

Subcommittee on
Immigration, Citizenship, Refugees, Border Security, and International Law

Hearing on the Need for Green Cards for Highly Skilled Workers

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Chairman Lofgren and Members of the Committee:

My name is Mary Amundson and I am an assistant professor at the Center for Rural Health, University of North Dakota School of Medicine and Health Sciences in Grand Forks, North Dakota. Thank you for allowing me to provide testimony on the Conrad State 30 program which helps to address a vital issue facing not only rural America but also urban areas across the country as well.

I have been working in the area of physician recruitment and retention for the past nineteen years, working with communities and health care providers to improve access to primary care services through a variety of federal and state programs.

Access to health care is a fundamental issue facing America's rural citizens. Rural Americans account for approximately one-fourth of the U.S. population; however, only about 10 percent of the physicians practice in rural areas. Rural communities in North Dakota, and throughout the country, are experiencing the closing of essential access points such as rural primary care clinics, home health care services, and even rural ambulances. The health care safety-net for rural America is threatened and the health status of rural Americans is compromised. Rural Americans do not seek unnecessary services, they do not seek more than what they need; they do however, expect that their legitimate access to health care services are commensurate with meeting the service needs of populations in more urban settings.

The Conrad J-1 Visa Waiver Program initiated in 1994 has been a very important program not only for North Dakota but for all 50 States and the District of Columbia. The amendments proposed in this new legislation will increase the supply of physicians to underserved areas all across the country.

Physician shortages are not unique to North Dakota but are evident in all 50 states and the District of Columbia. The demand for primary care physicians, especially the specialties of family medicine and general surgery is at an all time high. For example, the American Academy of Family Physicians (2008) notes a steady decline in the number of students choosing family medicine from 1997 – 2007. Today's medical students who are tomorrow's physicians, are not choosing primary care due, in part, to life style and income which negatively impacts access to care for those citizens living in rural areas where the shortage of providers is most evident. "Departing from past reports, the 16th Report to Congress from the Council on Graduate Medical Education (COGME) report warns of a physician deficit of 85,000 by 2020 and recommends increases in medical school and residency output"¹. Added to this dilemma is the fact that, according to the American Medical Association, 250,000 active physicians will retire by 2020.

¹ COGME's 16th Report to Congress: Too Many Physicians Could Be Worse Than Wasted . Robert L. Phillips, Jr, MD, MSPH¹, Martey Doodoo, PhD¹, Carlos R. Jaén, MD, PhD² and Larry A. Green, MD¹

In 2004, the U.S. Department of Health and Human Services reported that 34.9 million Americans live in federally-designated health professional shortage areas where there is less than one primary care physician for every 2,000 persons in urban, suburban, and rural areas. Nationally, 67 percent of the non-metropolitan areas in the U.S. are located in federally designated Health Professional Shortage Areas. By way of example, in North Dakota, 81 percent of the state is located in Health Professional Shortage Areas. Further, 91 percent of the state is located in Medically Underserved Areas which are also eligible areas for the Conrad Program².

Health provider need is determined by the number of vacancies or job openings. For example, on a recent survey of health care facilities in North Dakota, 46 percent of our health care facilities (32/69) reported vacancies for family medicine or internal medicine physicians. Of the facilities recruiting these providers, 73 percent of the sites were located in underserved areas.

If it were not for the Conrad J-1 Visa Program, I can assure you that more of our rural health care facilities all across the country would be closed today. For example, the health care facility in Crosby, ND, a town of about 1,000 people, utilized this program starting in 1995. From 1995-2005, the community recruited five physicians through this program that sustained their health care services. These physicians allowed the continuation of services to the citizens of Crosby until a U.S. physician was finally recruited to the community this past year. The Conrad Program provided a much needed bridge to services until a more permanent physician could be found. Scenarios like these can be cited in communities all across the nation particularly in the Midwest and West.

Although there is a call from the Association of American Medical Colleges to increase medical school class size, this will take time which our fragile rural health care systems don't have; our health care systems simply won't survive. Immediate policy solutions to the physician shortage problem are needed today.

The initial legislation enacted by Congress in 1994 provided a much needed resource to aid communities in recruiting providers; however, due to a decrease in the number of physicians entering training on the J-1 Visa, changes are needed. The Conrad 30 program has been very successful in providing 5,732 waivers from 2001 – 2007 and the proposed amendments by Senator Conrad will make it even stronger.

As I have stated, the Conrad 30 program is essential in increasing and assuring access to care for millions of Americans and we are appreciative of this program. However, advocating for its re-authorization every two years is precarious for these Americans. Consequently, the proposed legislation that makes the program permanent is extremely important to stabilizing health care services.

States are seeing a steady decline in the number of J-1 physicians applying for Conrad waivers from a high of 1,033 in 2003 to 866 waivers in 2007³. This decline is due to the increase in the

² Medically Underserved Areas are calculated based on population density, infant mortality/low birth-weight, provider ratios, and percent elderly

³ Texas Primary Care Office, Conrad 30 Program and from the GAO Report released in November 2007.

number of physicians entering the country on H-1B Visas. These visas do not require service to the underserved; these physicians simply need an employer. Policy changes need to be included that address the H-1B visa issue.

The Conrad State 30 Improvement Act proposes five principal reforms to the Conrad program. First, the Conrad State 30 Improvement Act would make the program permanent. Second, the act would allow physicians on H-1B visa to obtain a Conrad 30 waiver slot in return for a three-year service obligation in a federally designated shortage area. Third, the act would offer a green card cap exemption for physicians who have completed the Conrad 30 program. Fourth, the bill would provide increased flexibility for states to manage the program to meet their needs by increasing the Flex slots from five to ten per state. These slots are used for doctors employed at facilities that are not located in federally designated shortage area that serve patients who live in these designated areas. Finally, the bill would create a fair mechanism which would allow the 30 doctor per state cap to increase under certain conditions.

When the Conrad J-1 Visa Waiver program was first implemented in 1994, not all states participated in the program. But within a few years, states were realizing the benefits of this program and all states now participate. This is a very successful program and is helping to address our needs as a nation to improve access to care among the nation's most vulnerable populations. The amendments in the Conrad State 30 Improvement Act are important to further improve the program and ensure that physicians are available to serve the nations underserved.

In conclusion, the Conrad State 30 Improvement Act strikes the right balance between big and small states and has support from across the medical community, from groups that have disagreed in the past on how to improve the program. Those groups that have endorsed the bill include the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, American College of Physicians, the National Cooperative of Health Networks Association, National Health Care Access Coalition, National Organization of State Offices of Rural Health, National Rural Health Association, National Rural Recruitment and Retention Network (3RNet), North Dakota Hospital Association, and HealthPartners (MN).

Thank you for this opportunity to write in support of a critical program that improves the lives of millions of Americans.

I would be happy to work with you to elaborate on issues and answer your questions. For information regarding this testimony, please contact:

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