Immigration Policy as a Matter of Public Health: Reducing Barriers for International Medical Graduates in Ohio

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Executive Summary

Ohio faces an acute, pressing problem: a need for more healthcare professionals in the workforce. Current statistics report that by 2025, Ohio will be short of 1,200 primary care physicians, nearly 70% of nurses are seriously considering leaving the profession, and the United States is expected to have a deficit of 139,000 physicians by 2023 ("Physician Shortage in Ohio, U.S. Expected to Worsen," 2019)("Nursing Shortage Fact Sheet," 2024)(Boyle, 2020). With approximately 102 million people living in a primary care health provider shortage area (HPSA), 167 million people living in a mental health HPSA, and 77 million people living in a dental health HPSA, this local problem is reflected by ongoing workforce shortages across the nation, spelling bad news across the state if a solution is not found quickly. ("State of the U.S. Health Care Workforce, 2023," 2024). Counties across Ohio are impacted, with a lack of workers increasing consumer health costs, decreasing the quantity of care, and making care less accessible. During the pandemic, when the healthcare workforce shortage became especially apparent, hospitals and clinics resorted to calling physicians out of retirement, waiving out-of-state practice requirements, and expanding the capabilities of many practices. These solutions are simply unsustainable for the long term (Robeznieks, 2022).

International medical graduates, or IMGs, as well as international newcomers, are the key to fixing a system that has a severe lack of physicians, nurses, nurse practitioners, EMTs, phlebotomists, pharmacists, dentists, nursing home staff, home care workers, dental hygienists, technicians, and mental health providers. IMGs can hit the ground running, considering their previous training, rather than force local governments to allocate additional time and resources searching for new talent. International newcomers, lacking extensive career training and professional experience in the United States should be encouraged to pursue healthcare

professions, careers with high demand and strong benefits, and barriers should be reduced for these individuals seeking training opportunities.

IMGs are already being utilized to fill gaps in the healthcare workforce, proving their clear competency in assuming these positions. The National Institute of Health found that IMGs constitute 25% of the current healthcare workforce in the United States. Between 2010 and 2021 the number of IMGs increased by 18%, while the number of U.S. medical graduates only increased by 15%. According to the Annals of Internal Medicine, 18% of academic physicians are IMGs ("Cleveland's Healthcare Shortage - Here's Our Solution," 2024). Despite their undeniable impact on the field, IMGs are unfortunately severely underutilized in the United States with current estimates stating that "brain waste" is impacting over 250,000 individuals, meaning refugees and immigrants are working jobs far below their skill level. It is further estimated that 225,000 doctors, nurses, and home health aides lack lawful immigration status and 190,000 individuals working in custodial and administrative healthcare roles lack lawful immigration status, meaning thousands of individuals within the field are at risk of deportation (Kandel, Wilson, & Heisler, 2023). Policies reducing barriers to entry for these individuals are a necessity, to ensure workers providing necessary services to their local communities have proper paths to citizenship and long-term residency, and international medical graduates can work jobs indicative of their training and professional success. A recent summary published by the Economic Innovation Group shares that 75% of American voters support increasing immigration levels for the benefit of highly-skilled innovation. With 71% of Trump voters and 86% of Biden voters in support, this issue is inarguably bipartisan (Lettieri & O'Brien, 2024).

Further, reducing the barriers to education for short-term training positions within the health workforce (phlebotomy, emergency health services, technician work, home care aids,

custodial work, etc.) will allow international newcomers to attain much-needed jobs with strong benefits, opportunities for career growth, and the ability to support their families. The United States, particularly Ohio, must pull from a large employee market to fill these positions, and with fewer and fewer natural-born citizens choosing this line of work, international individuals must be considered in the healthcare professional applicant pool. International newcomers want the ability to work and study within the United States and are both capable and willing to fill these positions when given the chance. Funding education programs at local community colleges that push these certifications, offering services to help international newcomers navigate the bureaucracy of applying for these positions, and educating healthcare providers on the importance of hiring international talent is imperative.

If this concern remains unaddressed now, disastrous effects will ripple across Northeast Ohio and the greater Cleveland area in the future. Thousands of Ohioans are already suffering. Medical professionals across Northeast Ohio continue to provide quality care, but growing gaps in the workforce impact their ability to perform their jobs to the highest extent, due to an overburdened system that needs more labor. The solution is here: public health workforce policy that provides provisional licensure to international medical graduates and increased opportunities for training within the job market.

Scope of the Problem

Health provider shortage areas (HPSAs), are a growing problem across the United States. The Health Resources and Services Administration (HRSA) works closely with state governments to evaluate and assign HPSA designations based on scorings in the following four areas: population-to-provider ratio, percent of population below 100% of the Federal Poverty Level, Infant Health Index, and the travel time needed to reach the nearest care facility (Streeter et al., 2020). Based on current data, at the end of 2023, approximately 167 million people lived in a mental health HPSA, 77 million lived in a dental health HPSA, and 102 million lived in a primary care HPSA ("State of the U.S. Health Care Workforce, 2023," 2024). The Migration Policy Institute estimates that 18% of surgeons, doctors, and nurses are within ten years of projected retirement, making the provider shortage increasingly dire and increasing the risk of unavailable healthcare. Considering the Centers for Disease Control and Prevention reports that the U.S. birth rate continues to decrease every year, there will be nowhere near enough U.S.-born citizens available to close the gap in the job market ("Cleveland's Healthcare Shortage - Here's Our Solution," 2024). With HPSAs growing in number, the current demographics of medical professionals indicating a large percentage near retirement age, and a generation too small to take on the available jobs needed for economic growth, the current system is unsustainable.

