

Introduction

Natives and Newcomers, Partners in Health

Over 200 million of us are newcomers, travelers, and migrants living outside our nation of birth. Newcomers and natives alike live, work, play, and die together, a fact that became increasingly evident in 2015, as a rapid surge in migration from the Middle and Near East and North Africa led to more than a million newcomers arriving in Europe.

Across the globe, the increasing presence of newcomers has sparked intense backlashes. Buffeted by years of economic austerity, as well as fears of terrorism, epidemics, and a changing way of life, many natives have turned against newcomers and have demanded that their nations take bold and even punitive steps to stop the flow of migrants. But 2015's rapid rise in migration, including many forced migrants, also prompted expressions of generosity and solidarity, as doctors and nurses working for NGOs cared for the refugees as they arrived in Europe, and communities across the West opened their doors and hearts to new neighbors. Both reactions, the generous and the fearful, illustrate the complex and intense reactions that migration invites, as well as the increasing interdependency of newcomer and native.

The recent increase in human migration has coincided with a renewed awareness of the risks of microbial migration, and the interdependency of human health. In 2014, the world witnessed the worst Ebola epidemic to date, with more than 11,000 people dying of the disease in West Africa. Although the disease did not spread widely outside that region, with only a few cases occurring in the United States and Europe, Ebola underscored the interdependency of human health across the globe. The resources and efforts that the international community eventually invested to combat the epidemic, albeit late in coming, also demonstrated a recognition that in our global age, the health of people

in one part of the globe affects the health of people living far away. Or, as we shall argue, health is at least partially a global public good.

In this book we explore the connections and implications of these two insights—the interdependency of newcomer and native, and the public good aspect of health, arguing that the latter has important normative implications for how nations ought to respond to the health threats posed by as well as the needs presented by newcomers.

In so doing, we seek not only to demonstrate why it is rational and moral for nations to treat the health interests of natives and newcomers alike, but also to dispel myths about newcomers, that have undermined the willingness of natives to promote the health interests of newcomers as they would those of family and compatriots. For example, we show that contrary to the widely held belief that newcomers are especially unhealthy, newcomers are healthier in general than natives. We also argue that contrary to the belief that poor countries are responsible for their own health problems, the global economic structure, often instituted at the behest of wealthy countries, has contributed to the ill health of many of those who live in many poor countries. In addition, one of the key social determinants for health is inequality, both globally and nationally. Inequality hurts health. Although one might expect that inequality would hurt the health of the poor because they cannot afford food, shelter, medications, and top medical care, it hurts not only the poor, but all people, including affluent natives in wealthy countries.

Our goal in dispelling myths about migration and health is to unpack the many ways in which these myths have infiltrated public policy at the intersections of immigration and health. As we show, far too many policies that relate to immigrants and health undermine public health rather than securing it. Many of these policies are also, we argue, morally indefensible. Our hope is that once weaned from false beliefs about both newcomers and health, nations will tear down old policies relating to the health of newcomers and replace them with new approaches that are more effective in protecting the health of both natives and newcomers and more respectful of the rights of newcomers.

Plan of This Book

We begin in chapter 1 by offering some illustrations, in all-too-human terms, of the harms caused when health policies are infected by anti-immigration sentiment. We then survey the state of global migration today, a survey that illuminates both the diversity of newcomers, and the falsity of many commonly held beliefs about them. Chapter 1 concludes with a brief analysis of what we mean by health, and the factors that help shape human health. This relatively brief discussion lays the foundation for a thorough treatment of health as a public good later in the book.

Having introduced migration and health, we turn in the next four chapters to a review and critique of some of the laws and policies, both in the United States and across the globe, that lie at the nexus of health and migration. These chapters reveal the often-subtle ways in which myths about immigrants undermine health policy, and how misunderstandings about the nature of health have complicated immigration law. They also provide the policy backdrop for the normative arguments we develop in subsequent chapters. In effect, chapters 2 through 5 lay out and analyze the current policy climate, which is subjected to a normative challenge in later chapters.

Chapter 2, “Keep Out!: Immigration Control as Public Health Protection,” focuses on health-based immigration exclusions. As we demonstrate, human beings have long blamed people who appear to be different, including minorities and members of already stigmatized populations, for disease, especially for new and fearsome diseases. Immigrants have borne the brunt of this scapegoating, which has led nations to impose a range of health and disability-based limitations on immigration. For the most part, these exclusions are ineffective from a public health perspective. Rather than protecting the health of natives, they divert resources from effective public health interventions. They also reinforce the misimpression that nations can be free of disease and disability if only the “other” is kept out. By so doing, these policies not only add to the stigma experienced by newcomers but also exacerbate the stigma laid upon natives who live with the excluded conditions.

