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The Integration of Immigrant Health Professionals

Looking beyond the COVID-19 Crisis

ISSUE BRIEF

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Executive Summary

On March 11, 2021, the one-year anniversary of the World Health Organization (WHO) declaring the COVID-19 outbreak a pandemic, a grim new record was set: 29.1 million Americans had tested positive for the coronavirus and nearly 530,000 had died. The constant, year-long battle against the virus has stretched the capacity of the U.S. health-care system in unprecedented ways. Hospitals across the country have been overwhelmed, and high levels of stress and burnout among health service providers have led some to close their practices and opt for early retirement. The pandemic has also fallen much harder on already disadvantaged and vulnerable populations—racial and ethnic minorities, people with limited English proficiency, low-income families, and the uninsured.

But crises offer opportunities as well as challenges. During the first wave of the pandemic, in March and April 2020, several states adopted emergency measures to rapidly expand the number of health-care workers and inject flexibility into health systems. One innovative strategy was to create pathways for internationally trained health professionals to be licensed and practice. The policies represented a unique opportunity for underemployed immigrants and refugees with degrees in health and medicine to join the fight against the pandemic—at least in theory, given the obstacles that continue to prevent many from doing so. The Migration Policy Institute (MPI) has estimated that, before the pandemic began, there were approximately 270,000 immigrant and refugee health professionals either employed in jobs that require no more than a high school education or out of work. This untapped pool of health-care workers is part of a broader trend of brain waste that has seen many high-skilled immigrants unable to practice in their chosen professions and kept U.S. communities from fully benefitting from their expertise.

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How can these immigrant and refugee health professionals' skills be leveraged more strategically to tackle the most immediate challenges brought by the pandemic? And thinking beyond the public-health crisis, how can these professionals—who bring both technical knowledge, and linguistic and cultural skills—become a resource in a health-care system that lacks diversity and that faces both staffing shortages and geographic mismatches? This

issue brief, which draws on rich discussions with medical and public-health professionals, hospital administrators, labor market and health policy experts, and representatives of organizations promoting the integration of immigrant professionals, explores key trends and policy opportunities that include:

- Members of racial and ethnic minority groups, many of whom are from immigrant families, have disproportionately high rates of coronavirus infection, hospitalization, and death compared to their White counterparts. Evidence also suggests that access to vaccines has been uneven, despite many states' efforts to ensure racial equity.
- Employment in health services during the pandemic has been more volatile than in the past, but the sector has already begun to rebound from the heavy job losses seen in Spring 2020. In fact, demand for some health professionals—including mental-health and public-health specialists, as well as doctors and nurses—has grown.
- Long-term trends such as population aging and the retirement of large numbers of older health-care professionals may lead to future shortages of health-care workers. And while the U.S. health workforce is already much less diverse than the population it serves, this mismatch is particularly glaring as the nation's racial and ethnic minority populations are growing much more quickly than the White population.
- The professional, language, and cultural skills of internationally trained health professionals represent critical resources during the COVID-19 crisis and beyond. These professionals could join the strained U.S. health workforce at many different levels, ranging from physicians and nurses to contact tracers to those working to maximize vaccine receipt. Temporary licenses could also enable them to provide health services to underserved populations, such as immigrant-origin and rural communities. Yet many state efforts to rapidly employ internationally trained health professionals during the public-health crisis have hit up against long-standing barriers to entering the field; these experiences could present learning opportunities and drive home the importance of addressing this issue. The Biden administration could also consider strategies to make the integration of immigrant health-care professionals a focus of the new White House Task Force on New Americans.

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While problems of the limited supply of health-care workers and unequal access to care among disadvantaged populations existed before the COVID-19 outbreak, the pandemic has exacerbated these trends. The ongoing crisis offers an opportunity to rethink how to create a more flexible, resilient workforce that can nimbly respond to both short- and longer-term needs. Improving credentialing and employment opportunities for underemployed, internationally trained health-care professionals who are already part of communities across the nation is an important part of meeting the current and future challenges facing the U.S. health-care sector.

