Texas Public POLICY FOUNDATION

MEETING THE DOCTOR DEMAND:

How Texas Can Optimize Physician Licensing Pathways to Attract International Talent While Supporting U.S. Graduates

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KEY POINTS

- Texas is projected to be shortage 10,330 doctors by 2032.
- Texas does not need to wait on Congress to fund more doctor training programs.
- Texas has the opportunity to use top tier foreign-license doctors to supplement the shortage, while freeing up its capability to train more Texas doctors.
- Seven states have created alternative licensing pathways with more states projected to pass legislation soon.

EXECUTIVE SUMMARY

Texas is facing one of the nation's worst physician shortages, and a majority of Texas' rural counties still suffer the consequences of a poorly maldistributed medical labor force. The state's continued population growth, retiring physician population, medical graduate emigration, and capped number of residency programs for medical graduates stands to severely limit Texans' physical access to healthcare services. The consequences of doctor shortages in relation to healthcare access can be observed by longer medical-related commute times, non-medical delays in healthcare delivery, increased out-of-pocket spending from patients, increasing health insurance premiums, increased healthcare prices, lapses in continuity of care, and worsening health outcomes.

Despite congressional initiatives attempting to redirect more taxpayers' dollars towards teaching hospitals to create more residency programs, Texas will still most likely not see a change in the severity of its physician shortage for decades. Fortunately, Texas does not need to wait on Washington, D.C., for a resolution to combat shortages faster. Within the last two years, seven states have created new alternative physician licensing pathways that incentivize top-tier foreign-licensed doctors to come to their states and serve struggling localities. Currently, there are thousands of highly-skilled foreign-licensed doctors that would like to call Texas their home; however, they are hesitant about coming to the Lone Star State because most states require that any physician—regardless of merit, years of experience, and competency with American

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medical standards—needs to repeat three to eight years of medical training in order to obtain a medical license.

The seven states that created new pathways have effectively taken steps to assure foreign-licensed doctors can be given a chance to prove they do not need to redundantly repeat a three- to eight-year residency program. Because of the new pathways, foreign-licensed doctors are no longer in a situation where they would potentially take residency slots from American medical students who need to finish the rest of their general medical education to become licensed doctors. Bringing more physicians to Texas means greater healthcare access for patients to see the doctor they need and want. The longer Texas waits to allow qualified doctors to practice in the Lone Star State, the longer patients will suffer from a lack of healthcare access.

INTRODUCTION

When it comes to addressing the issue of improving healthcare access, actors in popular culture, the media, and politics often contend health financing to be the key determining factor over whether a patient can acquire essential medical services and medications in a timely fashion. On the surface, this makes sense, considering the consistent trends of rising healthcare prices, health insurance cost-sharing, and medical debt (Kaiser Family Foundation, 2023).

Still, health coverage and financing are only a fraction in determining patients' overall ability to access care. Arguably, a larger disruptor to Texans' healthcare access revolves around health professional shortages and a patient's ability to physically get care. For example, insurance coverage, regardless of its quality, will not improve a Texas patient's access to care if there are no providers within 100 miles to use their coverage. Currently, there is a low supply of physicians that is failing to meet the rapidly-scaling demand of Texas' increasing patient population—and according to recent projections, it will only worsen (Texas Health and Human Services, 2020, pp. 13-14). Hospitals, urgent care clinics, and ambulatory surgery centers (ASCs) in Texas are in desperate need to fill key positions (American Immigration Council, n.d., p. 1). Allowing these employment providers to hire top-tier medical is a critical step Texas can take to alleviate its provider shortage.

A snapshot of Texas' current physician supply and development trends show:

1. Texas' physician shortage is projected to increase from 6,218 in 2018 to 10,330 by 2032 (Texas Health and Human Services, 2020, p. 1).

2. Thirty-seven Texas counties have zero primary care physicians (Texas Health Data, n.d.).

3. Twenty-nine percent of Texas' current physicians are over the age of 65 and are expected to retire within the next five years (Association of American Medical Colleges, 2021, p. 1).

4. From 2000-2019, 50% of Texas' medical school graduates left the state to finish their Graduate Medical Education (GME) elsewhere in the nation (Texas Health and Human Services, 2022a, p. 10).

5. From 2011-2020, 33% of medical school graduates who start their residency in Texas (i.e., a hospital-based post-grad training program for physicians who have a Doctor of Medicine or a Doctor of Osteopathy degree) do not finish it in the state of Texas (Texas Health and Human Services, 2022a, p. 5).

