

US Policies May Lead to Fewer Opportunities for IMGs
But Self Sufficiency Not on the Agenda

Edward Salsberg
Director, Center for Workforce Studies
Association of American Medical Colleges
Washington, DC
USA

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Summary

Although there is an active discussion underway in the US regarding the physician workforce, this discussion has focused on whether the nation is likely to face a shortage and whether or how much medical school enrollment and graduate medical education (GME) positions should expand. All of these discussions assume a continuation of a high level of IMGs. In fact, with the exception of several articles by Fitzhugh Mullan¹ expressing concern with the impact of migration to the US on less developed countries, there has been almost no discussion among policy makers of the concept of national self-sufficiency or the consequences of migration to the US. Perhaps because new IMGs play such an important role in underserved areas and most analysts have concluded the nation is likely to face a major shortage of physicians, policy makers have not called for a reduction in the flow of IMGs. In fact, discussions around possible immigration reform have focused on increasing the service requirement of non-citizen IMGs wanting to stay in the US.² Despite the lack of public discussion or intention, it is possible that the US may have set in place policies that could lead to a reduction in the flow of IMGs into the country.

In 2006, in response to concerns of a likely shortage of physicians, the Association of American Medical Colleges (AAMC) recommended a 30% increase in medical school enrollment and a commensurate increase in GME positions to accommodate this growth.³ US medical and osteopathic school enrollment is rising; MD and DO (osteopathic) graduates in 2016 are expected to be about 5,200 higher than in 2006, an increase of 28%⁴. By 2020, MD and DO graduates are likely to be more than 8,000 above the number in 2006. However, to become licensed to practice medicine in the US, a physician must complete several years of GME and there has been no new financial support for an expansion of GME which has a different funding and decision makers than medical education. While there has been some limited recent growth in GME positions, additional growth without new funding is uncertain and chances for additional funding are limited at this time.

In 2007, an estimated 6,800 IMGs entered GME in the US (the only portal to practice in the US) of which about 5,000 were non-US citizens. If GME positions do not rise, the coming increase in US MD and DO graduates is likely to lead to a decrease in the number of IMGs that can obtain residency positions. While there is extensive debate as to whether Medicare reimbursement for GME (the major source of GME funding) should be increased or decreased, this discussion is focused on the cost issues and is not related to the self sufficiency issue.

The AAMC call for a 30% increase in medical school enrollment was intended to increase the overall supply in order to meet growing needs not to replace IMGs. But, if GME positions are not increased then IMGs are likely to be replaced by US MDs and DOs. Self sufficiency, that is educating enough physicians to meet the needs of the US

without significant in-migration of foreign educated physicians, would require the education and several thousand additional physicians and other health professionals.

There appear to be 3 very different scenarios for the future:

- ***A slight decrease in IMGs:*** Under this scenario, in the absence of new federal funding, GME positions grow but more slowly than medical school graduate; this reduces the inflow of IMGs to the 3,000 to 4,000 per year range and they remain an important source of physicians for the US. Growing demand is met by health systems reform and increased use of non physician clinicians (NPCs), such as physician assistants (PAs) and nurse practitioners (NPs).
- ***A sharp reduction in IMGs:*** Under this scenario, the number of MD and DO graduates increases as planned while Medicare funding for GME is cut and teaching hospitals can not afford to fund additional training positions. Without an increase in GME positions, the planned increases in MD and DO enrollment eliminates spaces for IMGs.
- ***A sharp increase in the number of IMGs:*** Demand and need for services is likely to far outstrip the increase in supply of physicians. In the absence of major health systems reform, this could lead to major access problems and an increase in prices. This could then lead to an increased willingness to use and even recruit IMGs perhaps even through the easing of the requirement that IMGs complete residency training in the US. A reduction in trainee work hours – which is being discussed by the Institute of Medicine⁵ - could also lead to a willingness to increase the number of residents in training to help meet hospital service needs.

At this point in time, it is not possible to know which of these scenarios is more likely.

