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DIALYSIS WITHOUT BORDERS

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Over 700,000 Americans have end stage renal disease. Hemodialysis is the most common treatment (63% of patients) and is typically performed three times a week at an outpatient facility. The Medicare program covers virtually all citizens with end stage renal disease, regardless of age, and spends \$34 billion annually for these patients (1).

By contrast, an estimated 6500 undocumented immigrants with kidney failure in the United States lack reliable access to dialysis treatment (2,3). Some cities and states have developed funding strategies to provide regular hemodialysis treatment (2,3). However, undocumented individuals in other regions must wait until they develop uremic complications, such as hyperkalemia or pulmonary edema, and then go to a hospital emergency department. Hospitals can then access federal emergency Medicaid funds to provide inpatient hemodialysis treatment. After 1–2 treatments, undocumented patients are discharged only to repeat the process several days later.

This problem of providing treatment to undocumented individuals with end stage renal disease has been examined from medical, financial, ethical, international, and professionalism perspectives. From a medical perspective, emergency-only dialysis is clearly inferior to standard thrice weekly dialysis. Patients receiving emergency-only dialysis have higher mortality, more hospitalizations, and worse nutritional markers compared to patients receiving standard dialysis (4). In addition, patients commonly have near-death and resuscitation experiences as well as recurrent anxiety about worsening uremic symptoms while they wait for the next emergency dialysis treatment (5).

From a financial perspective, emergency-only dialysis is associated with substantially higher costs compared to standard dialysis. Each emergency-only patient costs local health care systems an average of \$300,000–400,000 annually in Houston and Denver (2). By comparison, annual Medicare expenditures average \$90,000 per hemodialysis patient (1). Thus, extending Medicare coverage to the 6500 undocumented individuals needing hemodialysis would cost an estimated \$600 million annually. It is worth noting that a majority of undocumented individuals pay income taxes and all pay sales taxes (1). However, they receive little or no benefits in return. For example, a recent study estimated that undocumented individuals contributed \$35 billion to the Medicare program from 2000–2011 but received no benefits (6).

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From an ethical perspective, physicians and other health providers are expected to take care of the sick regardless of their social, political, or citizenship status. Even prisoners who commit heinous crimes and enemy soldiers who are captured in battle must receive medical care (7). Moreover, undocumented individuals often carry out the most disagreeable and difficult work in our society for the lowest wages. Providing health care for them and their families would be a good way to express social and communal respect for their contributions (8).

From an international perspective, several economically advanced countries (e.g. Canada, Germany, Italy) provide regular outpatient dialysis for undocumented immigrants (2). No evidence suggests that providing standard dialysis to undocumented individuals, as the state of California does, has incentivized and increased illegal immigration (2). In fact, descriptive studies suggest that most undocumented individuals developed end stage renal disease some years after migration to the United States (2,5).

From a professionalism perspective, previous writers have speculated that denial of care to undocumented individuals may undermine professionalism because health providers would no longer be following standards of practice or promoting the best interests of patients (7,8). The study by Cervantes et al. in this issue is the first to provide empirical evidence about the impact of emergency-only dialysis on professionalism (9). The investigators found that denial of standard dialysis contributes to burnout, moral distress, and discomfort with perverse financial incentives. On a more positive note, some providers reported being inspired toward advocacy for undocumented patients. Strengths of the study include involvement of a variety of providers experienced in caring for undocumented patients with end stage renal disease, use of open-ended questions, and careful qualitative analysis. Weaknesses include a modest sample size obtained from only two hospitals.

There are important parallels between providing standard dialysis to undocumented individuals and providing universal health coverage to all American citizens. Universal health coverage would probably improve medical outcomes, reduce financial costs, support ethical principles, emulate other advanced countries, and enhance professionalism. Yet neither standard dialysis for the undocumented nor universal health coverage for citizens is available. I believe both of these deficiencies are due to the same factors. Neither undocumented individuals nor poor citizens have sufficient power in our society to be able to demand health care. Many political leaders encourage us to categorize people as either deserving or undeserving of publicly-funded health care based on citizenship and employment. The recent effort to require Medicaid recipients to work is the latest example of this. The need for health care facilities to make a profit (or a surplus in the case of nonprofit institutions) and the linkage of payment to individual episodes of care (vs. lump-sum operating budgets) further constrain their ability to provide treatment to people unable to pay (10).

I recommend a two-pronged approach to address the problem of emergency-only dialysis. First, physicians and other advocates should work for universal health coverage that includes treatment of everyone within our borders, especially with respect to cost-effective treatments such as dialysis. Universal health coverage would also help prevent the development of end

stage renal disease, e.g. by treating hypertension and other contributors to renal failure. In addition, there is a need to advocate for comprehensive immigration reform. Second, the dialysis community in cities and states that don't provide standard dialysis to undocumented individuals should work together to create treatment mechanisms. This community, which includes health care professionals, hospitals, and dialysis chains, may consider successful approaches from other parts of the country such as sharing the costs of caring for undocumented patients, lobbying for additional Medicaid benefits, identifying tax revenues, and helping patients buy health insurance now that preexisting condition exclusions have been abolished (2,3).

National, state, and city borders are man-made creations that often ignore cultural, historical, and geographic connections among populations. Such borders should not define the line between life and death for end stage renal disease patients.

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