. Credentialing and licensing are mostly decentralized in the United States: federal, state, and local regulations overlap and are sometimes contradictory, and at present, no single system

governs certification or qualifications. In some instances, a professional governing body determines credentials, while other public and private agencies provide benchmark evaluations and tests. IMGs able to navigate these complicated systems find that they need to repeat the schooling and exams they completed in their home countries and face intense competition and significant personal expense in doing so. While credentialing is not a function of immigration policy, it affects foreign-born healthcare professionals significantly. It is imperative that highly qualified IMGs be integrated into the US system with a more seamless certification road map that recognizes their prior professional experience while maintaining the United States’ strong professional standards.

Allow undocumented individuals to access insurance

Although there has been significant pushback to providing insurance to undocumented individuals by expanding the ACA, that community’s inability to purchase insurance affects everyone. Undocumented immigrants often end up in the emergency room to treat common ailments—including those that could have been addressed or eliminated with more cost-effective, proactive, preventive options—because of limited entry points for them into the healthcare system. Providing individuals access to insurance exchanges,

or alternative employer options to provide basic insurance for employees, could reap better health outcomes for undocumented individuals and save taxpayers in the long run. While such reallocation will not eliminate use of emergency departments, it could drastically reduce the frequency of that use, resulting in significant cost savings for safety net hospitals.

Conclusion

The healthcare sector is an important part of the Midwest economy and the quality of life of its communities, and it relies significantly on a functional immigration system. For the past decade, as the federal government has grappled with immigration reform, the Midwest has faced significant challenges in filling gaps in its healthcare labor force; meeting the healthcare needs of its aging baby boomers; connecting undocumented populations with preventive, cost-effective medical options; and providing linguistically and culturally competent care for increasingly diverse demographics. In order for this sector to truly thrive and remain globally competitive, it needs updated immigration laws that reflect today’s realities and the region’s unique challenges.

To meet the looming labor gaps in the healthcare system head-on, it is important that the immigration

system be responsive to the system’s needs. Current legislation falls far short of incentivizing cost-effective care and long-term job retention. The nation must assess labor-sector needs, societal and economic changes, and healthcare demands of those in the country today and approach reforms accordingly.

While legislative proposals and short-term fixes are in place, it falls to Congress, working with the next administration, to create flexible immigration policies that support foreign-born physicians seeking work visas and permanent residence in the United States, along with mechanisms that expand access to health insurance and embrace immigrants’ much-needed linguistic and cultural skills in serving increasingly diverse patients. With sensible reforms, the federal government can create a more cost-effective healthcare sector that both employs and cares for the growing immigrant population in the Midwest.

Without immediate and sustainable reforms of US immigration policy, the healthcare sector—and the overall economy of the Midwest—will suffer significantly, and lives will be at stake. It is vitally important that the region properly plan for the employment, economic, and healthcare needs of all residents, regardless of country of origin.

Box 8

Training for Culturally Competent Care

Community education and cultural competency programs should be more readily available for healthcare professionals. A healthcare workforce that understands cultural differences of diverse communities—and is able to serve them in-language—improves health outcomes in patients and promotes cost savings for the facilities that serve them. Residency programs should include training in recognizing and responding to ethnic differences, disparities, and rural variances. Building competency in these areas begins with changes to residency requirements by the Accreditation Council on Graduate Medical Education and the Residency Review Committee. Additionally, more hospitals and healthcare systems need to institute trainings, within their communities and their walls, which build trust and partnerships with local residents.

About the author

Nicole Fisher is the founder and CEO of HHR Strategies, a healthcare- and human-rights-focused advising firm started in the Midwest. She is also a senior policy advisor on Capitol Hill and expert on health economics, technology, and reform, specifically as they impact vulnerable populations. Fisher runs a Health Innovation and Policy page at Forbes, highlighting ideas and advising companies and people that are changing the health landscape, and she curates a monthly international dinner series, “A Seat at the Table,” bringing together thought leaders for an off-the-record discussion of moving health policy and planning forward. She also runs the nonprofit Global Brain Health Coalition and is pursuing a doctoral degree in health policy at the University of North Carolina. Her writing has appeared in numerous journals and publications, and her talks can be found on the United Nations website and various news outlets. Before pursuing her PhD, Fisher earned her master’s degree in public policy from the University of Chicago and her undergraduate degree from the University of Missouri. Her healthcare and policy work at those institutions emphasized underserved populations, women’s and children’s issues, and brain health. She serves on several boards for domestic and international health organizations and frequently speaks on health reform, innovation, human rights, and the context surrounding health.

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