1 Introduction

The first wave of the COVID-19 pandemic and the economic crisis it triggered hit the United States with full force in March 2020. One year on, the nation had seen 29.1 million Americans test positive and suffered close to 530,000 deaths.[1] Even though the number of new cases is on the decline and the number of vaccine doses being administered daily was close to 2.5 million as of mid-March,[2] epidemiologists are wary of claiming a premature victory as new variants of the virus are spreading rapidly in the United States. Throughout the year, powerful images of health-care workers under incredible strain have come not only from the early epicenters, such as New York City and Seattle, but from urban and rural communities across the country.

Looking at the pandemic through both a public-health and an immigrant integration policy lens, the crisis has vividly illustrated two challenges facing the U.S. health-care sector. First, there is a significant population of internationally trained health professionals (and even some U.S.-trained professionals) who could contribute to meeting the health emergency's demands, but who are unemployed or working in low-skilled jobs.[3] This includes about 270,000 underemployed or out-of-work immigrant and refugee health professionals, according to Migration Policy Institute (MPI) estimates using 2019 data from the U.S. Census Bureau.[4] Second, the pandemic has highlighted the fact that the language and cultural skills many of these health professionals have could help bridge glaring gaps in the health-care workforce.

While the challenges brought by the pandemic are urgent and require immediate attention, other powerful drivers of supply and demand are shaping the health sector's future. These include the aging of the U.S. population, which will increase demand for certain types of care, and the upcoming retirement of many health-care professionals. Considering these trends, two questions present themselves: How will pre-pandemic and COVID-19-related trends influence the demand for and availability of health-care workers in the United States? And where do the 270,000 immigrant and refugee health workers whose skills are underutilized fit in efforts to meet that demand? To explore these questions, this issue brief draws on insights from a series of interviews, followed by a forum,[5] with more than 50 medical and public-health professionals, hospital administrators, labor market and health policy experts, and representatives of organizations that promote the integration of immigrant professionals.

2 The COVID-19 Crisis and Its Disparate Impacts on U.S. Communities

The coronavirus crisis, like many other public-health crises and disasters, has exposed and deepened social inequalities. Racial and ethnic minority communities, people not fully proficient in English, and rural communities have endured disproportionately high rates of infection, hospitalization, and death.

Take, for example, Washington State, one of the pandemic's first epicenters. As of mid-February 2021, Latinos—many of whom are from immigrant families—were being hospitalized at a rate five times that of non-Latino Whites. And the death rate among Latinos in the state was three times higher than among White residents.[6] Washington State is not an outlier. Data from the Centers for Disease Control and Prevention (CDC) have shown that, nationwide, Latinos and Blacks are roughly three times more likely to be hospitalized and twice as likely to die from the virus as Whites.[7] Multiple studies have also shown how the pandemic has disproportion-

ately affected Latinos and other racial and ethnic minority groups nationally and across most states,[8] with high rates of infection and death among Blacks, American Indians, Native Hawaiians, and Pacific Islanders.[9] While the number of vaccines administered each day is picking up speed across the country, early evidence suggests that vaccination rates are also lower among racial and ethnic minority groups.[10] Existing urban-rural disparities in health care have also been made highly visible by the pandemic. During a surge in infections in mid-Fall 2020, for example, rural areas were seeing more cases per capita than urban centers.[11]

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These disparate outcomes along racial, ethnic, and geographic lines owe to multiple layers of vulnerability and exposure. Among the factors at play are populations' levels of education, English proficiency, income and wealth, housing, access to health insurance and health-care facilities, pre-existing health conditions, and discrimination.[12]