Another factor that is likely to impact on the flow of non-citizen IMGs is the flow of US citizen IMGs. While most of the recent growth in IMGs has been US citizens going abroad, primarily to for-profit schools in the Caribbean, it is not clear whether the number of schools and students will continue to grow in the future. It is possible that expanding medical and osteopathic opportunities in the US along with an effort to establish an accreditation process in the Caribbean will lead to a decline in the number of US IMGs. This would most likely lead to greater demand for non-citizen IMGs.

US policy makers and the public are not yet convinced that international migration to the US is creating problems for less developed countries. Perhaps additional documentation and publicity related to the impact internationally and greater attention to the moral consequences could increase pressure to reduce IMG flows. There is also likely to be resistance to further increases in funding for medical school enrollment to replace IMGs and health systems reform has been limited. This all indicates the likely continued reliance on large numbers of IMGs. This is also consistent with American tradition of relying on international markets to meet their needs.

Background

International Medical School Graduates (IMGs)

Historically, the US has relied on IMGs. Currently, 25% of all active physicians and about 26% of all physicians in training are IMGs. The number of IMGs entering training in the US has increased steadily each year over the past decade reaching 6,800 in 2007. (Figure 1)

Figure 1. The Number of IMGs Entering GME Has Increased More Than 25% Over The Past Decade

	IMGs <u>Entering</u> GME*
1996-1997	5,379
1997-1998	5,414
1998-1999	5,371
1999-2000	5,905
2000-2001	6,097
2001-2002	6,170
2002-2003	6,208
2003-2004	5,985
2004-2005	6,338
2005-2006	6,570
2006-2007	6,802
Change 1996 – 2006	+1423 (+26%)

Note: IMG numbers include Fifth Pathway

Sources: 1995/96 to 2002/03 data based on Form 246 filings as of Aug. 2004.

2003/04 to 2006/07 data are from AAMC GME Track.

To practice in the US, IMGs must generally complete 3 years of accredited GME. While some return home after GME, the vast majority remain. The requirement for US GME may limit some migration of experienced physicians into the US. For the most part, IMG applicants to residency training far exceed the number of available positions. In 2008, of 11,141 non-US citizen IMGs registered for training positions through the National Residency Match Program (NRMP), only 3,108 of these physicians were matched into residency training positions through the NRMP⁶. As such there is very little, if any, actual recruiting of IMGs to come to the US.

IMGs fill important gaps in the US health care system. Many IMGs, in return for being allowed to stay in the US after training, agree to practice in an underserved area for several years. While some stay in the underserved areas once they obtain their permanent resident status, most appear to move out of the underserved communities. IMGs also fill

important gaps in specialties: IMGs tend to go into specialties that US MDs do not go into. Most recently there has been a sharp increase in the numbers of IMGs entering primary care specialties while the number of US MDs has decreased sharply⁷

There is no consensus that brain drain is a major problem. IMGs come from almost all countries around the world with the single largest source country being India. (Figure 2) Many Americans believe that these physicians were educated in India with the intent of migrating to the US. While there is greater concern regarding physicians from Africa, it appears that only about 250 African physicians migrate to the US each year. While this is a significant number for Africa, it is not significant in comparison to the 25,000 physicians who enter training each year in the US. The issue of brain drain has not been a major political issue in the US.

Figure 2. India and Pakistan Continue to be the Largest Sources of IMGs, but the Caribbean Islands Continue to Increase

	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>
India	1,442	1,578	1,627	1,621
Pakistan	475	440	476	392
Grenada (St. Georges)	348	348	361	375
Dominica (Ross)	312	323	377	360
Netherland Antilles	177	227	255	333
Philippines	245	268	237	275
China	156	198	209	259
Nigeria	138	162	144	151
Iran	92	123	143	140
Colombia	95	133	129	115
Mexico	132	159	144	114