Medical professionals with the capability of remaining in their careers long-term are quitting their jobs at higher rates. Safety concerns, increased working hours, and poorer working conditions throughout the COVID-19 pandemic and beyond have caused many healthcare professionals to leave the profession due to a lack of appreciation and general burnout. Between May and October 2020, a survey of over 20,000 U.S. healthcare workers illustrated that 49% reported burnout, and 43% reported being overworked ("State of the U.S. Health Care

Workforce, 2023," 2024). Mental health concerns resulting from an overburdened system are only increasing, with a Mayo Clinic Survey reporting that 23% of physicians reported feelings of depression in recent years, compared to 15% in 2018 ("State of the U.S. Health Care Workforce, 2023," 2024). Shekela McCarty, a nurse at a hospital in Columbus, Ohio, stated that the politicization of healthcare during the pandemic has significantly impacted her and her colleagues' mental health and desire to continue in the profession. "It started where we got all the support of the community. And then it turned into a kind of distrust between the healthcare community and then our community. It became where we felt more threatened as healthcare workers. And I was tired of feeling like that. We've seen a lot of death, a lot of very sick individuals. We've had to have some very difficult heart-to-hurt conversations with family. And it takes a toll on you mentally after a while," said McCarty in an interview with the Statehouse News Bureau. McCarty has since quit to work for an insurance agency (Ingles, 2021). A 2023 study published by the Ohio Nurses Association discovered that in a pool of 11,000 Ohio nurses just like McCarty, 70% were considering leaving their positions due to caseload, and 58% of nurses who recently left their roles did so because of their hefty caseloads (Siddiqi, 2024).

Further, many healthcare workers have become disenfranchised due to a poor work-life balance. According to a Mayo Clinic survey, in 2021 only 57.1% of physicians said they would opt to become a physician again if they were to go back in time and change their career path ("State of the U.S. Health Care Workforce, 2023," 2024). In addition to disenfranchised physicians, 28.7% of general healthcare workers and 41% of nurses stated they planned to leave their careers within two years ("State of the U.S. Health Care Workforce, 2023," 2024). Joe Fiorita, a recently retired recovery room nurse living in Dayton, Ohio, stated the burnout he faced pre-pandemic only became worse when his career turned on its head during the height of

COVID-19. Faced with constant emergency surgeries that interrupted his regular work schedule, he became exhausted and frustrated with the system. Despite previously wanting to continue in his field for years to come, he decided to retire in 2021 (Wildow, 2023).

In addition to providers leaving the field, an increasingly aging population has resulted in more individuals requiring care, and fewer individuals in the workforce able to provide. In 2021, 47% of all physicians were aged 55+, and the average age of registered nurses was approximately 44 years old, leaving almost half of the physician population expected to retire within the decade ("State of the U.S. Health Care Workforce, 2023," 2024). In 2017, even before the pandemic, more than half of U.S. nurses were over the age of 50, with 30% reportedly 60+ (Wildow, 2023). The Population Reference Bureau estimates that between 2022 and 2050, the number of Americans 65+ will increase by 47%, making the population of the United States older than it has ever been ("Cleveland's Healthcare Shortage - Here's Our Solution," 2024). This makes it unlikely that a substantial young workforce will be available to take on growing job openings and that a growing elderly population will cause an exponential demand for careers in the health sector.

Specifically, the state of Ohio has been left reeling from a talent shortage that has only been fueled by the COVID-19 pandemic. By 2025, Ohio is expected to be short of 1,200 primary care physicians ("Cleveland's Healthcare Shortage - Here's Our Solution," 2024). The U.S. Department of Health and Human Services has identified 133 "healthcare shortage areas" across the state, areas with residents equaling 1.2 million people. These areas have one doctor for every 3,500 people and limited access to emergency medical services (Lampman, 2015). Current solutions implemented in Ohio are expensive, difficult to administer, and focus on retaining current employees rather than recruiting much-needed new talent. Retention policies like

providing child care, providing mental health care, and allowing employees to have greater independence with their scheduling are certainly good measures, but they do nothing to address the gap between the employees currently in the workforce and the individuals needed to sustain growth in the medical field. Hospitals are using temporary work agencies to fill positions during the short term, increasing the costs in both onboarding constantly circulatory staff members and middleman agencies. In fact, between 2019 and 2022, contracted labor as a proportion of total labor expenses rose 178.6%. In an attempt to fuel profits, contracted labor agencies have only increased costs with the rise in demand, leaving hospitals scrambling to cover costs while several staffing firms tripled their revenues compared to 2021, and reaped $1.1 billion in the fourth quarter of 2021 alone (Wildow, 2023). Ohio’s current plan is a house of cards, and when the system eventually collapses due to a lack of resources, ordinary citizens will be most impacted; thousands will go without care, impacting the length and quality of lives.