The jobs people have matter as well. Immigrants and members of racial and ethnic minorities are more likely to be employed in agriculture, food production, grocery stores and delivery, and public transportation.[13] These jobs, while essential to the pandemic response, are much less likely to come with paid sick leave and offer few opportunities for remote work. Immigrant and racial and ethnic minority health-care workers' exposure to the virus is also higher because many work multiple jobs, often in high-risk settings such as nursing homes, emergency medicine, and as home health-care providers. So, while nurses of color accounted for 24 percent of all U.S. registered nurses, they represented 58 percent of the 213 nurses who had died from the coronavirus as of mid-September 2020.[14]

3 The Pandemic's Impact on Demand and Supply for Health-Care Workers

Before 2020, the health-care sector stood out for its strong growth during both robust and weak periods for the overall U.S. economy. At least initially, COVID-19 altered this long-standing trend. At the outset of the pandemic, intense demand for frontline health-care workers to fight new outbreaks of COVID-19 left hospital staff in short supply. States tried to meet this demand by calling in retired doctors, nurses, and other health professionals; tapping early graduates of medical schools; and easing entry for internationally trained health professionals.[15] But state bans on elective procedures and the lockdowns on nonessential businesses that followed led to a precipitous drop in the number of patients coming to private medical offices and community clinics. Between January and April 2020, the health services sector lost 1.4 million jobs, and employment in the sector has only partially recovered since then.[16] In addition, the surge in cases in October and November 2020 and accompanying concerns about staff's personal health, lack of protective equipment, and an unstable flow of patients have forced some small practices to close or some physicians and nurses in these practices to opt for early retirement.[17]

Since March 2020, as cases of infection and hospitalization accelerated across the country, the outbreak had seemingly contradictory impacts on the supply and demand of health-care providers. On the one hand, it has meant that many hospitals across the country—more than one in five by one account[18]—have faced shortages of doctors, nurses, and therapists. On the other hand, frontline health workers

are burning out and leaving the field, while other health providers are struggling to keep their practices afloat.

COVID-19 has thrown other health-care workforce issues into sharp relief. These include high levels of demand not just for physicians and nurses, but for public- and mental-health professionals as well as other specialists. Stress levels across the U.S. population have been high, with children and teens, elders, and people with pre-existing mental-health issues among the most vulnerable.[19] Health-care providers themselves have suffered the coronavirus' mental and physical toll, driven by more intense workloads, higher levels of stress, and poor organizational support for workers.[20] For example, a Medscape survey of nearly 7,500 physicians from the United States and seven other countries in June and July 2020 found that 64 percent of U.S. participants reported a higher level of burnout since the pandemic's start.[21]

The pandemic has also shed light on issues of underfunding within the public-health sector, whose professionals seek to prevent disease outbreaks in communities, track them if they spread, develop interventions, and educate community members about health and wellness. The massive, COVID-19-related expansion of demand for contact tracers, for example, at least initially outstripped available state and local funding.[22]

The challenges COVID-19 created or elevated across the public- and mental-health sectors go well beyond staffing shortages. Often, it is a question of not only ensuring that skilled workers are available, but also that they are representative of the communities they serve, sharing their languages and cultural experiences. These linguistic and cultural assets can improve the quality of care and help health-care workers earn the trust of their patients—something that is particularly vital now that vaccines have become available and trusting relationships can help those who are skeptical or fearful of being vaccinated understand the process and the vaccines' safety and effectiveness. At each turn, underemployed internationally trained health professionals can contribute.

4 The Impact of Other Macrotrends on Demand for Health-Care Workers

The dramatic changes to the health-sector workforce brought about by the pandemic have overshadowed, at least temporarily, macrotrends that have been underway for several decades. Yet many of these trends remain important and will continue to shape future demand for health-care professionals. One such trend is the aging of the U.S. population.[23] By 2030, every Baby Boomer will be age 65 or older, meaning that one in five U.S. residents will be of retirement age.[24] Leaving aside the thorny question of how to pay for health-related costs for a swelling senior-citizen population, it remains unclear whether the country will have an adequate supply of providers of primary, home-based, and long-term care.