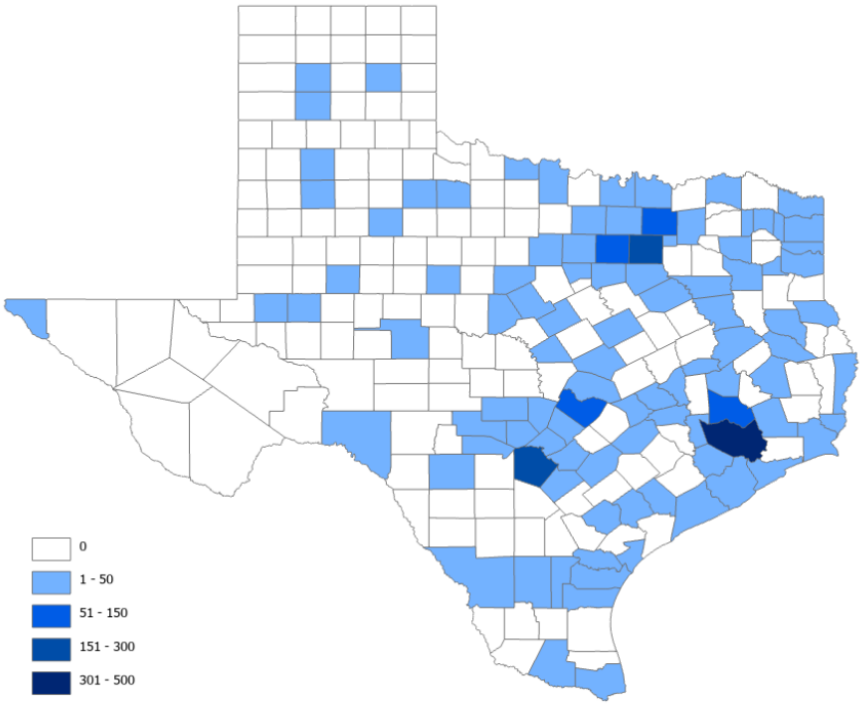
The doctor shortage has contributed to the exacerbation of medical deserts which primarily affect rural areas due to most doctors being concentrated in metropolitan areas (Texas Health Data, n.d.). Rural counties are hit hardest by these medical deserts which often compels Texans to travel across multiple counties for both catastrophic and preventative services (Government Accountability Office, 2020). Rural Texans' concerns over long drive times compounded with a limited amount of physical access to a healthcare provider ultimately translates into a

disproportionately worse disruption in overall healthcare access for rural communities compared to their metropolitan counterparts. While the promulgation of telehealth and its utilization has been helpful for rural communities to access mental healthcare services and other medical expertise, telehealth is still unable to fully address healthcare demands for in-person services. Therefore, policies that stand to bring physicians into Texas should be prioritized.

Texas is experiencing shortages in several physician disciplines. However, there are acute shortages within cardiology (see **Figure 1**), dermatology (see **Figure 2**), family medicine (see **Figure 3**), and obstetrics and gynecology (see **Figure 4**). Without physicians that can promptly identify problems with a patient's health, disease and chronic illness can go unchecked leading to avoidable catastrophic outcomes. Based on data from the Texas Medical Board, the divide between urban and rural access to doctors can be clearly observed.