Social Determinants

Ethnic background and country of origin are significant social determinants when considering the possibility of entry into the United States. Considering qualified doctors can originate from anywhere, current immigration laws that pose barriers for talented IMGs from many developing nations harm our healthcare system. Per-country immigration limits are blatantly discriminatory and disproportionately harm immigrants from large countries. Laws restricting prospective immigrants from different nations to only 7% of green cards available yearly disproportionately impact individuals from India, China, Mexico, and the Philippines, all non-European countries with large populations and great interest in American immigration (Bier, 2015). The treatment of immigrants as representatives from countries rather than individuals with differing goals and needs restricts not only the future of these people but also the American economy, as potential healthcare professionals from larger countries are likely to experience an expected 7 to 21-year waiting period for Visas (Bier, 2015). Further, undocumented immigrants experience varying degrees of treatment depending on their country of origin. Before the 1940s, lacking immigration enforcement policies and legal protections allowed European immigrants to enter the United States illegally, still receive public benefits, and begin their lives in a new country with few limitations. As immigration demographics transitioned from white European to primarily Latino, Asian, and African, immigration laws transitioned as well, tightening bureaucracy and making it much more difficult for illegal immigrants to find legal paths to citizenship (Kamasaki, 2021). In the present day, immigrants of color who enter the United States unlawfully are more likely to be apprehended compared to their white counterparts, and face much harsher consequences, impacting the ability of these individuals (in all sectors but notably health) to achieve citizenship and approval to work.

Moreover, gender and sexuality are determinants that can impact the ability of potential immigrants to receive work approval status. Gender bias is a social factor that impacts immigration as more women seek immigration status compared to men, making it difficult for women to receive green cards and ability to attain legal employment in the United States. Considering most immigrant families require dual incomes for survival, women are disproportionately forced into the underground economy, placing them at risk for exploitation, prostitution, and sexual assault ("Gender Bias and Immigration Policy," n.d.). Immigrant women also have greater difficulty attaining jobs in the United States relevant to prior work experience. According to Drexel University, immigrant women are 28% more likely to be underemployed given their educational background compared to immigrant men (Health Equity and Accountability Act, 2018). With members of the queer community often fleeing discrimination, physical harm, and unjust laws, there is a much greater need for these individuals to receive immediate aid and entry into the United States. Unfortunately, the difficulty in proving sexuality and the need for refugee status has impacted the ability of these individuals to receive green cards and right-to-work Visa status. (Usta & Ozbilgin, 2023). Gender and sexuality identities are a necessary part of any discussion surrounding immigration because one-size-fits-all policy typically appeals to non-marginalized demographics. Individuals from diverse or marginalized backgrounds hoping to immigrate face a wider array of challenges when entering the workforce, making this an important area of interest when developing public health legislation.

Perception of IMGs Nationwide

International medical professionals are impacted by the politicization of their identities in a variety of ways, particularly due to the intersection of being both healthcare workers and international individuals. At the beginning of the COVID-19 pandemic, there was a seemingly overpowering expression of support and approval for healthcare workers, "everyday heroes" who were risking their lives to help control an unprecedented virus. As misinformation surrounding the origins of the pandemic, and distrust for vaccinations, standard medical care, and proper health practices grew, healthcare providers were at risk for misplaced aggression and violence. According to the Cleveland Clinic, after April 2020 complaints of violent behavior against staff members jumped from 1.19 to 2.63 out of 1,000 patients, placing healthcare providers in dangerous situations during an average work day (Porath & Boissy, 2021). Further, a rise in extremist political rhetoric and draconian anti-immigration laws has resulted in growing anti-immigration sentiment. 52% of Americans now believe that the United States is witnessing an "invasion" at their southern border, and 49% of Americans believe that an influx of migrants is directly causing increased drug overdose deaths (Long Garcia, 2022). Once linked to fringe white supremacist groups, "invasion" ideology has become more commonplace. In 2018, 75% of Americans believed that immigration was an important aspect of national identity, and now only 56% of Americans echo this sentiment (Long Garcia, 2022). International medical graduates as practicing members of the health workforce and immigrants face a myriad of challenges at the crux of these identities and are likely to be faced with violence and discriminatory behavior at the hands of the patients they are tasked to treat.

The current state of the United States residency selection process is discriminatory against international medical graduates. Not only are natural-born physicians 80% more likely to

be selected by psychiatry and family practice programs compared to their foreign-born counterparts, but 70% of surgical program directors perceive discrimination between the two groups within their programs (Desbiens & Vidaillet Jr, 2010). Discrimination throughout the residency process occurs threefold: through refusal to admit international medical graduates into specific programs, quota systems (only allowing a percentage of IMGs into specific programs), and two-rank systems (ranking U.S.-born medical graduates against one another and separately ranking IMGs against one another). Limited residency spots pit U.S. medical students against international medical graduates, preventing the training of more doctors in the U.S. medical system, and limiting IMGs from practicing in fields they are already qualified in. Through the U.S. residency matching process, IMGs are perceived as less capable than their U.S.-educated peers, making success in the healthcare field for international newcomers multitudes more difficult when stacked against their U.S.-born counterparts.

Although external factors that have fueled anti-immigrant sentiment and distrust toward healthcare providers cause setbacks for IMGs, international healthcare workers can provide unique forms of care and develop a level of deeper understanding with their international patients. Foreign-born healthcare providers are in an important position when it comes to the provision of culturally competent care. When information comes from politicians, governments that are perceived as a threat to those waiting on green cards, and unrelatable medical professionals, at-risk communities are less likely to listen. However, when medical information, diagnosis, and treatment plans are delivered by someone who looks like their patient, in a language that makes sense to them, that can make all the difference when it comes to accepting life-saving medical treatment (Conger, 2021).

Fields Impacted by the Healthcare Worker Shortage

It is imperative that future legislation does not just provide international medical graduates with proper avenues to practice in underserved areas, but that barriers to entry for healthcare professions are reduced for prospective international talent keen to enter the workforce. Careers frequently ignored in the healthcare workforce, including phlebotomists, EMTs, home healthcare workers, and nursing home workers, are in high demand and require much less training than traditional physician and nursing careers. Encouraging both IMGs and immigrants interested in the professional medical landscape to train for these occupations is necessary to fill the current job market gap.