Another trend shaping the supply of health-care professionals during the crisis and beyond is the retirement of health-care workers. As of 2019, about 20 percent of practicing physicians, registered nurses, and home health aides were ages 55 to 64, as were 10 percent of physician assistants.[25] Within the next decade, these professionals will reach retirement age. The Association of American Medical Colleges estimates a shortage of approximately 122,000 physicians by 2032 as demand outpaces supply.[26]

A third macrotrend affecting the health-care field is related to the growing diversity of the nation's population and the many equity issues facing communities across the country. The U.S. population in general, including older adults, is becoming more racially and ethnically diverse. Blacks, Latinos, Pacific Islanders, and Native Americans continue to suffer from

structural inequities, including more limited access to health services than White Americans, leading to worse health outcomes.[27] But while these populations are growing much more quickly than the non-Latino White population, they remain woefully underrepresented within the health workforce and among medical students. For example, as of 2019, less than 13 percent of practicing U.S. physicians were Black, Hispanic, or Native American, compared to 33 percent of the U.S. population.[28]

Spatial mismatches also contribute to disparities in health services and outcomes. Health outcomes vary widely across the country, with rural communities and urban areas with large minority populations having especially high levels of death and illness and low life expectancies.[29] In 2013, there were 55 primary-care physicians per 100,000 rural residents versus 79 per 100,000 urban residents.[30] And while 20 percent of the U.S. population lives in rural communities, only 11 percent of physicians practice there.[31] Internationally trained doctors have long been an important source of care in these medically underserved communities.[32]

These enduring trends in supply and demand are likely to be further shaped by the pandemic, which is altering retirement patterns, licensure rules, reimbursement policies, and how care is delivered. COVID-19 has already dramatically increased the use of telehealth—medical appointments conducted in real time via video or telephone—both for practical and safety reasons during the pandemic, and because patients have been more frequently and fully reimbursed for such visits.[33] In some cases, physicians licensed in one state can even provide services via telehealth to patients in another, at least during the health emergency. In 2019, 11 percent of U.S. consumers used telehealth. This share more than quadrupled (to 46 percent) by the end of April 2020.[34] Even though the number of in-person medical visits increased during the summer, more than 80 percent of respondents in a December 2020 survey said that they had ever used telehealth, and most said they planned to use telehealth after the pandemic.[35]

5 What Has the Pandemic Taught Us So Far?

In Spring 2020, the governors of six states (Colorado, Massachusetts, Michigan, New Jersey, New York, and Nevada) and two state health departments (those in Idaho and Pennsylvania) used their executive authority to temporarily suspend or adjust licensing requirements to boost the ranks of available workers in health services. One group targeted by these policies was internationally trained professionals. The emergency orders adopted by states during the first wave of the pandemic represented a policy breakthrough of sorts. In theory, they embodied a greater acceptance of reciprocity and a loosening of the hardened arteries of licensing systems that remain barriers to many internationally trained high-skilled workers in health and other licensed professions applying their skills in the United States.

The emergency orders adopted by states during the first wave of the pandemic represented a policy breakthrough of sorts.

Several lessons can be derived from these state initiatives. In the first place, their implementation highlighted many enduring challenges. For example, in response to health-care staffing shortfalls the International Rescue Committee created a registry in mid-April 2020 in which internationally trained health professionals could post their availability and willingness to travel for work. But after six months, the registry had seen rather limited success in placing the 645 self-registered applicants.[36] The main roadblocks encountered were in many ways predictable, given they have long affected health

professionals with international credentials.[37] They included the fact that international licenses were often insufficient to get hired, and that the expenses, time, and effort associated with obtaining a license to practice in the United States can be prohibitive for many.