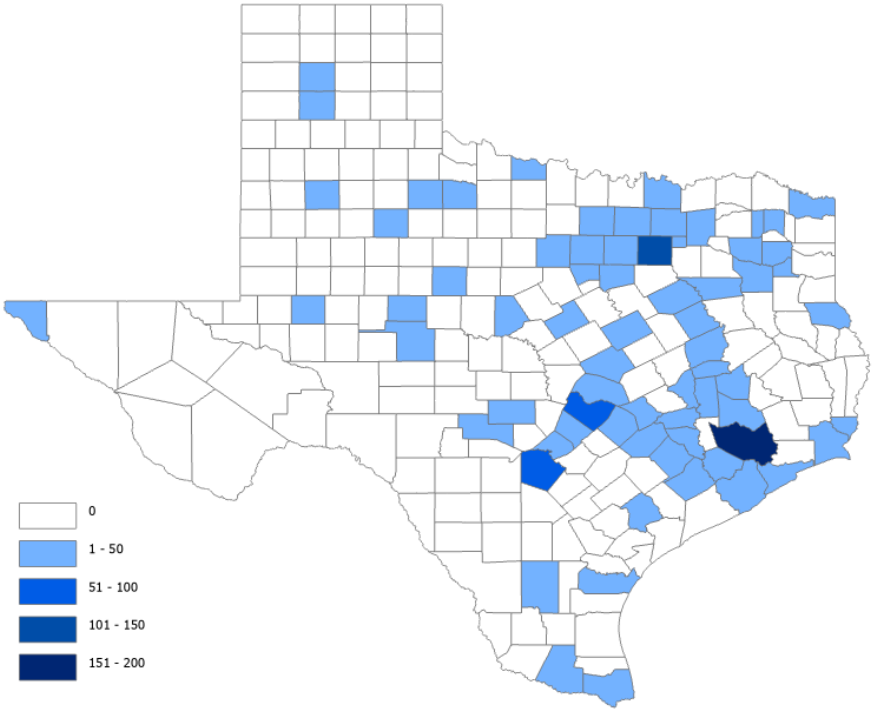
The growing physician shortage is well-documented; however, little action has been taken outside of a few congressional reforms (GlobalData Plc., 2024). When Congress passed the Balanced Budget Act of 1997, the policy capped the number of Medicare-funded residency slots medical school graduates need to complete their GME (H.R. 2015, 1997). The federal government spent an estimated $16.2 billion on GME in 2020, making it the largest funder of medical education (Congressional Research Service, 2022). Funding typically influences where medical school graduates receive their training and where they will later practice when licensed. For example, one analysis found that 56% of family medicine doctors practice within 100 miles of where they completed their residency (Fagan et al., 2013).

Figure 1: *Distribution of Cardiologists in Texas*



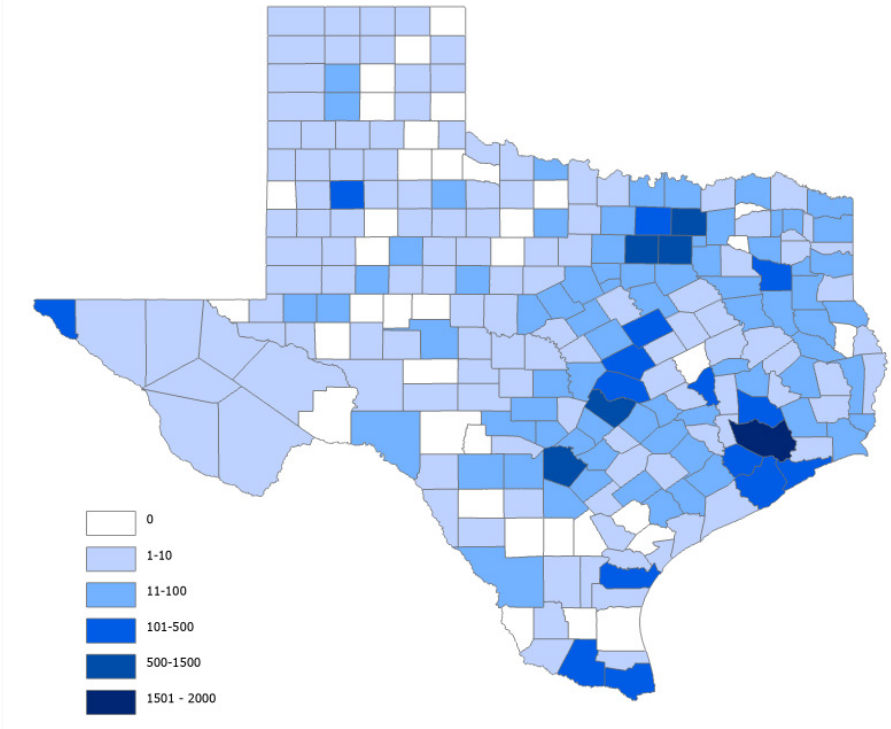
Note: Data from *Licensed Physician Database* by the Texas Medical Board Open Records Self Service Portal (ORSSP), 2024 (https://orssp.tmb.state.tx.us/Main.aspx) and author's calculations.