Note: IMG numbers do not include Fifth Pathway

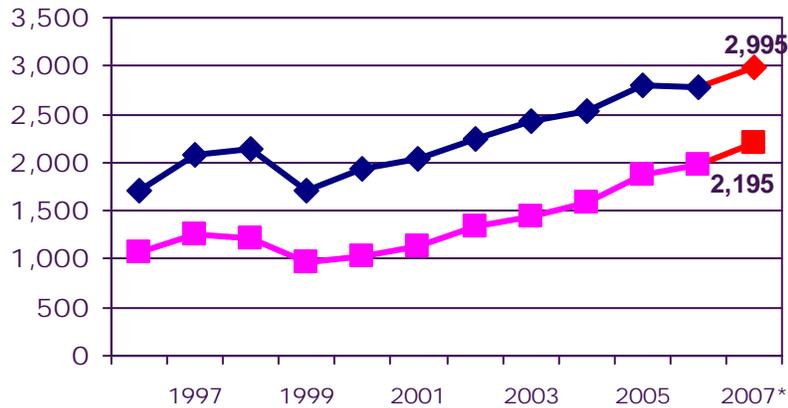
Source: AAMC GME Track

In fact, while immigration policy reform (in general, not just for health care) is actively being discussed in the US, there has been little or no push to restrict the flow of IMGs into the US. There are several proposals being promoted but these would revise visa categories and expand service requirements and would facilitate in migration rather than reduce it.

The failure of US medical schools to increase enrollment from 1980 till 2005 at a time when residency training positions were growing (except from 1997 to 2002) and job

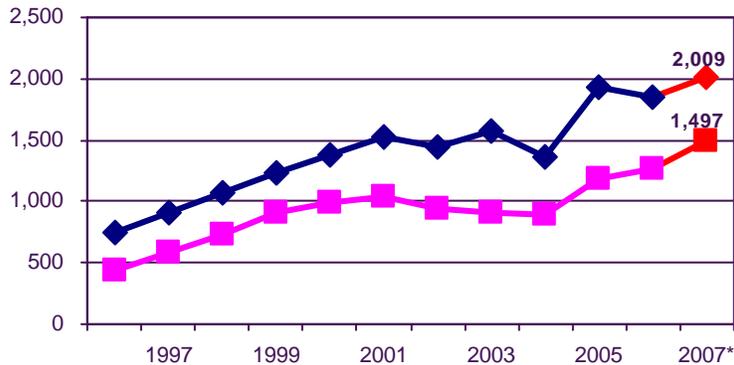
opportunities were abundant, may have contributed to a steady rise in the number of US citizens going to school outside the US. Exhibit 3 and 4 show the number of US citizen attending school outside the US and applying each year for an ECFMG certificate and the number of certificates awarded each year. The vast majority of these US IMGs have attended a school in the Caribbean. We estimate that about 90 to 95% of those obtaining an ECFMG certificate eventually end up in GME in the US.

Figure 3. New US IMG Applicants for ECFMG Certification are Approaching 3,000 Per Year



*2007 numbers are projections through 12/31/07 based on applicants as of 10/22/07
Source: ECFMG

Figure 4. Nearly 2,000 US IMGs Certified by ECFMG in 2007



*2007 numbers are projections through 12/31/07 based on certifications as of 10/22/07
Source: ECFMG

The growth in US citizen IMGs over the past decade may have helped slow the growth of non-citizen IMGs entering residency training in the US.

One other factor to consider: India is developing rapidly. It is possible that in the next decade or two, the opportunities for new physicians in India will grow to the point that

