The Potential Conflict Between Policy and Ethics in Caring for Undocumented Immigrants at Academic Health Centers

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Abstract

Academic health centers (AHCs) are at the forefront of delivering care to the diverse medically underserved and uninsured populations in the United States, as well as training the majority of the health care workforce, who are professionally obligated to serve all patients regardless of race or immigration status. Despite AHCs' central leadership role in these endeavors, few consolidated efforts have emerged to resolve potential conflicts between national, state, and local policies that exclude certain classifications of immigrants from receiving federal public assistance and health professionals' social missions and ethical oath to serve humanity. For instance, whereas the 2010 Patient Protection and Affordable Care Act provides a pathway to insurance coverage for more than 30 million Americans, undocumented immigrants and legally documented immigrants residing in the United States for less than five years are ineligible for Medicaid and excluded from purchasing any type of coverage through state exchanges. To inform this debate, the authors describe their experience at the University of New Mexico Hospital (UNMH) and discuss how the UNMH has responded to this challenge and overcome barriers. They offer three recommendations for aligning AHCs' social missions and professional ethics with organizational policies: (1) that AHCs determine eligibility for financial assistance based on residency rather than citizenship, (2) that models of medical education and health professions training provide students with service–learning opportunities and applied community experience, and (3) that frontline staff and health care professionals receive standardized training on eligibility policies to minimize discrimination towards immigrant patients.

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Academic health centers (AHCs) receive over 35 million nonemergency outpatient visits each year from the uninsured, and the 400 U.S. teaching hospitals affiliated with AHCs account for about 50% of all charity medical care for the nation's poor and medically underserved populations.[1] AHCs are also at the forefront of medical practice and research and train more than 15,000 physicians and health care workers annually. As part of their education and practice, most medical students make an ethical pledge, often in the form of the Oath of Geneva or a variant, declaring their commitment to treat all patients regardless of patients' social or economic circumstances. AHCs also play a critical role in setting local health policies, which may align or may clash with health professionals' historical mission to serve all. For instance, whereas the 2010 Patient Protection and Affordable Care Act provides a pathway to insurance coverage for more than 30 million Americans, undocumented immigrants and legally documented immigrants who have resided in the United States for less than five years are ineligible for Medicaid and excluded from purchasing any type of coverage through state exchanges.[2]

Despite AHCs' central leadership role in serving the most vulnerable and educating our nation's health professionals, few consolidated efforts have emerged to resolve potential conflicts between what is taught and what is practiced with regard to treating all patients regardless of circumstances. To inform this debate, we describe how the University of New Mexico Hospital (UNMH) and the University of New Mexico (UNM) medical students, family medicine residents, faculty, and community representatives have responded to this challenge and overcome barriers. We recommend three actions AHCs can take to balance their social mission and their professional ethics with their organizational policies.

The Tension Among Service Delivery, Policy, and Medical Education

Service delivery

The UNMH, a county-supported academic teaching facility, is the major tertiary care center in the state and the safety-net hospital for Bernalillo County, where a third of the state's population resides and where more than 20% of its residents lack health insurance coverage. Over the years, UNMH and its UNM clinical faculty and residents have implemented important innovations in service to the uninsured in the

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surrounding county and state. In 1997, UNMH created the UNM Care Program, a managed care model for uninsured county residents.[3] The program's intent was to address the high utilization by the medically underserved of inpatient and emergency department services for primary care sensitive conditions. Its key features included assignment of eligible uninsured patients to a primary care medical home supported by case managers at neighborhood clinics and implementation of an affordable sliding scale fee schedule for primary and specialty care and other services (lab tests, medications, and hospital stays). Over the first two years of the program, the quality of patient care improved, hospitalization rates plummeted, and UNMH saved millions of dollars. UNMH was then able to expand the program to its current level of 30,000 enrollees. Despite this progress, one group of indigent county residents was excluded from the UNM Care Program: undocumented immigrants.