While chapter 2 examines how a false association between immigrants and disease drives immigration policy, chapter 3 considers the impact of public health policies that pertain to newcomers once they are

in their new nations. We begin by noting that nations have a duty both normatively and under international law to protect the health of their populations. But far too often, states attempt to do so by restricting the liberties of immigrants. In effect, public health policies become meshed with, and offer a rationale for, punitive, anti-immigration measures.

We first illustrate the troubling association between public health protection and anti-immigrant policies by reviewing the history of the battles in the late nineteenth and early twentieth centuries between health authorities in San Francisco and that city's Chinese community, a struggle that helped establish the constitutional limits of state authority over non-citizens in the United States. Next we turn to an examination of public policies regarding tuberculosis. In many ways tuberculosis offers the strongest case for the disparate use of public health legal powers against immigrants. Tuberculosis is today the one significant communicable disease found more frequently in immigrant than native populations. Still, we argue, the threat of TB posed by newcomers is overstated. Moreover, the disparate use of highly coercive legal restraints such as isolation and quarantine on immigrants can never be justified. Both domestic and international human rights law sanction the use of significant restraints of liberty in the name of public health only when they are the least-restrictive means necessary for protecting public health. If less-restrictive means are available to natives, they must be used on newcomers. Moreover, we contend, at least in the case of tuberculosis, highly restrictive policies, such as enforced isolation, are likely to be ineffective for a number of reasons, including the fact that they deter people from seeking treatment. When it comes to public health, access to culturally competent health care is far more apt to be effective than policies that look "tough" on immigrants.

In chapters 4 and 5 we turn to policies affecting immigrants' access to health care, focusing in particular on access to the insurance that is so often necessary to pay for health care. Chapter 4 looks at the issue within the United States. Although the United States, unique among developed nations, does not ensure that all of its citizens have access to health care, it has established a complex patchwork of federal and state health insurance programs to cover large numbers of citizens. Some classes of immigrants are eligible for some of these programs. But many newcomers, especially those who are undocumented, are left without insurance.

Indeed, after the implementation of the Affordable Care Act, widely known as Obamacare, the uninsurance problem in the United States has become, to a large degree, an immigration problem.

But it is too simple to assert that the United States denies immigrants access to health care. The actual situation is far more nuanced, and more perplexing. Our survey of US policies pertaining to immigrants' access to care shows a tangle of inconsistent and conflicting policies, some opening the door to immigrants, others shutting the door. This morass, we contend, reveals deep conflicts in our attitudes toward the health of immigrants. At times we understand that newcomers are part of our communities, and that we cannot for both normative and pragmatic reasons ignore their health care needs. At other times, we seek to deny their participation in our health care system, often based on the false belief that including them will draw them to our borders.

The result of these inconsistent policies, we show in chapter 4, is a system that is far more complex and confused than it should be. Thus the complexity and fragmentation for which the US health care system is infamous is made worse by the inconsistent and incoherent policies that relate to newcomers. But even more problematic is the fact that the exclusions and inconsistencies are bad for the health of both newcomers and natives. As chapter 4 shows, because natives live among newcomers, and use the same health care institutions, they are affected when the diseases of newcomers are left untreated, or their providers are left unpaid.

Chapter 5 continues the exploration of immigrants' access to health care by looking at the situation in nations that purport to respect a human right to health, especially Canada and the nations within the European Union. As we explain, international human rights law establishes a right to health that demands that nations, subject to resource limitations, assure the means for accessing necessary health care services. There are strong reasons to conclude that that right to health applies in full force to newcomers, including those who are undocumented. However, caveats and limitations included in many international legal documents offer some support for a more limited conclusion: that nations must provide undocumented immigrants only with emergency care.

In fact, as our survey demonstrates, many nations, including some proclaiming respect for the right to health, provide less than full participation in their national health care programs for noncitizen newcomers.

Indeed, several nations provide only the bare minimum to undocumented newcomers. Many other nations impose a range of limitations and barriers that make it difficult for newcomers, sometimes even those with quasi-legal status, from attaining care. In short, once we focus on the health of newcomers it becomes all too apparent that even so-called universal health care systems are not really universal. And in these nations, as in the United States, the erection of barriers to care has had a deleterious impact on the health of both newcomers, and potentially natives.

After discussing in chapters 2 through 5 the myriad and problematic ways in which immigration and health policy intersect, and how myths about newcomers undermine nations' attempts to protect health, we turn in chapters 6 through 8 to a fuller discussion of the public and global nature of health. This analysis provides the foundation for the moral argument and policy recommendations that appear in chapters 9 and 10.