Figure 2: *Distribution of Dermatologists in Texas*



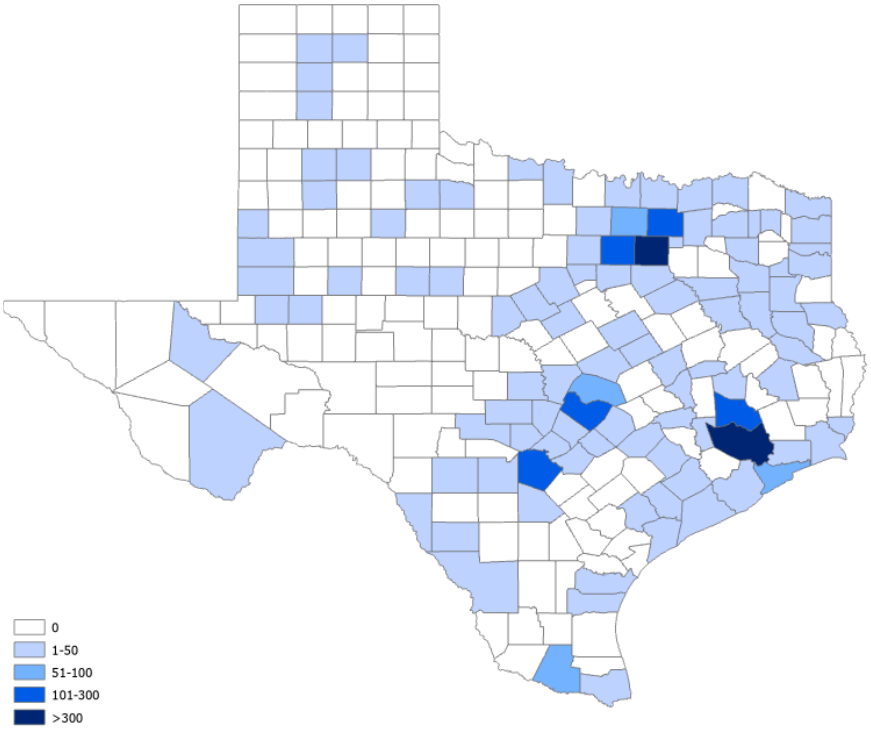
Note: Data from *Licensed Physician Database* by the Texas Medical Board Open Records Self Service Portal (ORSSP), 2024 (https://orssp.tmb.state.tx.us/Main.aspx) and author's calculations.

Figure 3: *Distribution of General Family Medicine Doctors in Texas*



Note: Data from *Licensed Physician Database* by the Texas Medical Board Open Records Self Service Portal (ORSSP), 2024 (https://orssp.tmb.state.tx.us/Main.aspx) and author's calculations.

Figure 4: *Distribution of OBGYNs in Texas*



Note: Data from *Licensed Physician Database* by the Texas Medical Board Open Records Self Service Portal (ORSSP), 2024 (https://orssp.tmb.state.tx.us/Main.aspx) and author's calculations.

The Balanced Budget Act's stagnant and inflexible cap did not fully account for population change and substantial domestic migration trends. As time passed, the number of residency training programs available in the states have not stayed commensurate with demand changes in given geographies. Cities like New Orleans have maintained the same number of Medicare-funded residency slots since the budget caps in 1997, even though their population has slightly declined in the past 25 years (Orr, 2023). Cities like Austin, Texas, have grown rapidly and have a relatively small share of Medicare funded residency slots and GME funding (Orr, 2023).

Recently, Congress removed the residency cap on GME funding with the passage of the Consolidated Appropriations Act (CAA) which created 1,000 new Medicare-funded GME positions (H.R. 133, 2021). The bill aims to fund 200 new residency slots over the next five years starting in 2023. The new residency spots will be distributed to priority communities, such as teaching hospitals offering care in underserved communities, hospitals with new medical centers, and hospitals training residents over their cap (H.R. 133, 2020).

The recently introduced Resident Physician Shortage Reduction Act of 2023 would add an additional 14,000 Medicare-funded residency positions if it becomes law (H.R. 2389, 2023). This bill would add an additional 2,000 residency positions per year (on top of the 1,000 spots created by the CAA) to be created per fiscal year from 2025 to 2031 to address shortages (H.R. 2389, 2023). While it is a seemingly valuable proposition to give states the capability to train more physicians, 15,000 additional residency slots will not fully correct the doctor shortage in America. Even if every slot was filled every year, it will not address the entirety of the shortage. Additionally, if Congress funds more residency spots, it will likely take 10 to 15 years before Americans can reap any notable benefit. Texas and the rest of the country

Currently, there is a low supply of physicians that is failing to meet the rapidly-scaling demand of Texas' increasing patient population—and according to recent projections, it will only worsen.

cannot rely on Congress to resolve this immediate shortage. Thankfully, there are methods states can use to alleviate doctor shortages without relying upon Congress or the federal government.

