Immigration Policies and the U.S. Medical Education System: A Diverse Physician Workforce to Reduce Health Disparities

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COMMENT

In the last 3 years, President Obama has taken unprecedented executive actions to protect immigrants in the United States. These new immigration policies provide previously undocumented immigrants living in the U.S. with lawful presence and new opportunities to participate in post-secondary education, including medical school, residency, fellowship training, and to practice as physicians. U.S. Medical Schools and Graduate Medical Education (GME) programs can now reach beyond the traditional pool of qualified applicants to enhance diversity and reduce racial, ethnic, and socioeconomic health disparities. It remains to be seen whether this will be possible, given the limited training opportunities, and medical licensing and financial aid barriers these immigrants face in becoming healthcare professionals.

President Obama's Immigration Accountability Executive Action shields approximately 50 % of the nation's 11.2 million unauthorized immigrants living in the U.S. from deportation.[1] This new executive action expands Deferred Action for Childhood Arrivals (DACA), a federal directive that began in 2012 to protect men and women who were born in another country and brought to the U.S. at a young age. DACA provides lawful U.S. presence, a social security number, and work authorization for undocumented immigrants who arrived in the U.S. before the age of 16, graduated from a high school, obtained a general education development (GED) certificate, or who are honorably discharged veterans. Approximately 690,000 out of the 1.9 million estimated young adults in the U.S. who are undocumented immigrants have been granted DACA.

Individuals who receive DACA immigration protection, however, are not guaranteed the same training opportunities as U.S. citizens or other authorized immigrants when they apply or gain admission to medical schools. Until recently, medical schools and training programs categorized individuals with DACA status as international students. In 2012, the Loyola University of Chicago Stritch School of Medicine was the first U.S. medical school to recognize applicants with DACA status as domestic students—not international students.[2] According to the American Association of Medical Colleges (AAMC), 16 out of 112 U.S. allopathic medical schools have publicly reported willingness to consider DACA applicants (DACA friendly list: https://www.aamc.org/students/download/404292/data/daca.pdf).[3] The AAMC list includes both private and public institutions, and this list will likely continue to expand as more medical schools announce they accept DACA applicants or acknowledge they have enrollees with DACA status. However, it is unknown how many GME residency and fellowship programs have DACA friendly policies.

The benefits of training individuals with DACA status may extend to patients.[2] DACA applicants are immigrants from all over the world and are commonly bilingual and bicultural because they immigrated to the U.S. at a young age. For example, in California an estimated 82 % of DACA-eligible young adults are Latino or from Spanish-speaking countries.[4] Accepting and supporting individuals with DACA status could provide minority and non-English speaking patient populations with improved access to care. Prior research suggests that minority and bilingual physicians disproportionately care for minority patients with limited English proficiency and other disadvantaged populations. In addition, physicians with DACA status, given their immigrant experiences, are more likely to serve underserved populations where physician shortages are most pronounced.[5] More generally, having a diverse physician pool will provide the nation's health care consumers with more choices and improve patient satisfaction through language and race-ethnic concordance.[5] Accepting individuals with DACA status provides another opportunity for training programs to change institutional culture and further reduce health disparities, specifically in communities with a large percentage of immigrants.

In most states, however, individuals with DACA status face significant obstacles to practicing because they are ineligible for medical licensure. This may severely discourage training programs from considering individuals with DACA status. There has been wide state-to-state variability in medical licensure eligibility requirements for immigrants, based on the interpretation of federal and state laws. In California and Florida, state legislation was passed to specifically include DACA as a permissible immigration status for professional licensure. However, in other states, individuals with DACA are ineligible for professional licenses because DACA is not a permanent immigration status and it must be renewed every 2 years. This technical distinction will continue to be

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challenged in the courts and legislatures as immigration policies evolve, but remains a challenge for physicians in training with DACA status.

Another major obstacle is the financing of educational and training costs for individuals with DACA status seeking to become physicians. Applicants with DACA status are excluded from receiving federally subsidized educational loans, fellowships or scholarships, despite having the greatest unmet financial need. For example, in California 62 % of individuals with DACA status reported a household income below $16,000 for a single individual.[4] In stark contrast, the national median student-reported parental income among matriculating medical students in 2013 was $120,000. The cost of medical school alone for these students may be prohibitive, given recent graduate debt levels reported at a mean of $167,763 for public and $190,053 for private institutions. Without high level policy changes such as the passage of true comprehensive federal immigration reform, most institutions are handling each DACA applicant on a case-by-case basis and have limited support to develop permanent educational and financial aid policies. Medical schools and graduate training programs are also facing significant budget constraints in an era of decreased state and federal funding. Public medical institutions in particular may face significant financial barriers in their efforts to enhance diversity through DACA friendly policies, as illustrated by the fact that 12 out of the 16 medical schools on the AAMC DACA friendly list are private medical schools. Thus, if medical schools accept individuals with DACA status, they are typically faced with a difficult dilemma of how to financially support these students and transition them to residency training programs. There has been some progress over the last 2 years to address the lack of equitable financial aid options for students with DACA status. Approximately 17 states allow individuals with DACA status to pay in-state college tuition and are considering other financial aid options. For example, California's Governor Jerry Brown recently signed a series of bills to support individuals with DACA by creating a 9.2 million dollar state loan program. These policies, however, are the exception in the U.S., and it is uncertain if these loans will be designated for professional or graduate programs.

Transparent medical admissions policies that allow individuals with DACA status to understand enrollment and financial aid opportunities are a work in progress. The AAMC's blueprint of an information repository where current and future medical students with DACA status can access information is a great first step. Without further guidance from the AAMC, GME, federal and state governments, we are pessimistic that more U.S. medical schools and physician training programs will implement robust admissions and financial aid policies for a significant number of individuals with DACA status. With comprehensive immigration reform unlikely, potential incremental reforms include elimination of state medical licensure barriers, and developing public and privately funded scholarships and loans for individuals with DACA status. Clearing a pathway for individuals with DACA status may be an important step toward increasing diversity in U.S. medical schools and in the physician workforce, and reducing health disparities.

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