Academic Health Centers and Care of Undocumented Immigrants in the United States: Servant Leaders or Uncourageous Followers?

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Abstract

Public dialogue and debate about the health care overhaul in the United States is centered on one contentious question: Is there a moral obligation to ensure that all people (including undocumented immigrants) within its borders have access to affordable health care? For academic health centers (AHCs), which often provide safety-net care to the uninsured, this question has moral and social implications. An estimated 11 million undocumented immigrants living in the United States (80% of whom are Latino) are uninsured and currently prohibited from purchasing exchange coverage under the Patient Protection and Affordable Care Act, even at full cost. The authors attempt to dispel the many misconceptions and distorted assumptions surrounding the use of health services by this vulnerable population. The authors also suggest that AHCs need to recalibrate their mission to focus on social accountability as well as the ethical and humanistic practice of medicine for *all* people, recognizing the significance of inclusion over exclusion in making progress on population health and health care. AHCs play a crucial role, both in educational policy and as a safety-net provider, in reducing health disparities that negatively impact vulnerable populations. Better health for all is possible through better alignment, collaboration, and partnering with other AHCs and safety-net providers. Through servant leadership, AHCs can be the leaders that this change imperative demands.

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Never before has public dialogue and debate in the United States been so intensely focused on the confluence of immigration reform and health care reform. The essence of this debate is centered on one contentious question: Does the United States have a moral obligation to ensure that all people living within its borders (including undocumented immigrants) have access to affordable health care? For the 141 U.S. medical schools, this question translates to, "Do academic health centers (AHCs) have a moral and social obligation to ensure that all people living within the communities they serve have access to affordable health care?"

There is an expectation that medical schools have a social mission to train physicians to care for the population as a whole, but there is notable variation in the success of medical schools in addressing this mission.[1] As the United States begins to implement the major reforms outlined in the Patient Protection and Affordable Care Act (ACA), it seems appropriate that all medical schools and AHCs examine their educational and service commitment to ensure they are meeting state and national needs.[1] Leaders have argued that social accountability of medical schools—"the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve"[2]—forms the essential foundation for medical practice and medical education.[3]

Health equity is a primary goal of the ACA, which is designed (1) to ensure that all Americans have access to quality, affordable health care and (2) to create transformation within the health care system to contain and possibly lower costs. Safety-net providers, including many AHCs, "organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients,"[4] and thus may be well positioned to play a leadership role in advancing the health equity goals embodied in the ACA.[5]

There are an estimated 11.2 million undocumented immigrants living in the United States, including 1 million children.[6] Eighty percent of undocumented immigrants in the United States are Latino[7] and are more likely to be uninsured because they often work in low-wage jobs that do not offer health insurance.[8] They are currently ineligible for federally funded programs (Medicare, Medicaid, Children's Health Insurance Program) and are prohibited from purchasing exchange coverage under the ACA, even at full cost.[7,8] Recent reports have found that legal immigrants in "mixed-status" families, who could qualify for coverage, do not enroll out of fear of exposing undocumented family members.[9] Six in 10 Latinos worry that they themselves or a family member will be deported.[6]

The lack of progress on immigration reform has placed financial pressures

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on safety-net health care organizations and has created ethical challenges for our AHCs, whose social mission in the past has been to provide access and quality of care to all patients who cross their threshold, even undocumented immigrants.[7] In this issue, Cacari Stone and colleagues[10] reflect on their experiences navigating these ethical issues at their own AHC. Throughout the United States, safety-net hospitals will be particularly affected by the ACA's scheduled reduction in disproportionate share hospital payments, which have previously cushioned the financial impact of providing uncompensated care. The reduction is planned in anticipation that many hospitals will have a lower burden of uncompensated care as a result of fewer uninsured patients, but those with a larger proportion of undocumented, uninsured immigrants may not benefit in the same way.[9] As a result, many AHCs across the country are closing their doors not only to undocumented immigrants but also to a majority of uninsured, underserved population groups for nonemergent care.

It is time for fresh thinking about what is actually possible. We agree with Wartman[11] and argue that it is time for our AHCs to recalibrate and bring the focus of our service and efforts back to the foundation that we were built on and that has sustained our core mission over decades. We need to refocus on social accountability and the ethical practice of medicine, and leverage our innovation and creativity to create the systems-based changes necessary to adapt to the present challenges we face and better prepare for the future. It is time to ask whether we see ourselves as servant leaders (focusing primarily on the growth and well-being of people and the communities to which we belong, and being a servant first, making the conscious decision to lead in order to better serve others rather than to increase our own power)[12] or as uncourageous followers (unwilling to be the first to take the lead in an unknown frontier, who prefer to wait for others to step up and take the lead).

