

**Statement  
of the  
American Hospital Association  
to the  
Subcommittee on Immigration, Citizenship, and Border Safety  
of the  
Committee on the Judiciary  
of the  
United States Senate**

**“Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care  
Workforce”**

**September 14, 2022**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Subcommittee on Immigration, Citizenship, and Border Safety of the Committee on the Judiciary examines the importance of improving the immigration process in order to help alleviate America’s health care workforce shortage.

The COVID-19 pandemic and its aftermath are still impacting the nation’s health care system, even as many Americans seek a “return to normal” with respect to managing transmission of the virus. As of this month, there have been more than 95 million cases of cases of COVID-19 in the U.S., over 5.2 million hospitalizations, and more than 1 million deaths. While fewer patients are being admitted for COVID-19 treatment now than during the pandemic’s peak periods, many hospitals are still experiencing significantly constrained capacity and high patient [acuity](#), as those patients that put off treatment during the pandemic are now seeking care.



Our hospitals and health systems — and their hard working teams — have been subject to enormous pressure as they continue serving their patients and communities throughout the pandemic. These challenges are severe: more clinicians are leaving the health care field due to burnout and retirement, thereby exacerbating already critical shortages. Hospitals are increasingly paying higher wages to keep and recruit enough staff. This is occurring at a time when many hospitals and health systems are facing significant financial constraints. While the U.S. must do more to invest in training the next generation of health care workers, we believe recruiting qualified immigrants, and expediting their entry into the country, is an effective short-term approach that deserves support from Congress.

## **HEALTH CARE WORKFORCE CHALLENGES**

While managing workforce pressures were a challenge for hospitals even before the pandemic, these challenges have only grown more acute. The incredible physical and emotional toll that hospital workers have endured in caring for patients during the pandemic has, among other issues, exacerbated the shortage of hospital workers. Hospitals have had to rely on contract labor resources, which increase workforce costs even more. Hospitals also have incurred significant costs in recruiting and retaining staff, which have included overtime pay, bonus pay and other incentives.

The workforce shortage is at a critical juncture. According to the most recent data, 778 hospitals in the U.S. (18.5% of reporting hospitals) report anticipating critical staffing shortages within the week of September 8. Nurses, who are critical members of the patient care team, are one of the many health care professions that are currently in shortage. The U.S. Bureau of Labor statistics is [projecting](#) 203,200 openings for registered nurses for each of the next 10 years due to the need to replace workers who move to other occupations or retire. Currently there are not enough nurses graduating from U.S. schools to meet this demand. According to the American Association of Colleges of Nursing, American nursing schools turned away over 80,000 qualified applicants from baccalaureate and graduate programs in nursing in 2019 alone due to an insufficient number of qualified faculty, clinical sites, classroom space, clinical preceptors and budget constraints. The low salaries for nursing faculty also are not commensurate with their level of educational preparation (i.e., master's degree level, or above), thereby making recruitment a challenge.

The shortage also extends to physicians practicing in the U.S. Data from the Association of American Medical Colleges [projects](#) a shortage of 124,000 physicians by 2034, including primary care physicians as well as specialists, such as pathologists, neurologists, radiologists and psychiatrists. While the aging of the U.S. population and the physician workforce drives some of the projected shortage, much of it stems from the caps on Medicare-funded residency slots imposed by Congress 25 years ago as a cost-saving measure. While the number of medical school graduates has increased significantly over the past two decades, Medicare-funded training opportunities for these graduates have remained frozen at 1996 levels. Furthermore, the caps have created imbalances that favor allocation of slots toward lower-cost and higher-reimbursement specialties, rather than more urgently needed primary care and behavioral health. While

some hospitals are self-funding a portion of their residency slots, this model is not sustainable in the long-term.

## **SKILLED IMMIGRANT WORKFORCE**

One of the short-term strategies used to ease pressure on the workforce shortage in the U.S. is the use of immigrant health care workers, which primarily include nurses and physicians. Recent [studies](#) show that 18.2% of U.S. health care workers were born outside of the U.S. For example, 29% of U.S. physicians are born in other countries, and almost 7% are not U.S. citizens. Similarly, foreign-born nurses account for 15% of registered nurses in the U.S., according to a [report](#) by the Institute for Immigration Research at George Mason University.

Foreign-trained nurses and doctors do not displace American workers. Instead they play critical roles in ensuring the health of the communities our hospitals serve. They are highly qualified and required to meet our nation's standards for education, English fluency and state licensure.

Foreign educated nurses (FENs) seeking to work in the U.S. gain entry via two pathways. They can apply for an H-1B Temporary Work Visa, but this option is limited to nurses who hold a four year degree or higher and can fulfill specialized roles, such as in critical care, emergency departments or cardiology. Most FENs instead opt to apply for legal permanent resident (LPR) status, or a green card, to be granted employment based (EB) immigration for themselves and their family members. Each year, the United States grants green card status to up to 140,000 EB immigrants and their family members (though this limit can be increased by the addition of unused visa numbers from the prior fiscal year). There are additional caps on each category for EB workers, and nurses are usually placed in the EB-3 category for "Skilled workers, professionals, and other workers," which totals 28.6% of worldwide limit or up to 40,040 immigrants. In practice, these restrictions result in around 10,000-12,000 nurses per year being admitted to the U.S., as most green cards go to professionals who are already residing in the states.