LEGISLATIVE EFFORTS IN OTHER STATES

Due to states' legislative sovereignty over professional medical licensing, they are poised to pursue reforms that could incentivize foreign-licensed doctors to relocate to Texas. To practice medicine in the U.S., doctors must be licensed in the state they wish to practice. In most cases, whether foreign or domestically trained, doctors must complete a U.S.-based residency accredited by the Accreditation Council for Graduate Medical Education[1] (ACGME), regardless of any previously completed GME or if they are fully licensed in their home country (American Medical Association, n.d.). This barrier to entry for foreign-licensed doctors arguably forces them to unnecessarily repeat three to eight years of their education, depending on their specialty (Murphy, 2020). Seven states (Tennessee, Florida, Iowa, Virginia, Idaho, Illinois, Wisconsin) have provided an alternative licensing pathway allowing qualified foreign-licensed doctors to omit completing a U.S.-based residency under certain conditions.

The framework for this alternative licensing pathway follows a pre-established certification process already in place for medical graduates who receive their medical education outside of the U.S. During the 1950s, the demand for health care services increased dramatically and the U.S. needed more doctors. In 1956, a private organization called the Evaluation Service for Foreign Medical Graduates (ESFMG) was established to evaluate the readiness of international medical graduates (IMGs) to practice in the U.S. (Educational Commission for Foreign Medical Graduates, n.d.). Later that year, the ESFMG changed its name to the Educational Council for Foreign Medical Graduates (ECFMG) and added medical science examinations and English language proficiency tests to their formal evaluations of IMGs. In 1974, the ECFMG merged with the Commission on Foreign Medical Graduates (CFMG) to help monitor the visa sponsorship of IMGs. The combined organizations became the Educational Commission for Foreign Medical Graduates (ECFMG) as it is known today. The ECFMG remains the international accrediting body that certifies non-U.S. medical school graduates entering the U.S. healthcare system.

IMGs must meet several requirements before being eligible to apply for a U.S.-based residency. To qualify, IMGs must obtain a medical degree from an ECFMG accredited program (Educational Commission for Foreign Medical Graduates, n.d.). Once the ECFMG accreditation is proven, the applicant must pass the United States Medical Licensing Examinations (USMLE). The USMLE is divided into three parts: Part 1 tests knowledge on science and principles for practicing medicine; Part 2 tests clinical knowledge and clinical skills; and Part 3 tests an IMG's ability to apply medical knowledge for the unsupervised practice of medicine (American Medical Association, 2024). Once these requirements and a few others are met, IMGs can apply for a U.S.-based residency. Currently, 1 in 4 Texas physicians were IMGs (Association of American Medical Colleges, 2021).

In 2023, Tennessee became the first state to create an alternative licensing pathway to help alleviate their doctor shortage. Tennessee, much like Texas, has experienced significant population and economic growth over the past five years (Kessler et al., 2024). Similarly, Tennessee is currently projected to

1 ACGME is a private non-profit body that accredits U.S. residencies and other medical training programs.

have a shortage of 6,000 physicians by 2030 (Zhang et al., 2020). With the increased need for physicians in the state, Tennessee Governor Bill Lee signed SB 1451, which created an alternative licensing pathway for foreign-licensed doctors (SB 1451, 2023). The requirements to be eligible for the alternative pathway are: 1) obtaining ECFMG accreditation, 2) passing Parts 1 and 2 of the USMLE, and 3) demonstrating a proficiency in English. However, instead of repeating residency, foreign-licensed doctors are issued a provisional license to practice medicine under the supervision of a fully Tennessee licensed provider for two years (SB 1451, 2023). Upon the uncompromised completion of the provisional license period, the Tennessee Medical Board will convert the provisional license into an unrestricted license to practice medicine (SB 1451, 2023).

Providing foreign-licensed doctors with an alternative accomplishes two major goals. First, it removes the unnecessary requirements for qualified foreign-licensed doctors to repeat parts of their medical education (a regulatory burden that detours many skilled physicians from coming to America). Second, it helps American medical graduates from needlessly competing with foreign-licensed doctors for the limited number of residency spots, which is already a hyper-competitive process.

For instance, if a licensed doctor from Germany, India, or the United Kingdom wanted to practice medicine (regardless of their success or experience), he or she would be pitted against an American medical graduate for a residency spot. If a U.S. medical graduate does not match into a residency slot, he or she cannot practice any level of medicine in most states. Under the new system, both the U.S. medical graduate and the foreign-licensed doctor could practice in the U.S. without having to compete with one another for a residency spot.

WHY FOREIGN-LICENSED DOCTORS WANT TO PRACTICE IN THE U.S.