Dispelling Myths About Undocumented Latino Immigrants and Utilization of Health Care

To increase access to quality care and improve the quality of life for all communities, we cannot leave behind the most vulnerable and undermine their human right to life.[7] The use of health care services by undocumented persons living in the United States and their eligibility for these and other services continues to be the subject of heated national debate, not only in the political arena but also among AHCs. This debate has focused on several concerns, including the misperception that undocumented immigrants consume large amounts of publicly funded health services, burdening state and local governments financially and reducing resources available to other populations, as well as the belief that government-funded benefits serve as an incentive for immigrants to come to the United States. A number of common misconceptions and distorted assumptions contribute to this debate. There is an urgency for reeducating our AHCs, administrative leaders, and some health care providers about these topics.

Do undocumented immigrants consume large quantities of publicly funded services?

One pervasive concern is that undocumented immigrants, many of whom are low income, unauthorized, and uninsured, rely on uncompensated care and Medicaid, draining medical resources that are predominantly contributed by U.S. taxpayers.[13] However, research demonstrates that the majority of undocumented immigrants in the United States are young, with a median age of 28 (over 50% were in the 18–34 age group)[14] compared with a median age of 37 for the overall U.S. population.[15] Further, most undocumented immigrants are relatively healthy and do not have chronic diseases (less than 1% were 65 years of age and over).[14] The majority come to the United States seeking jobs, not health care and not publicly funded health services.[16] No more than 1% of undocumented Latino immigrants living in California reported that they came to the United States to receive social services.[14]

Are undocumented immigrants drawn to the United States by the promise of publicly funded services?

The publicly funded safety net provides some access to health care for undocumented immigrants through state-level Emergency Medicaid to cover hospitalization for emergency medical treatment and through Federally Qualified Health Centers for primary care.[15] Because the overwhelming majority of undocumented immigrants do not have health insurance, they often use emergency rooms, though at a lower rate than the general population does. Research has demonstrated that undocumented immigrants in California use fewer health services than the rest of the population, including documented immigrants and citizens of Latino and non-Hispanic (NH) white backgrounds (89.3% of NH whites had accessed health services compared with 68.8% of all Latinos and 54.8% of undocumented Latino immigrants).[17] Undocumented immigrants were more apt to use hospital outpatient clinics, health centers, and public health clinics and *not* emergency rooms. In fact, legal immigrants and citizens were 72% more likely than undocumented Latinos to seek medical care.[17]

Mandating emergency treatment regardless of payment status or immigration status can lead to higher costs for hospitals, especially for non-emergency-related health care issues.[18] It is estimated to cost between $6 billion and $10 billion per year to provide health care to undocumented immigrants, but because of their lower rates of use of health care services, this accounts for only 1.5% of U.S. medical costs.[18] The estimated tax burden per U.S. household is only $11 per year for providing health care to undocumented immigrants.[18]

The nonpartisan Congressional Budget Office reported that undocumented immigrants contribute more in taxes than the costs of providing health care services at the federal and individual state levels.[18] In 2010, it was reported that undocumented immigrants contributed over $1.5 billion to Medicare and over $7 billion annually to Social Security.[18] More recent estimates indicate that undocumented workers contribute about $15 billion a year to Social Security via payroll taxes while they only take out $1 billion.[19]

Recalibrating the Thinking of AHCs

AHCs need to take responsibility for the health and well-being of the communities in which they play a central role.[11] We have an obligation as health care providers and medical educators to work

with our AHCs to undergo a societal transformation, returning to the value proposition of servant leadership.[12] This framework preserves the quality of our practice both in clinical settings and in the communities we serve, and preserves the professional and human dimensions in our practice of medicine.[20] As Swick[20] has stated eloquently:

> If the medical profession is to recapture and preserve the rich tapestry of professionalism and humanism that have, for so long, reflected the ideals of medicine, then those of us who are physicians must, individually and collectively, strive to express these qualities not only in clinical settings but also in the other communities we serve. It is a challenge we should embrace willingly.