Policy

The decision to exclude undocumented immigrants was the result of UNMH's interpretation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, or welfare reform).[4] Under welfare reform, undocumented immigrants were not eligible for Medicaid or other federally funded health benefits, with the exception of a state option to offer prenatal care to pregnant women. "Qualified immigrants" who entered the United States on or after August 22, 1996, were not eligible for these programs for the first five years after immigrating.[5] The "qualified" immigrant category is made up of Lawful Permanent Residents (or holders of "green cards"); refugees; asylees; persons granted withholding of deportation or removal; conditional entrants; persons granted Citizenship and Immigration Services humanitarian parole for a period of at least one year; Cuban/Haitian entrants; and certain individuals who are victims of domestic violence, their children, and/or their parents. "Not qualified" immigrants include undocumented immigrants as well as many immigrants who do not have green cards but nonetheless are lawfully present in the United States.[5]

Meanwhile, emergency treatment continued to be available to all immigrants regardless of their status.[6]

The provisions of welfare reform created ambiguity for county governments and publicly funded institutions, including AHCs, in making local decisions about providing services to low-income, uninsured immigrants who resided in their communities. In response to welfare reform, UNMH amended their financial assistance policies to limit services to "qualified immigrants," leaving undocumented immigrants eligible for limited financial assistance toward costs of emergency care only.[7]

For all other services, undocumented immigrants were considered "self-pay" patients and, as such, were required to provide a 50% up-front payment for services and to be billed subsequently at full charge. Since most low-income immigrant patients were not able to pay 50% out of pocket, either they did not access care or they experienced limited access. For instance, a study[8] assessing the impact of the financial assistance policy on undocumented immigrant patients found that

> compared to those with insurance, the majority (56% vs. 9%) had their recommended elective surgeries cancelled, presumably because they couldn't afford the 50% up-front payment required of those who are uninsured and not in the UNM Care Program.

In response to external pressure from community health advocates, in 2005 the UNMH created a program for self-pay patients who were ineligible for the hospital's financial assistance program but could demonstrate low-income status and residency in the county. A patient who qualified for the self-pay discount program could access medical services for a down payment as low as $5 and then be billed at 55% to 60% of the full charge for that service. Although the self-pay discount policy provided an alternative for undocumented immigrants, few are enrolled in the program because they not aware of it, or patients become enrolled after an expensive intervention has already been delivered. Another factor that impedes enrollment is fear of incurring medical debt. For example, to qualify for the $5 down payment option, a patient must live at 100% of the Federal Poverty Level ($11,490 for a one-person household). A regular clinic visit, even at the discounted rate, would result in a bill that exceeds what such a patient can afford to pay.

Medical education

The UNM School of Medicine is unique among U.S. medical schools in requiring all students to graduate with a public health certificate. The curriculum exposes students to key public health competencies and periodically places them in medically underserved communities. Annually, during the white coat ceremony at the beginning of medical school and again at graduation, medical students and faculty recite the Oath of Geneva. The oath states, in part,[9]

> I solemnly pledge myself to consecrate my life to the service of humanity;… I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient.

Despite this oath, many students and faculty express despair that their medical center's policies treat unauthorized immigrants differently than they treat other patients and hamper physicians' ability to offer optimum care.

Basing the application of UNMH's financial assistance policies on patients' immigration status has resulted in adverse consequences, including delayed treatment, overuse of emergency room care, high medical debt, and increased risks to the public's health. These consequences are illustrated through the experiences of two patients who were seen at a community clinic that provides free care to immigrants and is staffed by UNM health science students, family medicine residents, and faculty from the School of Medicine and College of Pharmacy.

The first patient was a young man, an undocumented immigrant who came to the free clinic after postponing care at UNMH, complaining of several months of weight loss accompanied by a chest lesion with purulent drainage. As his lesion was unresponsive to oral antibiotics and incision and drainage, the health team, coordinated by the clinic's community health worker (CHW), arranged for a chest X-ray, which demonstrated a retrosternal mass. Immediate hospitalization and chest surgery revealed the mass to be caused by tuberculosis. Because of advocacy efforts of the staff at the free clinic, UNMH eventually reduced the patient's responsibility for the costs of his surgery and a hospital stay of several days and arranged follow-up care with the New

Mexico Department of Health. UNMH's self-pay charges had caused this patient to delay seeking treatment because he could not afford out-of-pocket costs because of his low earning wages. This delay in care is typical for many impoverished, undocumented immigrants with an illness they hope will improve without requiring a costly clinic or hospital visit. This patient's delay in care then led to a prolonged exposure of family members and others in the community to his serious communicable disease.