Some of these same challenges could be seen in a New Jersey program that was launched in Spring 2020 to recruit foreign physicians with licenses that were valid in other countries. The program, which is considered one of the more successful emergency-driven initiatives, had received 1,100 applications as of November 2020.[38] However, by late Fall 2020, fewer than 45 physicians had gained a license to practice in the state, and it was unclear how many participants who had been approved to practice had been placed in a health-care position. One lesson from this experiment is that licensing criteria can easily become rigid to the point of preventing otherwise qualified professionals from providing care even in the face of great need. A particularly limiting constraint for immigrants and refugees in the New Jersey program was a requirement that physicians have at least five years of practical experience and that they must have practiced for at least one out of the last five years. Another type of barrier can be seen in Colorado, where efforts to extend licenses to international medical graduates were stymied by a requirement that these professionals carry malpractice insurance, which is expensive and unduly burdensome if the license allowing them to practice during the pandemic is only temporary.[39]

Idaho found itself in a relatively unique situation. Unlike the other seven states taking emergency action, Idaho already had a law in place that allows physicians with valid licenses from other countries or other U.S. states to practice in the state during emergencies (the *Idaho Medical Practice Act*). The Idaho State Board of Medicine invoked this law on March 18, 2020, following the governor's emergency declaration the week prior.[40] According to the Board of Medicine, 11 internationally trained physicians registered with it between the beginning of the COVID-19 emergency and mid-November 2020.[41] And the number to start practicing in the state may be even higher as physicians who begin practicing under this emergency provision are not required to register with the board. The board also noted that, as of late 2020, it had not received any complaints from patients in Idaho about the care they received from the internationally trained and out-of-state physicians who had registered and started practicing in the state.

Opportunities for the Future

One opportunity to bolster the public-health workforce and promote the integration of internationally trained health professionals is to encourage them to join the expanding corps of contact tracers. But to see these new recruits become part of the public-health sector on more than a short-term basis, work as a contact tracer needs to provide a pathway to a public-health career and/or the experience gained as a tracer could be counted for those individuals seeking a license in their original profession. In Spring 2020, Illinois responded to the need for more contact tracers by creating positions within local health departments, in coordination with the Illinois Department of Public Health, rather than by contracting them out.[42] This step put contact tracers in a position to potentially fill other public-health workforce needs.

Looking to the federal government, the Biden administration might consider several immigrant integration strategies that expand access to licensed professions for internationally trained health professionals. For example, it could provide leadership on this issue by putting the underemployment of immigrant and refugee health-care professionals on the agenda of the White House Task Force on New Americans.[43] The federal government could also provide funding to organizations with a strong record of promoting the integration of internationally trained

health professionals along the lines of what was set out in the *Professional's Access to Health (PATH) Workforce Integration Act*, sponsored by Congresswoman Lucille Roybal-Allard in 2018.[44] Or, it could provide federal grants that encourage states to establish administrative options for temporarily waiving state licensing requirements during emergencies, as the *Idaho Medical Practice Act* does. The Biden administration, which plans to expand the U.S. refugee resettlement program, could also promote strategies to help refugee health-care professionals access careers in the health sector to enable them to serve refugee and other immigrant-origin communities. Finally, the administration might consider increasing the flexibility of H-1B visas to allow health-care professionals in the United States to work at multiple locations or in multiple positions during health emergencies without filing amended petitions.

An additional impetus for fresh thinking on rapid credentialing and employment of underutilized health-care professionals, immigrant and U.S. born alike, could be the *American Rescue Plan Act of 2021*. Signed into law in mid-March 2021, the act's $1.9 trillion relief package includes significant funding opportunities to boost the public-health and mental-health workforce to fight the pandemic.[45] Demand for health-care services and practitioners may also rise with the increases in access and affordability of the health-care services afforded by the new legislation.

6 Conclusions

The difficult—and even dire—position of health-care systems in many states during the COVID-19 pandemic has underscored the fundamental need to ensure these systems are sufficiently flexible to meet the demands of public-health crises and other disasters. They must also be responsive to underlying macrotrends that are driving demand for health-care workers: the aging of the U.S. population, the retirement of large numbers of older health-care workers, spatial disparities between where care is needed and where it is available, and the growing diversity of the U.S. population. These trends point to the need for a health-care workforce that is employed across a wide range of specialties and that is as linguistically and culturally diverse as the communities it serves.