Physicians have traditionally served as more than just caregivers; we have long been seen as integral members of our communities. Despite the fiscal challenges of the current health care practice environment, "certain dimensions of medical professionalism—such as its implicit social contract—demand that physicians be active, participating members of the communities in which they live."[20] Physicians who "harbor the passion of humanism"—encompassing those attitudes and behaviors that emanate from a deep sensitivity and respect for others—are best positioned to "remain steadfast in fulfilling their professional abilities despite ever-present temptations to do otherwise."[21] Humanism comprises a set of deep-seated personal convictions about one's obligations to others, especially others in need. Physicians whose professionalism lacks a solid foundation in humanism are in constant danger of deviating from the ethical commitments of medicine.[21]

Since the late 1960s, AHCs have been instrumental in building the capacity of the health workforce and meeting the health care needs of the nation's diverse and underserved communities. Despite AHCs' role in shaping the nature of education in the health workforce, the persistent misalignment between curricula and the health care needs of the population requires the recalibration of the AHCs' educational programs.[11] We have an obligation to use education, research, and service activities to shape our future health care workforce's vocation in concert with the priority health concerns of the communities they will serve locally, regionally, nationally, and globally. AHCs play a crucial role, both in educational policy and as safety-net providers, in reducing health disparities that negatively impact underserved populations.

The Next Generation of Work

As Association of American Medical Colleges (AAMC) President and CEO Darrell G. Kirch, MD, stated in his leadership address at the 2013 AAMC annual meeting, medical schools, teaching hospitals, and the medical profession at large are facing a "moment of truth." There is a change imperative upon us, and Kirch called on AHCs "to embrace the responsibility for transforming our health care system."[22] The ACA has provided not only a number of challenges but also a number of opportunities for AHCs. The emphasis is on collaboration and partnerships.

The ACA offers opportunities specifically for safety-net providers to improve access to and quality of care through delivery and payment innovations, providing funding for demonstration projects, such as the development of pediatric accountable care organizations, medical homes serving chronically ill Medicaid beneficiaries, and community-based collaborative care networks to coordinate care for low-income populations.[5] One study of 46 medical home programs in 38 public hospitals demonstrated a nearly 25% improvement in access to culturally competent care by employing bilingual staff, providing on-site language services, partnering with culturally oriented community organizations, and offering mobile care. This led to a 33% reduction in emergency department visits for primary care.[5]

The ACA has also provided strong funding support for community health centers (CHCs), increasing their funding to $11 billion over the period from 2011 to 2014, to expand operational capacity, enhance health services, and meet capital needs to serve nearly 20 million new patients. This is a time for AHCs to partner with local CHCs to provide primary care through basic health services, including prevention and enhancement of patient health literacy. There are models demonstrating that local CHCs can provide continuity of care for patients with chronic conditions, with the aim of decreasing emergency room visits, decreasing length of hospital stays, and decreasing readmission rates. In return, AHCs can provide the tertiary and quaternary care for the same patient population. These all translate into cost savings for both the hospitals and the community.

Conclusion

AHCs have a moral and social obligation to ensure that all people living within the communities they serve, including undocumented immigrants, have access to affordable health care. The change imperative requires that our AHCs reassess their efforts to achieve their social mission and requires our physicians to reignite the value propositions of servant leadership and humanism. The change imperative requires alignment, collaboration, and partnerships among AHCs and other safety-net providers who need to participate actively in innovative and meaningful systems-based thinking to create the solutions that will bring about change in the delivery of community-based health care. Cacari Stone and colleagues offer some recommendations for AHCs navigating the intersection between complying with local and federal policies and fulfilling the social mission of caring for all patients.[10] As wisely stated by Kuczewski and Brubaker[23]:

> To wait to act until all future contingencies are resolved and success is guaranteed is to bypass opportunities.… It is important that our educational and medical institutions be seen as being quick to cut through … injustice in the service of their mission. In the long run, this stewards a legacy that inspires the trust of the general public and solidifies the role of these institutions as part of the infrastructure of shared communal values.

