

The Effect of the Physician J-1 Visa Waiver on Rural Wisconsin

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ABSTRACT

Context: One strategy to increase the number of physicians in rural and other underserved areas grants a waiver to foreign physicians in this country on a J-1 education visa allowing them to stay in the United States if they practice in designated underserved areas.

Purpose: The goal of this study is to evaluate the retention and acceptance of the J-1 Visa Waiver physicians in rural Wisconsin.

Methods: Sites in Wisconsin at which physicians with a J-1 Visa Waiver practiced between 1996 and 2002 were identified. A 12-item survey that assessed the acceptance and retention of these physicians was sent to leaders of institutions that had participated in this program. Retention of J-1 Visa Waiver physicians was compared to other physicians recruited to rural Wisconsin practices by the Wisconsin Office of Rural Health during the same time period.

Findings: While there was a general perception that the communities were well satisfied with the care provided and the physicians worked well with the medical community, there was a lower satisfaction with physician integration into the community-at-large. This was found to correlate with the poor retention rate of physicians with a J-1 Visa Waiver. Physicians participating

in a placement program without J-1 Visa Waivers entering practice in rural communities had a significantly higher retention rate.

Conclusions: Physicians with J-1 Visa Waivers appear to provide good care and work well in health care environments while fulfilling the waiver requirements. To keep these physicians practicing in these communities, successful integration into the community is important.

INTRODUCTION

One factor that directly affects access to health care in Wisconsin and ultimately the quality of the health of the residents of Wisconsin is an adequate physician workforce. While there have been several Governors' Task Forces established to look at health care professional workforce issues in Wisconsin, physician workforce has not been a major focus of these groups.¹ In 2004, a task force established by the Wisconsin Hospital Association and the Wisconsin Medical Society addressed the issue of physician workforce shortages. They found a shortage of primary care physicians in rural areas of Wisconsin and projected a greater shortage for 2015 based on increased demand for services resulting from an enlarging and aging population.² In 2000, only 11% of Wisconsin's physicians practiced in rural areas, while more than 33% of the state's citizens reside in rural communities. This geographic disparity will increase over the next decade if the overall shortage of physicians in rural communities continues to grow.

Wisconsin's rural citizens are generally sicker, poorer, older, and more likely to be uninsured than the overall population. In the year 2003, 60 of the 72 Wisconsin counties listed as total or partial Health Professional Shortage Areas (HPSA) were non-metropolitan counties. Roughly 1 million Wisconsin residents live in rural

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communities designated as HPSA. Collectively, they represent the largest underserved population in the state. With an older population base in rural communities and an associated greater number of chronic diseases, there is an increased need for services that compounds the shortage of physicians.

One of the strategies in this country to address physician shortages in underserved areas is the J-1 Visa Waiver Program. This program allows graduates from international medical schools to enter the United States for educational purposes on a J-1 Visa. Upon completion of their education, which in this context is their post-graduate residency education, they must return to their country of origin for 2 years before being eligible to return to the United States. If they agree to work in a HPSA, they are eligible to apply for a waiver of the requirement to return to their home country. After completion of the required 3-year service obligation, the physician can seek practice opportunities in non-shortage areas.

Previously, the US Department of Agriculture (USDA), and US Department of Housing and Urban Development (HUD) had programs that offered waivers, but these programs no longer exist. Current sources of J-1 Visa Waivers for physicians are the US Department of Health and Human Services and the Conrad State 30 Programs. Since 1996, in Wisconsin it has been possible for 20 physicians a year to participate in the waiver program. In 2002, this was increased to 30 waivers per year and is commonly known as the “Conrad 30 Program,” in recognition of the North Dakota legislator who championed the legislation, or the “State 30 Program.” The J-1 Visa Waiver Program was reauthorized in 2004 through May 31, 2006.