There is a myriad of reasons why foreign-licensed doctors seek to practice in the United States. For instance, the U.S. is internationally renowned for its prestige in practicing medicine. Additionally, America provides foreign-licensed doctors with economic opportunities not available in their home countries. A survey of doctors in 11 countries found that the average American doctor's salary was $352,000, which is the highest average salary of all surveyed countries (Frellick, 2023). Comparatively, doctors in Germany make an average of $160,000, Canadian doctors make an average of $273,000, and doctors from the United Kingdom make an average of $122,000 (Frellick, 2023). Some factors that contribute to the pay gap amongst countries include cost of living, scope of practice laws, cost of medical school, health coverage, and regulation.

KEY ASPECTS OF AN ALTERNATIVE LICENSING PATHWAY

Every state that has created an alternative licensing pathway for foreign-licensed physicians has incorporated different versions of the following key aspects:

1. **Residency Exemption:** Allows a foreign-licensed doctor, not international medical graduate, to omit completing an American residency program under select prior education and work conditions.

2. **Provisional License Periods:** Qualifying physicians in an alternative licensing pathway must finish a provisional licensing period before becoming eligible to obtain a full unrestricted state medical license. These provisional licensing periods must be completed with the initial sponsoring provider. (Medical boards have been tasked with creating protocols for if and when a foreign-licensed doctor is laid off due to non-performance related reasons.) States have varied in how long they require this provisional licensing period to last. For instance, Tennessee requires two years, while Wisconsin requires a three-year provisional licensing period (SB 1451, 2023; AB 954, 2024).

Additionally, states have varied how the transition of a provisional license to full unrestricted license works. Some state medical boards will automatically approve a conversion so long as there are no disciplinary incidents recorded during the provisional license period (SB 1451, 2023). Other states have left the approval process to the medical board's discretion in designing a review process (i.e., both the supervising physician and foreign-licensed doctor provide performance attestations to the medical board). The protocols to monitor a foreign-licensed doctor's progress during the provisional license period have often been left up to the discretion of the state medical board.

3. **Sponsoring Providers:** Every state requires that a foreign-licensed doctor can only be granted a provisional license if they receive an employment letter from a certain type of state-licensed provider (e.g., solo private practices, urgent care clinics, free standing emergency centers, free standings imaging centers, ASCs). This aspect of the policy varies the most with some states allowing only licensed hospitals to become sponsoring providers while others allow for all licensed providers to become sponsoring providers.

4. **English Proficiency:** All states have required prospective foreign-licensed doctors to possess English fluency.

5. **Qualifying Education & Work Conditions:** Despite there being slightly more substantial variations with different aspects of this policy, states have stayed consistent with certain preceding education and work requirements a foreign-licensed doctor will need to be able to prove in order to be granted a provisional license:

    - Obtained a degree from an ECFMG accredited medical school.
    - Passed Parts 1 and 2 of the USMLE.
    - Is a foreign-licensed doctor with five or more years of continuous practice (i.e., does not have a multi-year lapse in practice).
    - Is in good standing with their country-of-origin medical board or regulatory entity.
    - Possesses proficiency in English.
    - Possesses sufficient skills to be offered employment by a state licensed provider. (Due to state licensed providers being under legal liabilities, bill drafters realized that employing providers have a strong incentive to hire only competent physicians—which is an important incentive that better guarantees that only skilled foreign-licensed doctors who work well with American physicians are selected.)

RECOMMENDATIONS

Provisional Licensing Period

With seven states having already passed several different alternative licensing pathways, Texas needs to recognize that there is now interstate competition for attracting talented foreign-licensed doctors to engage with their state's pathway. A key factor that will most likely determine where the influx of these foreign-licensed doctors initially go depends on the regulatory burden the hypothetical pathway imposes on the prospective doctor. For example, on one hand Tennessee designated that foreign-licensed doctors will need to complete a two year provisional license period before a state medical board will begin the protocols for approving a full unrestricted medical license (SB 1451, 2023). On the other hand, Arizona introduced an alternative licensing bill containing language that would create a four year provisional license period (SB 1406, 2024). While the difference in provisional licensing period lengths may seem superficially insignificant, prospective foreign-licensed doctors are more likely incentivized to seek out employment opportunities in states with a shorter provisional license period in order to obtain a fully unrestricted medical license sooner. The Texas legislature

should recognize any additional regulatory burden, relative to other states, stands to create a disincentive compelling highly skilled foreign-licensed doctors to serve another state's patients over Texans.