Workforce challenges are facing blood centers, most notably severe labor shortages, with many centers reporting a staff turnover rate of over 20% ("AABB News: Workforce Issues Compound Blood Collectors' Challenges," 2022). Staffing shortages have forced many centers to require that employees work seven days a week and take little paid time off, forcing overburdened staff out of the industry. Consistent clogging of the system has resulted in dangerous and life-threatening errors, with the New England Journal of Medicine reporting that the number of central lines, often used to draw blood, associated bloodstream infections increased by 28% between 2019 to 2020. The only way to fix this problem is to hire from a new pool of employees, immigrants. Considering the majority of programs only require a high school degree or equivalent GED, 4-8 months of training, and a certification from either the American Society for Clinical Pathology or the National Phlebotomy Association, work in phlebotomy could be potentially accessible to thousands of immigrants unable to pay for expensive nursing and physician licensures (Missman, 2021).

Careers in emergency health services are community-serving, in-demand professions that are in dire need of a new workforce population. The current turnover rate for Emergency Medical Technicians (EMTs) is currently 20-30%, meaning that the majority of employees leave the profession within four years ("Congressional Letter on the EMS Worker Shortage," 2021). Over the next decade, it is anticipated that there will be 18,100 EMT positions available every year, with the majority of jobs emerging due to a high rate of retirement from individuals aging out of the profession ("EMTs and Paramedics," 2024). Considering EMT training requires passage of a background check, schooling for approximately six months, and passage of a certification exam, this is a necessary and quick-training career in the medical field ("Becoming an EMT in Ohio," n.d.). The majority of local and community colleges in Northeast Ohio offer some form of night classes to attain EMT certifications, meaning with expansive resources that reduce the costs of these programs, hours are typically accessible even to those working full-time jobs.

Home healthcare work and nursing home care are both fields that must be encouraged for international talent. By 2025, the United States is estimated to have a shortage of 446,000 home health aides (Johnson, 2022). Home care workers provide help with a variety of domestic tasks including meal preparation, cooking, cleaning, transportation, emotional support, medication administration, shopping, and, depending on the urgency of care, may or may not provide medical aid. Home healthcare workers are primarily hired through outside agencies, and a variety of certifications and skills can help individuals receive work. Providing easy and cheap access to technician and emergency service certifications will allow international newcomers to be productive and competitive participants in this specific workforce. Further, nursing homes are facing a severe lack of care workers within their facilities. Between 2020 and 2022, 400,000

nursing and assisted living home staff members left their positions, faced with feelings of discouragement. 10,000 people every day reach the 65+ demographic, and birth rates are only continuing to decline (once again proving that domestic populations are unable to fill this labor gap in addition to the increasing need for elder care). The Bureau of Labor Statistics anticipates that the field of home health and personal care aides will grow by 33% within the decade, but there simply are not enough bodies to fill the demand (Moe, 2022). Historically, elder care has been supported by immigrant populations, and with immigration numbers at record lows, the industry is facing massive problems. Eldercare positions have the possibility of providing immigrant populations with advancement opportunities, benefits, steady wages, and a future in the larger healthcare field, while simultaneously providing elderly populations with the resources needed to age with grace and dignity.

The growing industry of behavioral and mental health has resulted in mass amounts of job openings not able to be filled by natural-born citizens alone. As of March 2023, 8,000 more mental health professionals are needed to sustain current industry demand and growth (Counts, 2023). Culturally and linguistically competent care is perhaps more imperative in mental health care compared to other healthcare fields. Currently, only approximately 10% of mental health providers come from Black and Hispanic populations, despite these communities making up 33% of the U.S. population (Counts, 2023). In both the State of Washington v. Sisouvanh (2012) and the State of Washington v. Ortiz-Abrego (2017), it was ruled that cultural competency was necessary when providing psychological evaluations to individuals on trial after it was deemed legally unfair for defendants to be reliant on mental health providers that did not understand their cultural backgrounds. In the more recent 2017 case, defendant Ortiz-Abrego who spoke native Spanish was evaluated by a Spanish-speaking neuropsychologist, whose competency evaluation

was weighed more heavily than the competency exam performed by a team of primarily English-speaking psychologists - although this decision was criticized within the court system, it is notable that cultural competency has historically been legally recognized as a necessary consideration when it comes to psychological examination (Bergkamp, McIntyre, & Hauser, 2023). In a study conducted in Canada, the "healthy immigrant effect" (HIE) was evaluated. Immigrants who were comparatively healthier than natural-born citizens before their immigration experienced a pattern of health decline post immigration leaving them with less healthy bodies compared to their natural-born counterparts. HIE has been observed in a variety of developed nations including the United States, Australia, and the United Kingdom, even with immigrants coming from nations with historically less developed healthcare infrastructure (Zghal, El-Masri, McMurphy, & Pfaff, 2021). Researchers concluded that a key factor in this health decline was discrimination and lacking understanding of cultural practices across the healthcare field, particularly mental health. In a field that requires patients to feel completely comfortable sharing personal thoughts with their providers, and a field designed to help individuals going through difficult transition periods, cultural competence in mental health is a necessity.