Failure to retain J-1 Visa Waiver physicians in rural practice after their 3 years of service is a concern. It has been suggested that factors involved with physician retention relate to issues involving the physician, the medical community, and the community-at-large. The better these issues are addressed, the greater the likelihood the physician will remain in the community.³

With a shortage of physicians in rural Wisconsin and controversy existing about the J-1 Visa Waiver Program, more information on this program in rural Wisconsin was needed. The goal of this study is to evaluate the retention and acceptance of the J-1 Visa Waiver physicians in rural Wisconsin.

METHODS

With the assistance of the Wisconsin Department of Health and Family Services, the Wisconsin Office of

Rural Health (WORH) identified physicians receiving a J-1 Visa Waiver from 1996 through 2002 to practice in Wisconsin in rural communities—defined as communities with a population <20,000 and not contiguous with a major metropolitan area. A survey was developed and reviewed by the University of Wisconsin Health Sciences Human Subjects Committee. This survey consisted of 12 specific questions and an opportunity for general comments. The 12 questions asked about the physician’s starting date, current employment status, and ending date of the physician’s employment if not still employed, as well as demographics about the physicians including gender, age, nationality, medical school and residency location, and type of specialty. Three questions asked about the physician’s acceptance by patients in the practice, the physician’s adjustment and integration into the medical community, and the physician and his or her family integrating into the community at large, which considered social, educational, and religious issues. The responses to these questions were measured on a 4-point Likert scale ranging from very unsatisfied/very poorly to very satisfied/very well.

The surveys were mailed to the chief executive officer or human resources representative of all health care facilities that had participated in the J-1 Visa Waiver program from 1996 through 2002. There were 18 hospitals and 19 clinics surveyed; 84% (16 of 19) of clinics were private and all hospitals were public. If there was not a response to the initial mailing, a second survey was mailed approximately 1 month later.

Since the WORH had participated in the placement of a larger number of traditional physicians who were not part of the J-1 Visa Waiver program, information on the physician retention rate of physicians participating in WORH’s Physician Recruitment program during the same time period was also collected, analyzed, and compared with the J-1 Visa Waiver Program physicians.

RESULTS

Of the 145 physicians identified as having received a J-1 Visa Waiver to work in Wisconsin between 1996 and 2002, 104 physicians practiced in rural communities. Information was returned on 72 physicians for a 69% response rate to the 2 survey requests. There were 2 instances where a waiver had been granted, but the physician never practiced in the community. This may have happened because, in the 1990s, several governmental organizations (USDA, HUD, or the state) were providing J-1 Visa Waivers and physicians could apply to different organizations and potentially receive several waivers, but they only use 1 waiver.

Table 1. Gender, Specialty and Nationality of Wisconsin Rural Physicians by Recruitment Group, 1996-2002

	All J-1 Visa Waiver Group n=72	Office of Rural Health Traditional Recruitment Group n=58
Gender		
Male	46 (64%)	33 (57%)
Female	26 (36%)	25 (43%)
Specialty		
Family Med	26 (36%)	50 (86%)
Internal Med	43 (60%)	6 (10%)
Pediatrics	3 (4%)	2 (3%)
Nationality		
Philippine	27 (37%)	
India	15 (21%)	
Pakistan	7 (10%)	
Syria	6 (8%)	
Poland	4 (5%)	
Other	13 (18%)	
US		58 (100%)

The distribution of the gender, specialty, and country of origin of the physicians in the J-1 Visa Waiver group and Office of Rural Health traditional recruitment group is seen in Table 1.

Overall, respondents reported that the patients in the community were pleased with the care and interactions with the J-1 Visa Waiver physicians. Ninety percent rated the patient satisfaction as satisfied or very satisfied, with the modal response being very satisfied, the highest ranking. Similarly, it was reported that the interaction between these physicians and other physicians and medical staff was good, with 92% of respondents rating the quality of interactions as “well” or “very well” with the modal response being “well.” The integration into the community by the physician and the physician’s family was perceived to be accomplished “well” or “very well” by 64% of the respondents, with the modal response being “well.” Written comments related to those situations where integration into the community was “less than well” identified issues such as religious choice and cultural needs as areas that were not being met in the community.