The second patient was a single mother who could no longer work because of chronic, debilitating back pain caused by the loosening of a metal rod that had been inserted in her back to stabilize injury-related vertebral fractures sustained when she lived in Mexico. An orthopedic surgeon at UNMH confirmed the need for surgery to remove the rod, but her surgery was repeatedly postponed because she had no insurance, did not qualify for the charity care program, and could not afford the recommended postoperative inpatient rehabilitation, all because of her immigration status. Community health advocates and UNM students and residents argued her case before hospital leadership and secured a commitment from community organizations to support the patient and her family in her postsurgical recovery. After one year of advocacy from these supporters and in spite of institutional skepticism that the hospital would receive payment, an orthopedic surgeon sided with the patient's advocates and performed the surgery. A month later, pain free, the patient was able to return to the free clinic for ongoing care.

Both of these examples illustrate the ethical and fiscal quandaries of providing care to immigrants (documented and undocumented) and the conflict between health policy, medical education, and optimum service delivery. Although UNMH is not representative of all AHCs, our experience suggests that for the most part, teaching hospitals have the authority and latitude to leverage their social mission and professional ethics to influence the administrative and financial eligibility policies of the institutions with which they are affiliated. More recently, health care providers and community advocates have swayed UNMH to broaden existing pay policies for self-pay patients presenting with certain conditions that are allowable under welfare reform. Today, if an indigent patient presents to UNMH facilities showing signs or symptoms of a communicable disease or needing an immunization, if they are county residents but ineligible for the UNM Care Program, they can be charged only an affordable co-pay with no subsequent charges. This is similar to the pay policy under the UNM Care Program.

Recommendations

On the basis of our experience, we offer three recommendations to help guide AHCs in developing health policies pertaining to undocumented and/or recent legal immigrant patients.

Health policy

It is within the legal authority and obligation of AHCs to provide and/or restore public health and preventive benefits to all their patients as a human entitlement.[4] Exceptions are allowed for nonqualified immigrants, including "Public health assistance for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not such symptoms are caused by a communicable disease."[4] Other AHCs across the country are exercising this authority by making the number of days a patient has resided in a county an eligibility requirement for financial assistance and charity care. In our review of online policies and in e-mail and phone contact with individuals at other public AHCs, we found that other AHCs (in Arizona, Florida, and Minnesota) were covering "all indigents regardless of immigration status."[10–12] Although there is variation in establishing eligibility criteria across AHCs, many public hospitals only require that patients establish residency within the state or county of residence, and it is not necessary that they be U.S. citizens to qualify for financial assistance.

Medical education

AHCs should ensure that the public health principles they teach are reflected in their institution's service policies. For the quality of care to be improved and racial/ethnic health disparities to be reduced, health provider education must go beyond training in cross-cultural and linguistic competencies and also cover how to assess and act on the basis of the social conditions affecting the health of diverse patients. New models of medical education and health professions training are providing students with service–learning opportunities and applied community experience.[13] Medical educators should encourage innovative ways to address the ethical dilemmas that can emerge when public health principles are inconsistent with medical practice. AHCs who mentor students on how to resolve these dilemmas from a human rights approach are more likely to obtain positive outcomes for students' professional growth as well as for their ability to advocate for health equity and become active in health policy debates, as illustrated in the case examples above.

Service delivery

AHCs should provide consistent training to financial counselors and health care professionals to implement standard admission and financial assistance policies and procedures. Within the maze of complex federal, state, and institutional policies regarding immigrants, frontline health care providers and eligibility workers may interpret them in ways that lead to practice bias and discrimination. All financial counselors and health care professionals must be trained to follow a certain script to minimize racial profiling, stigmatization, discrimination, and disparate treatment of immigrant patients. As in the case examples described earlier, immigrants and their children also benefit from the assistance of CHWs, who are able to help immigrants navigate complicated eligibility and benefits policies, reduce their fear of seeking services, and advocate for fair and equitable services.[14]

Conclusion

AHCs provide the majority of care to the nation's diverse and medically underserved populations and play a critical role in making local health policies. Despite the critical role that AHCs play in promoting population health, there exist myriad health policies and practices regarding immigrants that may conflict with the social mission of the institution and professional ethics of health providers. Resolution of the challenges that arise between the ethics of medical education, service delivery, and local health policy will depend on both clinical and administrative AHC leaders who are willing to balance economic and

fiscal demands with a commitment to professional ethics and population health.

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