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The COVID-19 crisis has drawn renewed attention to the underutilized skills of close to 270,000 immigrants and refugees across the country who have four-year college degrees in health or medicine but are either working in low-skill jobs or out of work. While the state initiatives introduced in Spring 2020 appear to have had only limited success in expanding internationally trained health professionals' access to work in U.S. health-care systems, it could be argued that they represent a shift toward increased tolerance for reciprocity between U.S. and internationally earned health credentials and an increased desire to address the constraints that keep many internationally trained health professionals from practicing in the United States. These state initiatives can also be seen as helpful pilots on the way to deeper, more expansive reforms. They may also hold lessons for other licensed professions that are inaccessible to high-skilled immigrant professionals. Efforts to address licensing, placement, training, and educational barriers will primarily need to be implemented at the state level—where these powers are lodged—but the federal government can step in by providing leadership and funding for reforms.

Endnotes

1 Centers for Disease Control and Prevention (CDC), "Trends in Number of COVID-19 Cases and Deaths in the US Reported to CDC, by State/Territory," accessed March 16, 2021.
2 *The New York Times*, "See How the Vaccine Rollout Is Going in Your State," updated March 17, 2021.
3 Within this broader population of underemployed internationally trained health-care workers are some U.S.-born as well as immigrant and refugee professionals who earned degrees abroad. For a discussion of the challenges many of these professionals face, see Emma Goldberg, "'I Am Worth It': Why Thousands of Doctors in America Can't Get a Job," *The New York Times*, February 23, 2021.
4 Authors' analysis of data from the U.S. Census Bureau's 2019 American Community Survey (ACS).
5 The agenda for this October 2020 forum can be found on the Migration Policy Institute (MPI) website. See MPI, "Demand for Health-Care Workers during the COVID-19 Pandemic and Beyond: Where Do Immigrants and Refugees Fit In?" (meeting agenda, MPI, October 7, 2020).
6 Washington State Department of Health, *COVID-19 Morbidity and Mortality by Race, Ethnicity and Spoken Language in Washington State* (Shoreline, WA: Washington State Department of Health, 2021), 1–20.
7 CDC, "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity," updated February 18, 2021.
8 Daniel Wood, "As Pandemic Deaths Add Up, Racial Disparities Persist — And in Some Cases Worsen," NPR, September 23, 2020.
9 Pacific Islander Center of Primary Care Excellence, "Pacific Islander COVID-19 Response Team," updated January 6, 2021; Eva Clark, Karla Fredricks, Laila Woc-Colburn, Maria Elena Bottazzi, and Jill Weatherhead, "Disproportionate Impact of the COVID-19 Pandemic on Immigrant Communities in the United States," *PLOS Neglected Tropical Diseases* 14, no. 7 (2020): e0008484; Don B. Geno Tai, Aditya Shah, Chyke A. Doubeni, Irene G. Sia, and Mark L. Wieland, "The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States," *Clinical Infectious Diseases* 72, no. 4 (2021): 703–06; Karthik Sivashanker, Tam Duong, Shauna Ford, Cheryl Clark, and Sunil Eappen, "A Data-Driven Approach to Addressing Racial Disparities in Health Care Outcomes," *Harvard Business Review*, July 21, 2020.