When analyzing the retention rate for the J-1 Visa Waiver program in Wisconsin, a Kaplan-Meier method was used to develop a survival plot for retention (Figure 1). Data on the 72 physicians in the J-1 Visa Waiver program were compared to those who participated in the WORH Placement Program (n=58). There is a statisti-

cally significant difference between the WORH traditional recruitment group and the J-1 Visa Waiver group, with a *P* value of 0.001 for the log-rank test. Among the J-1 Visa recipients, statistical analysis revealed no significant differences in retention by specialty, gender, or nationality. Logistic regression analyses for leaving within 3 years and leaving within 4 years revealed, after adjusting for gender and age, the key predictor of leaving within 3 or 4 years was physician integration into the community (odds ratio=6.04, *P*=0.013 for leaving in 3 years; odds ratio=4.95, *P*=0.019 for leaving in 4 years). There was no significant difference between the 2 groups relating to patient satisfaction or physician integration into the medical community and physician retention.

The timeline for retention begins at the time of hire. While there is a 3-year obligation associated with the J-1 Visa Waiver program, 30% of these physicians did not complete 3 years in these communities. This study did not determine where these physicians relocated.

LIMITATIONS

There are a number of limitations to this study. The data collected on patient satisfaction and physician integration into the group and community is from a health care facilities observer. It was not possible to contact the physicians directly since relocation information was not available for many of the physicians who left the community. The individuals who responded to the survey were, however, in a position to be familiar with patient satisfaction information and local physician dynamics. There is the possibility of recall bias and a possible selection bias among those not responding. This study is limited to the experience of physicians in rural Wisconsin so its generalizability may be limited. The results, however, are similar to other studies analyzing issues in rural HPSAs.^{4,5}

DISCUSSION

During the 6-year time period of this study, 105 physicians with a J-1 Visa Waiver entered practice in HPSAs in rural Wisconsin. This particular workforce met a need within Wisconsin and provided access to health care for residents in HPSAs. This is consistent with the observations and comments of Hagopian⁴ on the health policy approach to meet physician shortages through the Conrad J-1 Visa Waiver Program. The results in this study indicate that the health care systems felt that patients were satisfied with the care they received from J-1 Visa Waiver physicians and that these physicians worked well within the health care systems.

The J-1 Visa Waiver physicians and their families appeared to integrate into the community less effectively, reflected by responses indicating 33% of the physicians and families were perceived to integrate poorly in the community. This is consistent with the findings of Hagopian, where only a third were very satisfied with their practice sites.⁴ Our results suggest that integration into the community-at-large is the most important of the 3 domains or areas from Cutchin's framework predicting physician retention.³ J-1 Visa Waiver physicians leave the rural community at a rate significantly greater than US physicians recruited to rural practices in Wisconsin. The retention results in this study, at 2 years, are very similar to Pathman's findings among physicians in HPSA and non-HPSA areas. At 5 years however, the retention rates in this study of Wisconsin J-1 Visa Waiver physicians was much lower, while the retention among WORH traditional physicians was greater than that found by Pathman.⁵

A lower long-term retention rate is economically costly to the rural community and health care system. There are expenses involved with recruitment of physicians to replace the departing professional. There are lost revenues to the local health care system as well as direct recruitment costs. The 2003 Wisconsin Health Demand Assessment⁶ found that while it took up to 6 months for the majority of sites statewide to recruit a primary care physician, it was not uncommon to take 12 or more months. HPSAs by definition do not have enough physicians and are more likely to require more time to recruit a physician. If there is a frequent change in physicians and gaps in service, health care may be sought outside of the community, which represents lost business to the community that may not be recovered in the future. Retention is an economic issue for rural communities as well as a health care access issue.