For physicians to practice in the U.S., they must complete one to three years of graduate medical education (GME), even if they have foreign training and already completed medical residency in their home country. Some states eased licensing [restrictions](#) during the COVID-19 pandemic and may consider continuing this flexibility after the public health emergency (PHE) to help address the staffing shortages. In order to pursue U.S.-based GME, the physician must apply for a J-1 visa. Once the educational component is completed, the individual is required to leave the U.S. and fulfill a two-year home-country physical presence requirement. In order to waive this obligation, a foreign medical student can apply for a waiver through the Conrad 30 Waiver Program. The program is available in all 50 states, the District of Columbia, Puerto Rico, and Guam, and they can sponsor up to 30 international medical graduates each year for a J1 waiver. Each state has developed its own application rules and guidelines for these waivers, but all J-1 graduate students are required to, among other conditions, fulfill a three-year commitment to practice medicine in an H-1B nonimmigrant

status at a health care facility located in an area or serving a population designated by the U.S. Department of Health and Human Services as a Health Professional Shortage Area, Medically Underserved Area, or Medically Underserved Population.

Despite the challenges in hiring immigrant health care workers in hospitals and health systems, our members are increasing their efforts to utilize this resource to help alleviate some of the staffing shortages, especially in rural and underrepresented areas. A [study](#) published in JAMA last year looked at the characteristics of non-U.S.-born health care professionals (HCPs) and found that “Overall, non-U.S.-born HCPs worked more hours, were more likely to work at night and in skilled nursing and/or home health settings, and were more likely to reside in medically underserved areas than U.S.-born HCPs ... These findings suggest that non-U.S.-born HCPs are making significant contributions to health care in the U.S.” The study also noted that immigrants contribute to the racial and ethnic diversity of the U.S. health care workforce.

## **AHA ADVOCACY**

In spring of 2021, the U.S. State Department announced a new visa prioritization system that relegated nurses and health professionals to the last tier. In June of last year, in the midst of the COVID-19 pandemic, the AHA [urged](#) the State Department to give foreign-trained nurses seeking immigrant visas priority for processing to address the backlog of immigrant visas for eligible FENs. This effort resulted in a new directive to U.S. embassies and consulates in September 2021 to prioritize “as emergencies on a case-by-case basis the immigrant visa cases of certain health care professionals who will work at a facility engaged in pandemic response.” Thus health care staff who planned to work at a facility engaged in COVID-19 response and had an approved U.S. immigrant visa petition, with a current priority date for an Immediate Relative, Family Preference, or Employment-Based Preference case, could request an emergency visa appointment. By November 2021, the State Department [rescinded](#) the tier-based prioritization system and gave embassies and consulates “broad discretion” to determine how to organize visa appointments. The November directive, as well as proactive efforts by consulates in countries such as the Philippines from which a majority number of nurses enter the U.S., have helped alleviate some of the backlogs in processing nurse visas. But the challenges remain.

## **POLICY RECOMMENDATIONS**

The slow processing of immigrant visas for foreign-trained nurses exacerbates the nation’s workforce shortages. The AHA believes the State Department and its National Visa Center, along with the U.S. Department of Homeland Security’s U.S. Customs and Immigration Service (USCIS), can and should alleviate this situation by ensuring efforts are made to prioritize and expedite the visa issuance process for eligible nurses. We ask Congress to work with the State Department and USCIS to achieve this goal. We also would ask Congress to consider the following legislative initiatives to improve the immigration process for health care workers:

- Pass the bipartisan Healthcare Workforce Resilience Act (S.1024/H.R. 2255), which would make up to 40,000 unused visas available to nurses and physicians who petition for such a visa up to 90 days after the end of the COVID-19 PHE. We would encourage the modification of this legislation to allow the visas to be available beyond the PHE.
- Reauthorize and make improvements to the Conrad 30 program. We support The Conrad State 30 and Physician Access Reauthorization Act (S. 1810/H.R. 3541) that reauthorizes the program for three years, increases state allocations to 35 physicians per year and provides flexibility to expand the number of waivers in states where demand exceeds that limit.
- Support the visa recapture provisions included in the fiscal year (FY) 2023 DHS Appropriations Act (H.R. 8257/S. 4678) that allow unused employment- and family-based visas from FYs 1992-2022 to remain available in FY 2023.

In addition to the suggestions outlined above, we encourage Congress to help address domestic health care workforce shortages by:

- lifting the cap on Medicare residency positions, as well as addressing the shortages of substance use disorder treatment providers by adding 1,000 Medicare-funded training positions in approved residency programs in addiction medicine, addiction psychiatry or pain medicine;
- providing resources to increase nursing student and faculty populations, as well as support educational programming at schools of nursing;
- providing continued and increased funding for the Health Resources and Services Administration's title VII and VIII programs, including the health professions program, the National Health Service Corps and the nursing workforce development program, which includes loan programs for nursing faculty; and
- expanding the loan program to allied professionals and targeting support for community college education to programs that help address health care workforce shortages.

Finally, we appreciate Congress enacting earlier this year the AHA-supported Dr. Lorna Breen Health Care Provider Protection Act, which aims to prevent suicide, burnout and behavioral health disorders among health care professionals. We encourage Congress to provide robust funding for these programs during the appropriations process for FY 2023.

Thank you for this opportunity to submit comments to the Subcommittee. Our hospital and health systems look forward to working with you to improve and sustain the health care workforce so that we can continue to serve all of our patients and communities.