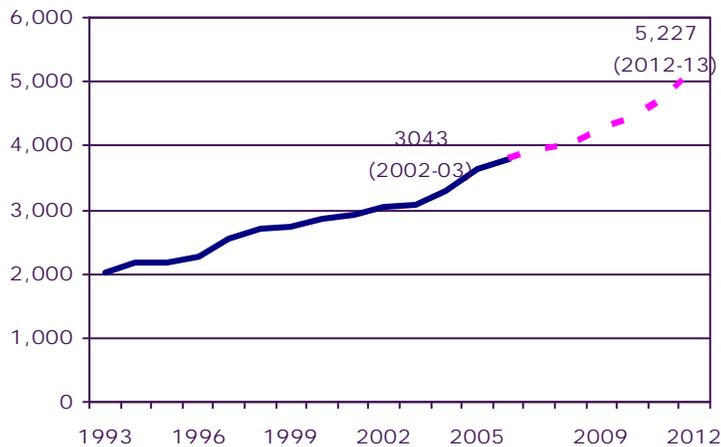
1,600 or so new Indian physicians will not be available to migrate each year to the US. In all likelihood, this would open up opportunities for physicians from other parts of the world both in the US and in India.

Physician Workforce Policies and Decision Making in the US

To assess whether the US is likely to adopt policies that move towards self sufficiency in the physician supply, it is important to understand physician workforce decision making in US. *There is no structure for workforce planning in the US.* The US system is very pluralistic with many disparate decision makers. In fact, there is no connection between decisions related to the medical school enrollment, the number of residency training positions or US visa policies. While the relative size of medical and osteopathic enrollment and the number of GME positions determines the spots available for IMGs, there has not been an explicit policy on how many IMGs are appropriate for the US. In fact, the decision makers and factors that influence medical school enrollment are different from the decision makers and factors influencing the number of residency training slots which is different from those that influence immigration policies.

Medical and osteopathic enrollment is determined by each of the 129 medical schools (MD) and 25 DO schools. While the majority of schools receive public support, this is from the state they are located in not the federal government. While the AAMC recommended a 30% increase in medical school enrollment, each school and state decides whether to expand. It now appears that the US medical schools will reach the 30% goal by for first year enrollment by 2015 or 2016. DO enrollment has been growing even more rapidly. (Figure 5)

Figure 5. First Year Enrollment in Osteopathic Schools Expected To Surpass 5,000 by 2012



Source: 2007 AACOM Enrollment Survey: Preliminary Findings

Individual hospitals sponsor residency training programs with approval of specialty specific residency review committees (RRCs). The primary source of funding for this training is the federal Medicare program with support coming through hospital reimbursement each time a Medicare patient uses the hospital. In 1997, federal legislation capped the number of positions Medicare would pay for. This contributed to a stable number of positions for 5 years after passage of this legislation, but since then there has been an increase of about 8% over the past 5 years. While most teaching programs are affiliated with a medical school, hospital administrators and RRCs rather than medical schools decide whether to offer a training program and its size. While the Medicare program is the largest source of funding for training, the Medicare program does not proscribe the number or types of training that can be offered in the US.

There have been a number of proposals to reduce the amount of support that teaching hospitals receive from Medicare for GME along with other proposals to reduce Medicare and Medicaid payments to teaching hospitals. Decreased funding is likely to be driven by efforts to constrain Medicare and Medicaid expenditures rather than as a workforce policy. Nevertheless, major cutbacks in hospital funding are likely to discourage an increase in training positions in the US. Thus, while US medical and osteopathic enrollment is rising rapidly in response to growing concerns with possible shortages, there is no national commitment to also increase GME funding.

Projecting Future Supply and Demand: How Close is the US Likely to be to “Self Sufficiency”?