The issue of relying on international medical graduates to address the physician shortages in the United States and in Wisconsin is increasingly being debated. There are now more common references to the 'global economy.' With increased global awareness, there is greater concern about the international drain of human resources caused by the US policy of relying on international medical graduates to help underserved population in the United States. The "Commonwealth Code of Practice for the International Recruitment of Health Workers" was adopted in 2003⁷ by the Commonwealth, an international association of over 50 countries. Groups within the World Health Organization have supported this code, which calls on developed countries to address their health professional shortages internally and not drain other nations of the health care workers needed in

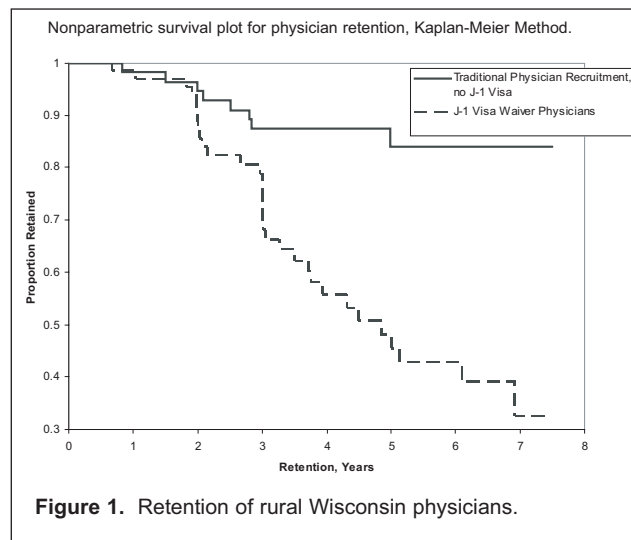


Figure 1. Retention of rural Wisconsin physicians.

many of the J1 Visa Waiver physicians' countries of origin. Hallock⁸ discusses this concern while noting there is a demand by international physicians to come to the United States. Mullan⁹ reveals the global movement of physicians among the nations of the world with the poorest, most needy countries experiencing a net loss of physicians. The changes in the 21st century with the global nature of the economy and an awareness of the US role in global health challenges us to look at our immigration policies and public policy addressing health care professional shortages.

How can US medical schools promote educational programs to better address the health care needs of its own regions? There are a greater number of adequately qualified applicants to the medical schools in the United States than there are positions. Fink¹⁰ indicates in his work that US graduates are just as likely to practice in rural underserved regions as are international medical graduates. The US graduates are more likely to be in family medicine, the specialty that distributes itself throughout the country in the same manner as the general population. A public health policy promoting admissions of a greater number of US medical students with support for primary care and an emphasis on family medicine might better meet the needs of rural underserved regions without promoting the loss of health care professionals from international settings. The University of Wisconsin School of Medicine and Public Health is working to increase the size of the medical school class, focusing on educating additional physicians for rural Wisconsin.

CONCLUSIONS

The J-1 Visa Waiver Program, now enacted as the "Con-

rad 30 Program,” is part of the US policy to address the physician workforce needs in rural and urban underserved areas. In Wisconsin, this has resulted in over 100 physicians working in HPSAs. The perception of the care provided by these physicians and working relationships with these physicians is good. The integration of the international physicians and families into the communities has been less successful and there is a lower rate of long-term retention. J-1 Visa Waiver physicians should be seen as a short-term solution to physician shortages in the United States and in Wisconsin, as it has a negative impact on the international countries these physicians are leaving. We should take advantage of opportunities to increase the number of US-born physicians to meet the needs of Wisconsin and the United States.

ACKNOWLEDGMENTS

Special thanks go to Marlon Mundt, MS, for his assistance in the statistical analysis of data presented in this article.

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Wisconsin Medical Journal

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The *Wisconsin Medical Journal* (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of the *Wisconsin Medical Journal*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *Wisconsin Medical Journal* nor the Society take responsibility. The *Wisconsin Medical Journal* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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