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References

1 Mullan F, Chen C, Petterson S, Kolsky G, Spagnola M. The social mission of medical education: Ranking the schools. Ann Intern Med. 2010;152:804–811.
2 Boelan C, Heck JE. Defining and Measuring the Social Accountability of Medical Schools. Geneva, Switzerland: World Health

Organization; 1995. http://whqlibdoc.who.int/hq/1995/WHO_HRH_95.7.pdf. Accessed December 22, 2013.
3 Rourke J. AM last page. Social accountability of medical schools. Acad Med. 2013;88:430.
4 Institute of Medicine. America's Health Care Safety Net: Intact but Endangered. Washington, DC: National Academy Press; 2000.
5 Andrulis DP, Siddiqui NJ. Health reform holds both risks and rewards for safety-net providers and racially and ethnically diverse patients. Health Aff (Millwood). 2011;30:1–7.
6 Pew Hispanic Center. Hispanics and Arizona's new immigration law. 2010. http://pewresearch.org/pubs/1579/arizona-immigration-law-fact-sheet-hispanic-population-opinion-discrimination. Accessed December 22, 2013.
7 Berlinger N, Gusmano MK. Undocumented patients: Undocumented immigrants and access to health care. The Hastings Center Undocumented Patients Project. March 2013. http://www.undocumentedpatients.org. Accessed December 22, 2013.
8 Henry J. Kaiser Family Foundation. Immigration reform and access to health coverage: Key issues to consider. Kaiser Commission on Key Facts, Medicaid and Uninsured, February 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8420.pdf. Accessed December 22, 2013.
9 Wallace SP, Torres JM, Nobari TZ, Pourat N. Undocumented and uninsured: Barriers to affordable care for immigrant populations. The Commonwealth Fund, UCLA Center for Health Policy Research, August 2013. http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Aug/Undocumented-and-Uninsured.aspx. Accessed December 22, 2013.
10 Cacari Stone L, Steimel L, Vasquez-Guzman E, Kaufman A. The potential conflict between policy and ethics in caring for undocumented immigrants at academic health centers. Acad Med. 2014;89:536–539.
11 Wartman SA. Commentary: Academic health centers: The compelling need for recalibration. Acad Med. 2010;85:1821–1822.
12 Graham JW. Servant-leadership in organizations: Inspirational and moral. Leadersh Q. 1991;2:105–119.
13 Zallman L, Woolhandler S, Himmelstein D, Bor D, McCormick D. Immigrants contributed an estimated $115.2 billion more to the Medicare Trust Fund than they took out in 2002–09. Health Aff (Millwood). 2013;32:1153–1160.
14 Schur CL, Berk ML, Good CD, Gardner EN. California's Undocumented Latino Immigrants: A Report on Access to Health Care Services. Menlo Park, Calif: Henry J. Kaiser Family Foundation; May 1999. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/california-s-undocumented-latino-immigrants-a-report-on-access-to-health-care-services-report.pdf. Access December 30, 2013.
15 Martin TW, Campo-Flores A, Rutland M. Health overhaul targets Hispanics: Uninsured Hispanics represent big opportunity for insurers, the government. Wall St J. 2013. http://online.wsj.com/news/articles/SB10001424127887323423804579021691445787818. Accessed December 30, 2013.
16 Derose KP, Escarce JJ, Lurie N. Immigrants and health care: Sources of vulnerability. Health Aff (Millwood). 2007;26:1258–1268.
17 Chavez KR. Undocumented immigrants and their use of medical services in Orange County, California. Soc Sci Med. 2012;74:887–893.
18 Becerra D, Androff KD, Ayon C. Fear vs. facts: Examining the economic impact of undocumented immigrants in the U.S. J Soc Soc Welf. 2012;34(4):111–135.
19 Davidson A. Do illegal immigrants actually hurt the U.S. economy? N Y Times. February 12, 2013. http://www.nytimes.com/2013/02/17/magazine/do-illegal-immigrants-actually-hurt-the-us-economy.html?_r=0. Accessed December 30, 2013.
20 Swick HM. Viewpoint: Professionalism and humanism beyond the academic health center. Acad Med. 2007;82:1022–1028.
21 Cohen JJ. Viewpoint: Linking professionalism to humanism: What it means, why it matters. Acad Med. 2007;82:1029–1032.
22 Davis A, Greenberg R. AAMC annual meeting embraces change to shape future health care. AAMC Reporter. November 2013. https://www.aamc.org/newsroom/reporter/november2013/362056/annual-meeting.html. Accessed December 30, 2013.
23 Kuczewski MG, Brubaker L. Medical education as mission: Why one medical school chose to accept DREAMers. Hastings Cent Rep. 2013;43:21–24.