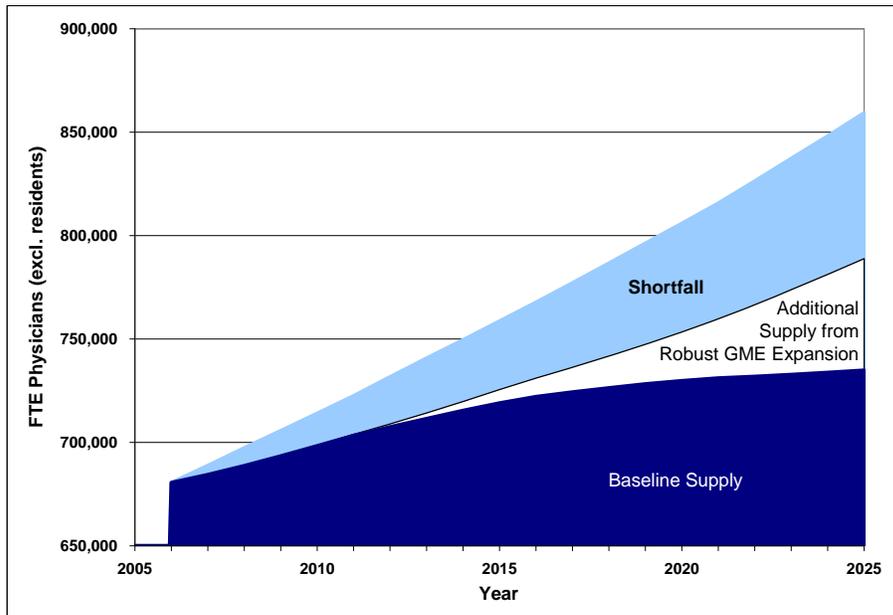
Based on a study of supply and demand released by the federal government in 2006 and a new study by the AAMC to be released later this year, it appears that demand will rise far more rapidly in the coming decades than supply. As indicated in Figure 6, even with a significant increase in residency training positions over the next decade, the US is likely to face a significant shortage and hence a continued demand for IMGs. The AAMC report will explore a number of alternative scenarios for both future supply and demand. These scenarios provide a sense of the potential impact of alternative strategies in balancing future supply and demand and assuring access to care.

On the supply side, the aging of the physician workforce (one-third of active physicians are over 55) will be a key factor limiting future growth. The work patterns of younger physicians will also moderate the impact of the new supply of physicians. While the expansion in medical and osteopathic enrollment if accompanied with an increase in GME can contribute to an increase in supply, due to the time needed to educate and train a physician, phasing in an increase in GME over the next decade from the current 25,000 entrants per year to 32,000 per year, would only produce an additional 54,000 physicians by 2025. This would still leave a major shortfall in demand and need.

On the demand side, the nation’s population is growing by 25 million every decade and the number over 65, who use twice as many physician visits per person, will double between 2000 and 2030. There is little that can be done in terms of these basic

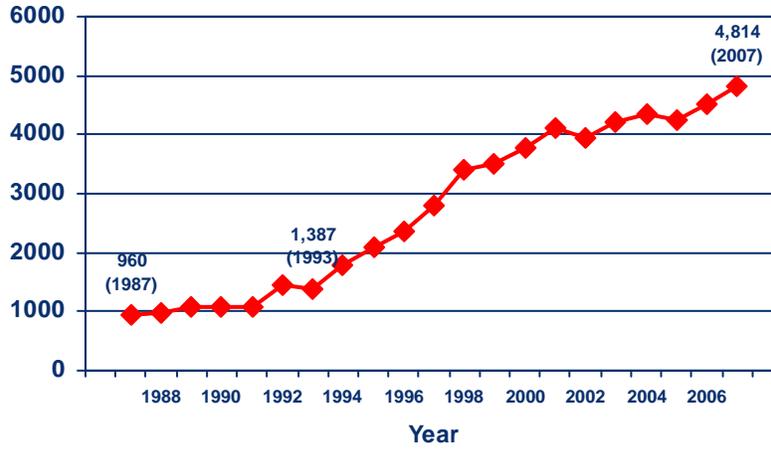
demographics to reduce the need for services. Furthermore, there is a good chance that over the next 20 years, the nation will find a way to provide coverage for the 48 million Americans who lack health insurance. This too will drive up demand.