10 Nambi Ndugga, Olivia Pham, Latoya Hill, Samantha Artiga, and Salem Mengistu, "Early State Vaccination Data Raise Warning Flags for Racial Equity," Kaiser Family Foundation, January 21, 2021.
11 Katheryn Houghton, "COVID Spikes Exacerbate Health Worker Shortages in Rocky Mountains, Great Plains," Kaiser Health News, October 26, 2020.
12 Neeta Thakur, Stephanie Lovinsky-Desir, Christian Bime, and Juan P. Wisnivesky, "The Structural and Social Determinants of the Racial/Ethnic Disparities in the U.S. COVID-19 Pandemic. What's Our Role?" *American Journal of Respiratory and Critical Care Medicine* 202, no.7 (2020): 943–49; Lisa C. Diamond, Elizabeth A. Jacobs, and Leah Karliner, "Providing Equitable Care to Patients with Limited Dominant Language Proficiency amid the COVID-19 Pandemic," *Patient Education and Counseling* 103, no. 8 (2020): 1451–52; Roni Caryn Rabin, "The U.S. Surpasses 11 Million Infections; Black and Latino Americans Still Shoulder an Outsize Share," *The New York Times*, December 23, 2020; Samantha Artiga, "Growing Gaps in COVID-19 Vaccinations among Hispanic People," Kaiser Family Foundation, February 22, 2021.
13 Julia Gelatt, *Immigrant Workers: Vital to the U.S. COVID-19 Response, Disproportionately Vulnerable* (Washington, DC: MPI, 2020).
14 National Nurses United, *Sins of Omission: How Government Failures to Track COVID-19 Data Have Led to More than 1,700 Health Care Worker Deaths and Jeopardize Public Health* (Silver Spring, MD: National Nurses United, 2020).
15 Jeanne Batalova, Michael Fix, and Sarah Pierce, *Brain Waste among U.S. Immigrants with Health Degrees: A Multi-State Profile* (Washington, DC: MPI, 2020).
16 U.S. Bureau of Labor Statistics, "Employment by Industry, Monthly Changes—Employment Change by Industry, December 2020, Seasonally Adjusted, 1-Month Net Change," accessed January 13, 2021.
17 Reed Abelson, "Doctors Are Calling It Quits under Stress of the Pandemic," *The New York Times*, November 25, 2020.
18 Alexis C. Madrigal, "Hospitals Can't Go on Like This," *The Atlantic*, November 17, 2020.
19 Nirmita Panchal, Rabah Kamal, Cynthia Cox, and Rachel Garfield, "The Implications of COVID-19 for Mental Health and Substance Use" (issue brief, Kaiser Family Foundation, Washington, DC, February 2021).
20 Luca A. Morgantini et al., "Factors Contributing to Healthcare Professional Burnout during the COVID-19 Pandemic: A Rapid Turnaround Global Survey," *PLoS ONE* 15, no. 9 (2020): e0238217.
21 Medscape, "U.S. and International Physicians' COVID-19 Experience Report: Risk, Burnout, Loneliness," accessed February 22, 2021.
22 Lois Parshley, "The Magnitude of America's Contact Tracing Crisis is Hard to Overstate," *National Geographic,* September 1, 2020.
23 University at Albany, School of Public Health, Center for Health Workforce Studies, *The Impact of the Aging Population on the Health Workforce in the United States: Summary of Key Findings* (Rensselaer, NY: University at Albany, 2006); Merritt Hawkins, *The Aging Physician Workforce: A Demographic Dilemma* (Irving, TX: Merritt Hawkins, 2015); William A. Haseltine, "Aging Populations Will Challenge Healthcare Systems All over the World," *Forbes*, April 2, 2018.
24 Andrew Meola, "The Aging Population in the U.S. is Causing Problems for Our Healthcare Costs," *Business Insider*, July 18, 2019.
25 Authors' analysis of data from the 2019 ACS.
26 Association of American Medical Colleges, "New Findings Confirm Predictions on Physician Shortage" (press release, April 23, 2019).