Specialists in children's and adolescents' mental health, particularly those who recognize cultural differences, are in growing demand. According to the American Academy of Child and Adolescent Psychology, there is a median of 11 psychiatric specialists per 100,000 children, allocating approximately one psychiatrist to represent 9,000 children. As mental health becomes increasingly recognized as equally important as physical health, and depression rates continue to increase among adolescents in the United States, it is no longer becoming possible for the current rate of specialists to keep up with the growing clientele. A recent study conducted by RAND

Corp. further elaborates that 70% of counties in the United States lack access to one of these specialists, deepening the problem (Robeznieks, 2022). According to Dr. Afifa Adiba, an international medical graduate from Bangladesh and a practicing child psychiatrist in Maryland, patients are typically forced to wait four to seven months before booking an appointment, because her services are in such high demand (Robeznieks, 2022). Allowing child and adolescent psychologists who have graduated internationally easier access to practice in the United States would be life-changing for patients, families, and medical professionals alike.

Traditional hospitals are feeling the brunt of the healthcare provider shortage. According to a recent report published by Kaufman Hall, hospital labor costs rose by 37% between 2019 and 2022 due to the constant turnover of employees and the need to expend more resources to retain current employees (Johnson, 2022). A poll conducted by Ipsos and US Today concludes that as of 2022, nearly 25% of over 1,000 healthcare workers surveyed planned on leaving the field imminently (Johnson, 2022). This is a growing problem, across a variety of fields, that can only be addressed by expanding the potential workforce. Custodial, administrative, and secretarial positions are all necessary careers in healthcare that do not necessarily require a background in medical services. Providing immigrants and refugees with the resources needed to pass basic certifications, and English proficiency tests, and attain strong interview skills is a requirement for ensuring United States hospitals are viable long-term. These jobs are the frequently overlooked backbone of the health industry and are necessary for sustaining a functional healthcare system in the United States.

Impact of Healthcare Worker Shortage on Health Outcomes

Disillusion from healthcare workers has significantly impacted the quality of care across the United States. According to the Center for Healthcare Quality and Payment Reform, over 600 rural hospitals across the United States are on the brink of collapse due to worker shortages, leading to potentially disastrous consequences both within the greater U.S. and particularly in Ohio (Higgs, 2023). For the majority of these communities, hospitals serve as emergency rooms, primary care facilities, and health clinics, and are the only source of healthcare resources within the immediate area. Memorial Hospital in Wyoming was forced to close its labor and delivery programs due to staffing shortages, forcing expectant parents to travel 90 minutes to the closest delivery location several counties away (Johnson, 2022). As shortages worsen, Ohio care centers are expected to face similar consequences. Trumbull Regional Medical Center (TRMC), a care facility in Warren, Ohio is in danger of closing, forcing residents to travel outside of Trumbull County to receive care. The union representing nearly 700 workers at TRMC has reentered negotiations with the hospital, citing poor hours and working conditions due to a lack of available labor (Wizner, 2024). The Dallas-based parent company for TRMC is facing greater debt and organizational problems, problems that are only exacerbated by a worker shortage. TRMC was ordered to let go of nearly 300 workers in recent years due to a combination of severe budget costs, the increased demand for healthcare workers, and increased labor costs for healthcare workers due to limited supply (Wizner, 2024). According to Columbus Business First, the four largest hospital systems in central Ohio are currently struggling to fill 2,200 necessary positions, "care deserts" have left multiple counties in critical need of specialists, and nursing home facilities across the region do not have the labor capacity to allow Ohio's elderly to age with care and dignity ("There's a Shortage of Doctors, Nurses. Columbus Metropolitan Club:

Prescription for Change," 2024). Upper Valley Medical Center in Troy, Ohio was forced to close its labor and delivery unit on February 29th due to staffing shortages, forcing residents to travel much farther for equivalent care. In cases where patients must see a physician immediately, this will greatly reduce health outcomes for Ohio citizens (Haeffele, 2024).

A greater quality of care can be provided by IMGs due to their diverse skill set and experiences with fieldwork in a variety of conditions. Elderly patients treated by IMGs compared to their counterparts treated by natural-born physicians were less likely to die within 30 days of treatment. This could be due to a variety of factors including improved bedside matter from IMGs and a greater reverence for elderly populations (Tsugawa, Jena, Orav, & Jha, 2017). Immigrants who attended medical schools in war-torn areas or nations with limited technological access display quick decision-making and can provide emergency care regardless of location. Additionally, since 1995 international medical graduates have outperformed U.S.-born medical graduates on their In-Training Examination, designed to evaluate the readiness of medical residents entering the field (Desbiens & Vidaillet Jr, 2010). Arguments claiming that IMGs are unable to fill U.S. healthcare positions because of cultural barriers, international training, or limited access to technology create a monolith out of a wide range of people and prevent qualified IMGs from taking part in the workforce.

Consumers of U.S. healthcare are harmed not just in quantity and quality, but in cost. Reduced availability of specialists heavily increases costs, making quality healthcare inaccessible to ordinary Americans (Sutton, 2020). According to Kaufman Hall, a healthcare management consultant agency, since 2019 the median labor expense per discharge has increased by 33%, increasing expenses for both hospitals and patients ("Report: Labor Costs Driving Hospital Expenses Up, Margins Down," 2022). Encouraging a larger labor pool is the

simplest way to increase the supply of healthcare providers and decrease costs for providers and patients alike. In a country where consumer healthcare costs are already far greater compared to similarly developed countries, any opportunity to increase supply and decrease demand is imperative.