Figure 6. Projected National Supply & Shortfall of Physicians with GME Expansion



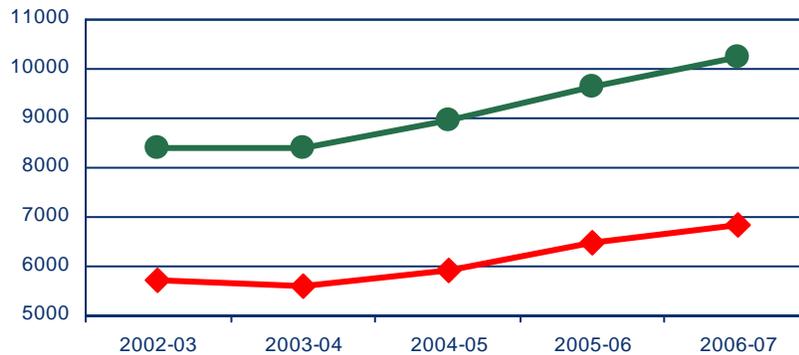
The most promising general strategy to reduce future demand for physician services is improving the efficiency and effectiveness of the health care delivery system. While the health care system has been trying to improve efficiency and reduce the rate in growth of expenditures for several decades, there has been little progress. Perhaps most promising in terms of reducing demand for physicians is the expanded use of physician assistants, nurse practitioners and other non-physician clinicians (NPCs). Both the number and scope of practice of these practitioners has been increasing. As can be seen in Exhibits 7 and 8, the number of new PAs and NPs have been increasing rapidly. This will undoubtedly help reduce demand for physicians, including IMGs.

Figure 7. The Number of PAs Will Continue to Grow Rapidly as the Number of New PAs Entering Practice Each Year Has Grown 5 Fold in the Past 15 Years



Source: National Commission on Certification of Physician Assistants, April 2008

Figure 8. The Number of New Advanced Practice Nurses is Also Growing Rapidly



Source: American Association of Colleges of Nursing
 Total APN includes: NP, CNS, Combined NP/CNS, Nurse Midwifery, Nurse Anesthesia, and Post-Master's NP

While it is possible that there will be other improvements in productivity, this is likely to be off set by continued improvements in medicine that improve the quality of life and longevity.

Some have suggested that eliminating variation in utilization rates could reduce the need for physician services. However, while there are significant variations, some of this reflects significant under-use, some of which is related to lack of insurance, lack of access or other factors. The growing literature on disparities of care indicates that there may be as much under-use as over-use.

In conclusion, even with an increase in US medical and osteopathic enrollment and the continued inflow of IMGs, the US is likely to continue to face significant unmet need and demand. The nation will be tempted to continue or even increase the inflow of foreign educated physicians. Unless there is a greater effort to document the problems created globally by this migration, the US is not likely to sacrifice meeting its needs for the needs of other countries.

¹ - Mullan, F. (2005) "The Metrics of the Physician Brain Drain". NEJM, 353: 1810-1818

² – AAMC (Association of American Medical Colleges) Washington Highlights April 4, 2008. Available at: <http://www.aamc.org/advocacy/library/washhigh/2008/040408/start.htm>) Accessed 28 August 2008.

³ – AAMC The Physician Workforce: Position Statement Available at: <http://www.aamc.org/workforce/workforceposition.pdf>) Accessed 28 August 2008

⁴ - AAMC Center for Workforce Studies. Medical School Enrollment Plans: Analysis of the 2007 AAMC Survey. Available at: https://services.aamc.org/Publications/showfile.cfm?file=version111.pdf&prd_id=229&prv_id=279&pdf_id=111) Accessed 28 August 2008

⁵ – Insitution of Medicine. Meeting of the Committee on Optomizing Graduate Medical Trainee (Resident). Available at: (<http://www.iom.edu/CMS/3809/48553/53906/53908.aspx>) Accessed 28 August 2008.

⁶ National Residency Match Program: <http://www.nrmp.org/data/advancedatatables2008.pdf> accessed 29 August 28, 2008.

⁷ Salsberg E, Rockey PH, Rivers KL, Brotherton SE, Jackson GR, "US Residency Training Before and After the 1997 Balanced Budget Act." JAMA. 2008;300(1) In press.