Sponsoring Providers for Foreign-Licensed Doctors

As previously stated, Texas is grappling with a severe doctor shortage and maldistribution of its current physician labor force. For example, Hutchinson County had a patient-doctor ratio of 3,051 to 1, whereas Harris County had a population ratio of 1,066 to 1 primary care physician in 2024 (Texas Health Data, n.d.). There are 214 Texas counties that have been classified as primary care health professional shortage areas (PCHPSA), with an additional 10 counties deemed as partial PCHPSA designations (Texas Health and Human Services, n.d.).

The Texas Legislature should recognize the ability of an alternative licensing pathway to steer foreign-licensed doctors to underserved regions will most likely be contingent on which type of fully licensed Texas healthcare provider is allowed to be a sponsoring provider. For example, if the sponsoring provider list is confined to just "teaching hospitals" that predominantly reside in or adjacent to metropolitan areas, the result will most likely be that prospective foreign-licensed doctors will only work and continue to work in more adequately served metropolitan counties. This requirement would provide little to no benefit for rural Texas counties that need physicians.

Most of the other states who have already passed alternative licensing pathways were aware that confining the sponsoring provider list to teaching hospitals could lead to already adequately served metropolitan areas becoming further saturated with doctors. Therefore, states passed legislation that allowed multiple types of employing providers (i.e., private practices, urgent cares, ASCs, free standing emergency centers, and non-teaching hospitals) to be eligible for becoming a sponsoring provider.

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If the impetus for developing alternative licensing pathway legislation hinges on what it can do to supplement underserved rural regions with doctors, Texas lawmakers can always designate that sponsoring providers must reside within the bounds of a health professional shortage area (HPSA). This guardrail could theoretically better guarantee that foreign-licensed doctors will more likely go to and continue working in underserved communities, instead of highly competitive and doctor-saturated metropolitan areas. For example, Virginia has a two-step process to obtain an unrestricted medical license. Under Virginia law, a foreign-licensed doctor is issued a provisional license for no more than two years, and is then eligible for a renewable two-year license if the doctor practices in a medically underserved area (H.B. 995, 2024). After two years of practice under the renewable license in a medically underserved area, the foreign-licensed doctor can apply for a full, unrestricted license to practice medicine (H.B. 995, 2024).

Private Equity and Corporate Practice of Medicine Concerns

An important nuance to highlight within the doctor shortage is the lack of independent practitioners not employed by private equity firms, hospital systems, or health insurers. According to the Physicians Advocacy Institute, 77% of doctors are now employed by hospitals, private equity firms, and insurance companies (Physicians Advocacy Institute, 2024). This is problematic considering the rising body of literature showing there is a strong correlation between healthcare provider consolidation and rising prices for services and health insurance premiums. When

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studying non-profit hospitals, the RAND Corporation found price increases between 3% to 65% after mergers (Liu et al., 2022).

One of the few reasonable methods to combat the negative consequences of near oligopolies and monopolies is by assuring the regulations effecting market entry for competitors (who can undercut high pricing) do not skew in favor of incumbent market behemoths. This would include making legislative efforts that do not blatantly give near exclusive employing power over entrants in the medical labor force to high market share incumbents. The introduction of a new foreign-licensed doctor population stands to play a pivotal role in giving smaller providers the labor they need to compete with large market share entities. With this in mind, it is fair and advisable that alternative licensing pathways do not exclusively confine foreign-licensed doctors to work for large health systems in order to obtain their provisional or full license.

Board Certification

An important caveat to note is that the states that created an alternative licensing pathway have not yet made proposals for foreign-licensed doctors to have a pathway to national board certification and eligibility. Being board certified is an important credential to physicians, especially to specialists and those seeking insurance reimbursement as solo practitioners. It is often phrased that licensure signifies basic competency and legal authorization to practice medicine in a state, whereas board certification signifies that a physician possesses a specialized expertise and has committed to additional training on top of what is necessary to practice medicine legally in the states (Texas Medical Board, n.d.).

Board-certified physicians are often compensated more and are regarded as experts in a specialty or sub-specialty—meaning, they stand to offer skills for which non-board-certified doctors have yet to be accredited or recognized. This certification plays a role in influencing their employment opportunities, medical malpractice insurance premiums, and compensation. For example, a primary care physician that graduated with a medical doctorate and finished their GME (without finishing boards or taking steps to get board-certified) is not automatically regarded as possessing a proficiency in addressing unique medical needs with children or women. If a hospital possesses a large panel of women and children, they will be most likely looking for a physician that obtained specialty board certification in pediatrics, obstetrics, and gynecology.