Impact of Healthcare Worker Shortage on Medical Education

Natural-born doctors are missing out on the education and knowledge foreign-born doctors can provide. IMGs who completed their education with limited technology have improved bedside manners, and have better skills for working in trauma units due to their ability to complete complicated medical procedures with limited technology in tense situations (Namak, Sahhar, Kureshi, El Rayess, & Mishori, n.d.). Expanding the healthcare infrastructure in the United States is reliant on diverse perspectives coming together to combine their shared knowledge. Both natural-born and foreign-born doctors benefit from trading skills to improve their collective abilities.

Even if the United States was able to encourage enough natural-born citizens to join the healthcare sector (an outcome that is both unlikely and would harm other labor-driven fields in the process), it would come at an immense cost to the nation. Relying on other countries to outsource medical education would save the United States more money than attempting to solve the healthcare worker shortage by pushing natural-born citizens into the medical field. The United States invests $48,000-$51,000 in instructional costs and $80,000-$105,000 in educational resource costs per medical student per year, making the education of U.S. medical students a major expense (Desbiens & Vidaillet Jr, 2010). By recruiting international talent, the medical education burden will not impact the U.S., creating a path for a new labor force with limited costs.

Worries about residency programs, educational experiences, and the ability of IMGs to assimilate into the U.S. healthcare system lack substantial backing, however, recent changes made by the Educational Commission for Foreign Medical Graduates have made it easier than ever to evaluate the career-readiness of IMGs. IMGs are required to take the same standardized exam as United States medical graduates (USMGs) (the USMLE), an exam proving competency in English (either the TOEFL or the ECFMG), and must undergo a clinical skills assessment in the United States (Desbiens & Vidaillet Jr, 2010). These measures have been proven over several years, to effectively evaluate a medical professional's ability to succeed in the United States. IMGs who can excel in the same standardized testing procedures as natural-born graduates should be granted the same opportunities as citizen medical professionals.

Policy Alternatives

Nearly 50% of all states have either introduced or passed legislation altering the requirements for IMGs to attain full licensure in the United States. IMG legislation nationwide has been the result of bipartisan efforts to tackle the national healthcare workforce shortage, with Alabama, Alaska, Arkansas, Idaho, and Tennessee passing IMG legislation under republican legislatures and Colorado, Illinois, Maine, and Washington passing IMG legislation under democrat legislatures. Legislators on both sides of the aisle are increasingly recognizing IMG policy as a matter of public health, and not as a matter of immigration.

Many states have been highly successful at passing legislation that addresses key problems in both the healthcare worker shortage and the troubles IMGs face when attempting to practice in the United States. In 2023, Alabama passed the Physician Workforce Act that incentivizes physicians to move to the state by removing an additional examination for physicians accredited in another state, allowing IMGs to apply for a medical license a year earlier in their training, and allowing graduate physicians to shadow and form apprenticeships with licensed physicians while they await residency reapplications ("'Alabama Needs More Doctors': House Passes Physician Workforce Act," 2023). In Colorado, two programs were developed in the state's labor and employment department to specifically aid IMGs. The IMG assistance program helps IMGs by reviewing their credentials, experience, and previous licensure and then providing recommendations, scholarships, and career advice to best integrate these individuals into the workforce. The clinic readiness program establishes a specific curriculum for IMGs that provides them with the knowledge needed to pass assessments to enter residency programs. Further, section 4 of this bill reduces the amount of postgraduate clinical training needed to attain a medical license from three years to one ("International Medical

Graduate Integrate Health-Care Workforce | Colorado General Assembly," n.d.). A 2024 Virginia bill allows IMGs to attain provisional licenses for two years in exchange for practicing in underserved areas, providing a path to full licensure following this period ("LIS > Bill Tracking > HB995 > 2024 Session," n.d.). Wisconsin similarly provides provisional licenses for three years, with a consecutive full path to licensure, provided the respective IMG already has an offer for employment ("Wisconsin Legislature: AB954: Bill Text," n.d.). In Iowa, a recent bill provides IMGs with a provisional license, as long as they have passed the USMLE and have a job offer from a U.S. hospital. This provisional license can be transitioned into a standard U.S. medical license after three years ("IA - SF477," n.d.). Effective legislation that allows IMGs to practice at their skill level is possible across several states with varying degrees of need and is certainly possible in Ohio.

Other states have passed legislation that has addressed the problem of IMGs' inability to practice despite proven skill, although not to the capacity needed to solve this problem effectively. The Alaska IMG bill allows the medical board to license IMGs within the state without residency repetition as long as they display "proof of competency". However, the bill lists examples of proper proof of competency, including the completion of residency in another state, current licensure in another state, and prior work at an accredited hospital (a qualification that typically requires U.S. residency). This bill makes it difficult for IMGs to prove competency without U.S. residency, eliminating many qualified health professionals from benefitting ("Alaska State Legislature," n.d.). Any policy that advances the professional goals of IMGs is a success, however, when developing potential legislation for Ohio, the effectiveness of a possible solution must be considered. Future legislation must allow a significant number of IMGs to practice for international talent to fix the workforce shortage.

Perhaps the most trailblazing and successful piece of legislation centering IMGs was passed in Tennessee and is set to take effect in July 2024. This newly enacted law provides IMGs with a clear path to full licensure, after two years of working at a post-graduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME). Without needing to complete the U.S. residency, IMGs can attain a full license provided they attend a medical school deemed acceptable, pay an application fee, are in good licensing standing in their home country, receive an employment offer, are a U.S. citizen or have a right-to-work Visa, display English proficiency, pass the USMLE, and receive a certification from the Educational Commission for Foreign Medical Graduates ("Tennessee's Groundbreaking New Law for International Medical Graduates," n.d.). The Tennessee law continues to be referenced by legislators, hoping to institute similar programs in their state, due to its success in encouraging international talent to fill the healthcare worker shortage gap. Tennessee, a firmly red state, recognizes that this is a public health and workforce issue, not an immigration one, and has instituted the most pro-IMG bill in the United States.