27 National Academies of Sciences, Engineering, and Medicine, *Future Directions for the Demography of Aging: Proceedings of a Workshop* (Washington, DC: The National Academies Press, 2018); National Academies of Sciences, Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: The National Academies Press, 2003).
28 Authors' analysis of data from the 2019 ACS; American Medical Association, "New Policy Aimed at Increasing Diversity in Physician Workforce" (press release June 12, 2019).
29 Robin Warshaw, "Health Disparities Affect Millions in Rural U.S. Communities," Association of American Medical Colleges, October 31, 2017; Paola Scommegna, Mark Mather, and Lillian Kilduff, "Eight Demographic Trends Transforming America's Older Population," Population Reference Bureau, November 12, 2018.
30 Warshaw, "Health Disparities Affect Millions."
31 Peter Jaret, "Attracting the Next Generation of Physicians to Rural Medicine," Association of American Medical Colleges, February 3, 2020.
32 American Immigration Council, "Foreign-Trained Doctors Are Critical to Serving Many U.S. Communities," accessed March 22, 2021; Nicole Fisher, "Midwest Diagnosis: Immigration Reform and the Healthcare Sector," *American Journal of Medical Research* 3, no. 2 (2016): 84–114.
33 Marc Zarefsky, "5 Huge Ways The Pandemic Has Changed Telemedicine," American Medical Association, August 26, 2020.
34 Oleg Bestsennyy, Greg Gilbert, Alex Harris, and Jennifer Rost, "Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?" McKinsey & Company, May 29, 2020; Bart Astor, "After Covid-19: A Health Care Forecast for Older Americans," *Forbes*, July 28, 2020.
35 Elise Reuter, "Poll: Most Americans Plan to Use Telehealth after the Pandemic," MedCityNews, January 6, 2021.
36 Participant comments during the MPI teleforum "Demand for Health-Care Workers during the COVID-19 Pandemic and Beyond: Where Do Immigrants and Refugees Fit In?" October 7, 2020.
37 Linda Rabben, *Credential Recognition in the United States for Foreign Professionals* (Washington, DC: MPI, 2013).
38 Participant comments during the MPI teleforum "Demand for Health-Care Workers."
39 Participant comments during the MPI teleforum "Demand for Health-Care Workers."
40 Idaho State Board of Medicine, "Idaho State Board of Medicine Proclamation" (proclamation, March 13, 2020); Idaho State Board of Medicine, "Frequently Asked Questions – COVID-19," accessed July 19, 2020.
41 Authors' correspondence with Anne K. Lawler, Executive Director of the Idaho State Board of Medicine, November 18, 2020. As of mid-November, altogether there were about 1,350 physicians and a few physician assistants who were not licensed in Idaho who requested to provide care in the state during the COVID-19 pandemic, including 11 internationally trained physicians.
42 NBC Chicago, "Want to Become a Contact Tracer in Illinois? Here's How to Apply," NBC Chicago, May 18, 2020.
43 On February 2, 2021, President Biden issued an executive order calling for the establishment of a Task Force on New Americans—one of many efforts by the Biden administration to undo its predecessor's policy focus and rhetoric regarding immigrants and their integration. See White House, "Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans" (executive order, February 2, 2021).
44 Congressional Office of Lucille Roybal-Allard, "Rep. Roybal-Allard Reintroduces PATH Act to Integrate Internationally Trained Health Professionals into U.S. Health Workforce" (press release, May 22, 2018).
45 Katie Keith, "Final Coverage Provisions in the American Rescue Plan and What Comes Next," Health Affairs, March 11, 2021; American Public Health Association, "APHA Applauds Passage of American Rescue Plan Act of 2021 as a Step Toward Healing and Recovery" (press release, March 10, 2021).

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This issue brief is part of a larger, ongoing effort by the Migration Policy Institute (MPI) to explore the ways in which U.S. immigration and immigrant integration policies can promote not only immigrant well-being, but also the economic growth of the communities in which immigrants live, the sectors in which they work, and the nation more broadly. Related forthcoming publications will explore: (1) national and state-level trends in underemployment among highly skilled immigrants, and (2) the underemployment of highly skilled immigrants in Illinois and the Chicago metropolitan region.

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