While there are international accrediting bodies (like the ECFMG) that verify a foreign-licensed doctor has obtained the necessary base skills to eventually succeed in America, those same accrediting bodies do not fully assure a foreign-licensed doctor has completed steps to become board-certified in their specialty. The pathway to board certification varies based on the specialty in question (i.e., the steps and time to become a board eligible or certified anesthesiologist versus a cardiologist are different).

Many foreign-licensed doctors possess the medical knowledge and training to become a licensed doctor in America. Although, there are several American specific training milestones required by specialty boards which bar them from obtaining board certification. For example, even if a foreign licensed doctor theoretically completed an international program that precisely mimicked the training imparted in certain ACGME-accredited programs for specialties like orthopedics, it would not count as satisfactory in the board's eyes. This is most like-

ly a consequence of specialty boards operating off of an America-centered basis, and early board requirements not anticipating that states would start creating alternative licensing pathways for foreign licensed physicians.

While board certification does not ultimately impede states in creating alternative licensing pathways or prevent foreign-licensed doctors from obtaining a full American medical license, it does impact the way foreign-licensed doctors will be compensated and perceived by their peers. If board certification is left unaddressed, there is a risk that foreign-licensed doctors embarking on an alternative licensing pathway will effectively become second-class doctors with no opportunity or equivalency metric to prove they are on par with their domestically trained peers' merit and knowledge.

It is advisable for the Texas Legislature to collaborate with the Texas Medical Board to see what can be done to create pathways to board certification as well as investigate what can be done to create equivalency testing opportunities for their foreign training. Collaboration between specialty boards and state medical boards is key to creating a functional pathway to board certification for foreign-licensed doctors. Nothing is stopping Texas from being the state to lead the charge.

Country Lists

In some of the initial reiterations of alternative licensing pathway legislation (before the passage of Tennessee's SB 1451), some introduced bills possessed language akin to "only foreign-licensed physicians licensed in these countries… may be issued a provisional license." This type of language is colloquially referred to as a "country list." The reason for country lists being a part of the prototyped criteria to determine which foreign-licensed doctors can be eligible for an alternative licensing pathway came from Canada's methodology. Canada uses a country list to determine which Commonwealth countries it has international licensure reciprocity with (i.e., which countries have similar enough medical training standards to produce competent physicians that have received GME equivalent to Canada's medical training standards). Some of these countries include the United States, the United Kingdom, and Australia.

Drafters of alternative licensing pathway legislation initially thought that adhering to a Canadian-inspired country list would make it easier for state medical boards and relevant regulatory bodies to use as a basis to assure the competency of foreign-licensed doctors' training. However, when these country list bills started going through the legislative process, unexpected political and cultural tensions exploded and ultimately led to bills dying. Instead of disagreements on public safety guardrails and overall efficacy in attracting highly skilled foreign-licensed doctors, country list bills typically faced legislative drag due to legislators focusing on why certain countries were on the list and others were not.

Another area of tension that country list bills generated was imposing a duty on state medical boards to accredit and determine training equivalency of other countries' licensing pathways and training programs. The responses from state medical boards on country list bills varied. Some medical boards believed they had enough resources to succinctly verify foreign-licensed doctors' accreditation, but others believed they would be too ill-equipped to verify accreditation while abiding by their states' standards and regulations. It was not uncommon to see a reluctant medical board, believing they were ill-equipped to issue warnings, and claiming that they would need to make personnel hires and supplemental appropriation requests from the legislatures in order to successfully execute any passed legislation. This potential fiscal consideration led to country bills having less political lift and delays in the legislative process.

Due to the issues experienced with country list bills, states that have successfully created alternative licensing pathways have omitted any requirements restricting access to foreign-licensed doctors from

select countries. Instead of a country list, many bill drafters realized it was more politically feasible and optimal to open alternative licensing pathways to all foreign-licensed physicians under certain meritorious conditions.

This departure away from country lists seemingly reshaped the political reception of alternative licensing pathways to be more about assessing an individual physician's merit, as opposed to merely comparing other countries' medical training programs to that in the U.S. Additionally, by refraining from adding a country list, states that have passed legislation were more able to get resolution on what key training milestones are truly needed to determine which foreign-licensed doctors are up to the task of living up to America's renowned medical standards.

Final Recommendation

The 89th Texas Legislature should create an alternative pathway to licensure to attract foreign-licensed doctors to practice in Texas. By providing an alternative to the residency requirement, Texas can increase the share of doctors in the state and decrease the healthcare access disparities between rural and urban regions. ■

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