Similar to the United States, Canada also relies on international medical graduates to fill 25% of their physician workforce positions, however, they have taken more proactive steps to increase their population of international physicians. In 2002, the Canadian Task Force on Licensure of International Medical Graduates was created, and within a year they released six recommendations aimed at increasing the capacity to evaluate IMGs, standardize licensure requirements, create programs to help IMGs meet licensure requirements, assist faculty with uncommon challenges when working with IMGs, increase the flow of information tracking the retention of IMGs, and develop a national research program tasked with evaluating the integration of IMGs (Bartman, Touchie, Topps, & Boulet, 2022). Although Canada continues to

face similar discriminatory practices to the United States when it comes to accepting IMGs into residency programs, the Canadian government's pursuit of increased knowledge regarding the integration of IMGs is admirable.

Current policy alternatives have been unprecedentedly successful at reducing workforce gaps across the nation. Ohio is in a perfect position to institute this legislation, considering the states that have gone before it have been successful, and policymakers have strong examples of provisions that must be included in an IMG law. Ohio legislators can not allow the state to fall behind its neighbors and must work to urgently create quicker paths to licensure for international medical graduates.

Policy Failures

Although the current positive policies that have successfully passed through state legislatures are model examples of potential Ohio can strive for, failed national policies also provide a view on provisions that are needed across the nation and can be implemented in Ohio.

Bills such as the Physician Access Reauthorization Act and the Doctors Helping Heroes Act of 2015 attempted to add to current aid to IMGs provided by the Conrad 30 program. The Conrad 30 program, which provides each state with 30 spots for potential international medical graduates who have completed a J-1 visa exchange program to qualify for a two-year foreign residence waiver, is significantly limited in its outreach to local communities. Although this program has certainly been beneficial, eligibility requirements are steep, leaving the majority of states unable to fill their 30 vacancies. Individuals hoping to fill a Conrad 30 spot must be admitted into the United States to receive graduate medical training, must agree to serve for three years in a Health Provider Shortage Area (HPSA), and must agree to return to their home country following the completion of the program ("Conrad 30 Waiver Program," 2020). The Physician Access Reauthorization Act aimed to remove the Conrad 30 requirement that physicians must leave the United States for two years following the completion of the program, allowing international physicians who met certain work requirements the ability to continue practicing in the United States. This bill would have also increased the number of Conrad 30 spots from 30 to 35, to states that displayed sufficient interest, not only better integrating international physicians into the workforce but allowing a greater number entry (Physician Access Reauthorization Act, 2023). The Doctors Helping Heroes Act would have further developed the Conrad 30 program, reducing barriers to entry, expanding the spots available, and

amending the Immigration and Nationality Technical Corrections Act of 1994 to solidify the Conrad 30 program as permanent (Doctors Helping Heroes Act, 2015).

Other bills have addressed the necessity of reducing research gaps within the intersection of IMGs and public health, notably the Health Equity and Accountability Act of 2020. Although this bill does not directly impact IMGs, many included provisions emphasize the importance of culturally competent care. Intending to reduce health disparities, this bill requires greater data on demographics and health disparities, directs funds to support diversity in healthcare, increases access to culturally and linguistically appropriate care, modifies requirements for public and private insurance options, and improves health technology systems. Notably, section 202 of this bill would have required every federal agency providing a health service to construct a plan improving linguistically competent care for patients with a lack of English proficiency. Further, section 203 would have effectively amended the Affordable Care Act, requiring federal health providers to provide detailed strategies for better implementing culturally and linguistically appropriate care among their diverse demographics. Indirectly, the provisions in this bill can be tied to IMGs, individuals who are likely to provide international perspectives and make up for lacking cultural competence and linguistic diversity in the United States healthcare system (Health Equity and Accountability Act, 2020).

The Emergency Nursing Supply Relief Act of 2017, the Grant Residency for Additional Doctors Act of 2021, and the International Medical Graduates Assistance Act of 2023 are all bills that contain provisions that center further learning when accounting for IMGs and promote public health policy through educational spaces. The Emergency Nursing Supply Relief Act would have lifted limitations on employment-based Visas for nurses and physical therapists for two years and mandated that the Department of Labor create a partnership program to provide

grants and encourage further education for nurses (Emergency Nursing Supply Relief Act, 2007). Providing grants, support, and established pipelines for healthcare workers in the United States would allow IMGs to not only advance in their careers but would promote professional development and boost the experience level of healthcare job applicants nationwide. The Grant Residency for Additional Doctors Act hoped to address the physician shortage impacting the rural United States shortly following the pandemic. Marketed as a way to reduce bureaucratic delays in the immigration process, and ensure hospitals stayed afloat, this bill would have allocated additional staff in the Department of State to expeditiously process J-1 visa applications ("Emmer Introduces Legislation to Address Shortages of Medical Personnel in Rural Communities," 2021). The International Medical Graduates Assistance Act of 2023 would have encouraged the education and implementation of IMGs into the workforce by directing the Department of Health and Human Services to award grants to states and territories willing to allow IMGs to practice under the guidance of a licensed physician while studying for the USMLE (International Medical Graduates Assistance Act, 2023).

Regarding legislation promoting IMGs in the workforce, solutions traditionally either focus on improving underserved communities or addressing the concern of immigrant underemployment. Considering healthcare workforce shortages primarily impact low-income, rural, and historically marginalized communities, bills that contain provisions directly serving these constituents, including the Physician Visa Reform Act of 2018, are imperative to work in the IMG space. Although many policy alternatives and failures discussed in this paper provide direct aid to HPSAs, this bill specifically revises the Immigration and Nationality Act to allow international physicians the ability to practice (with the approval of a licensed physician) in an HPSA without being required to pass a traditional medical board examination (Physician Visa

Reform Act, 2018). The Professional's Access to Health Workforce Integration Act of 2022 is an additional bill to provide grants to organizations willing to help underemployed and unemployed find jobs as health professionals (Professional's Access to Health Workforce Integration Act, 2022). Directly assisting underemployed physicians, this legislation prioritizes aid to underemployed and unemployed international medical professionals.

Although the majority of bills introduced in state legislatures nationwide have been largely successful, analyzing failed bills is a necessity when promoting IMG legislation in Ohio. In Arizona, a failed bill hoped to encourage IMGs by accepting licenses from the following areas: Australia, Canada, Hong Kong, Ireland, Israel, New Zealand, Singapore, South Africa, Switzerland, and the United Kingdom ("Arizona SB1406 | 2024 | Fifty-Sixth Legislature 2nd Regular," n.d.). A similar bill introduced in Missouri also provides specific country requirements for licensure. The specifications and reasoning behind choosing certain countries are often arbitrary and do not reflect the well-established view that excellent medical professionals can originate from anywhere. Provisions such as country specification are limiting, and disastrous when campaigning for the passage of IMG legislation. In Georgia, a failed bill planned to provide two forms of restricted licensure for IMGs, allowing review boards discretion on an IMGs education and clinical experience, and issuing temporary licenses to physicians willing to practice in underserved communities ("GA - SB529," n.d.). Review boards are difficult to assemble, as state governments become tasked with the additional requirement of compiling qualified individuals who can properly speak on all aspects of IMG ability. Laws that allow IMGs who pass the standardized U.S. medical exams, the same qualifying exams required by natural-born citizens, are typically more successful because they require less bureaucracy and additional resources to be provided by respective states.

The largest problem facing the world of IMG legislation is a lack of comprehensive solutions. Many of both the current laws and the failing bills impacting international newcomers are hyperfocused on specific subsets of an already small population and lack enough breadth to make a necessary difference in the healthcare shortages facing the nation. When pursuing future action, solutions implemented in Ohio must take strides to create tangible, immediate, and positive change.

Gaps in Research

Growing problems within the healthcare industry have only been exacerbated by the COVID-19 pandemic. Even though the pandemic continues to rage in many parts of the nation, particularly HPSAs, there is no doubt that the U.S. economy has relatively returned to normal with less frequent office and workforce closures. A large portion of recent data surrounding the healthcare workforce has no doubt been tainted by the pandemic, with healthcare providers often forced to work consistently brutal hours amidst poor conditions. There is no way of telling how the healthcare workforce will continue to react throughout the United States' recovery period. Regardless, the healthcare workforce shortage is still present, however, to what extent is to be determined.

Current IMG laws have been widely successful nationwide when reducing worker shortage gaps. Nonetheless, IMG bills are new, and recent proof of success can predict but does not guarantee, long-term gain. Due to the recency of IMG legislation, the full impact of increasing international medical professionals is yet to be determined, proving to be another gap in the current literature.

Policy Recommendations

Based on the current analysis regarding the state of IMG policy nationwide, potential legislation in Ohio must allow IMGs to attain a provisional license provided they:

- Pass the United States Medical Licensure Exam (USMLE)
- Attended an accredited medical school in another country
- Remain in strong licensure standing within their home country
- Completed residency training in another country
- Have a right-to-work Visa or green card status
- Attain a certification from the Education Commission for Foreign Medical Graduates

After three years of full-time work within the Ohio medical system, IMGs should be provided with a path to full licensure in the form of a standard U.S. medical license.

It is further recommended that Ohio take greater steps to encourage international newcomers to pursue careers in healthcare services by allocating generous grant funding to colleges and universities willing to provide scholarships to international students and extend class hours to accommodate a variety of schedules. Ohio must launch a media campaign promoting healthcare careers to international newcomers and natural-born citizens alike, to display how all residents can contribute to the industry.

Conclusion

Current statistics are grim: reporting that by 2025, Ohio will be short of 1,200 primary care physicians, almost 70% of nurses are seriously considering leaving the profession, and the United States is expected to have a deficit of 139,000 physicians by 2023 ("Physician Shortage in Ohio, U.S. Expected to Worsen," 2019)("Nursing Shortage Fact Sheet," 2024)(Boyle, 2020). Counties across Ohio are facing skyrocketing healthcare costs, decreasing quality of care, and a lack of local specialists in their vicinity. However, Ohio can learn from other states that have solved similar workforce problems, particularly by utilizing an immigrant and refugee population. As indicated by successful legislation in Tennessee, Colorado, Alabama, etc., providing an easy path to licensure for international medical graduates can significantly increase the physician population. National bills have attempted to increase funding to university programs and launch initiatives tailored to promoting international newcomers in the health services fields, another solution Ohio lawmakers can utilize to further phlebotomy, emergency health services, and technician programs. Previous legislation has been widely bipartisan, proving the necessity and commonsense nature of this legislation. Law that encourages international newcomers to pursue healthcare careers is not immigration policy, but a matter of public health. Provided barriers for international medical graduates are reduced, a solution in Ohio is possible.

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