In chapter 6, "Health as a Global Public Good," we argue that health has global public good dimensions. In this respect we depart from the standard view, which generally holds that health is a private good. Understanding health as a global public good underscores the fact that when it comes to health we are all in this together. This means that we are likely to cause more harm in general if we treat health as a private good, and create more good when we recognize health's public good dimensions.

This conclusion would certainly resonate with utilitarians. Attending to the health needs of newcomers and citizens alike will produce better health for both, a conclusion that we demonstrated empirically in prior chapters and support conceptually in chapter 6. For example, in a context in which natives and newcomers dwell together, often intimately, if we only treat the health needs of natives and ignore those of newcomers, the health of both will be compromised. If newcomers are left untreated, their illness will have consequences for both natives and newcomers. In a world in which natives and newcomers live side by side, ignoring the health of the latter is at the health peril of the former.

The insight that health is a global public good does double duty in this volume. It grounds practical and self-interested reasons for treating newcomers and natives in the same way, and provides a utilitarian

foundation for doing so. In subsequent chapters we provide additional moral reasons for equal treatment.

In chapter 7 we explain that our obligation to treat the health needs of newcomers is not solely based on the good outcomes that will follow. Instead, we show that receiving nations have strict moral duties to newcomers, based on the harms that they have caused to the global poor. In other words, following philosopher Thomas Pogge and others, we argue that people in affluent countries have strict moral duties to people in poor countries because of the role affluent countries have played with respect to poverty and, in turn, health. Given this, the duty to fulfill the health rights of newcomers is morally demanding. It is not only that it would be good and charitable for us to recognize newcomers' health rights, we are morally obligated to do so because of the harms we have caused, and the attending moral responsibility to address them.

Taken together, chapters 6 and 7 show that it is in the interest of receiving countries to attend to the health of newcomers because health is a global public good, and that because affluent nations have compromised the health of the global poor, they have duties to address those harms.

The global nature of health, as well as the claim that receiving nations have duties to newcomers, are further developed in chapter 8. In "Strangers for the Sake of Health," we introduce three ways in which health is treated as a global resource by people in affluent nations, and in some cases people from the same nations that draw migrants to their shores. First, and significantly for both sending and receiving nations, many health care workers migrate from poor countries, overburdened with disease, to affluent nations. Unfortunately, this practice often leaves poor sending countries without enough health workers to meet their own needs, even when they have subsidized the training and education of health workers. Second, we discuss the example of medical tourism, the growing practice of people from wealthy countries traveling to other countries, often very poor countries, in order to purchase health care, ranging from knee and hip surgery to cosmetic surgery. Typically, patients travel to other nations for medical care because it is less expensive than what is available in their home country. Medical tourism can have harmful consequences for the health of people in the poor nations where care is received. Medical tourists can be a lucrative source of in-

come for medical workers—shifting their interest and expertise from local patients and their needs to the needs of international patients. Finally, we consider the example of international transplantation in which people travel to another country to both purchase an organ and to have the transplantation done. Again, this can have an adverse impact on the health of natives.

These examples of health's global dimension illustrate two points. First, they show that health is a global undertaking in some significant ways, and that affluent nations have made substantial use of the health resources of poor countries. Morally, this raises concerns about reciprocity and fairness. For our purposes, it shows that although natives express fear and sometimes hysteria about the health of newcomers and the diseases they carry, the natives of wealthy countries also are eager to use the health resources of the very nations from which the newcomers migrate. It would not be surprising to find, for example, that a migrant nurse from Africa is not only the object of fear that he might bring a loathsome disease, putting natives at risk, but also the very same person caring for patients in a hospital in Canada. Rather than consider what this might demonstrate about the bias against newcomers, especially when it comes to redistribution of wealth to "strangers," we think it demonstrates reason for optimism—namely, that when it comes to strangers, whether next door, or across the ocean, people from affluent countries are able to trust those in poor countries. The ability to trust strangers is important not only for health reasons. It also speaks to the possibility of natives acting in solidarity with newcomers for the sake of newcomers' health.

In chapter 9, we develop this point and argue that solidarity need not be tied to citizenship and that it is indeed possible for natives to act in solidarity with migrants, for the sake of the health of newcomers. Not only is it possible for trust and solidarity to exist among diverse people, but we argue, using Iris Young's notion of structural injustice, that it is morally indicated. For Young, duties of solidarity are triggered in part by our connection to a harm and ability to effectively change the injustice. There is an enormous amount of injustice in the world, and people in affluent nations are tied to much of it, whether by recruiting scarce migrant workers or buying inexpensive clothes made in factories that exploit workers. Arguably, it would be difficult, if not, impossible

to redress all the injustice with which we are implicated. Using Young's parameters, we argue that the health of newcomers has priority both because our ties are close, but also because the health infrastructure is in place to effect the change.

In the final chapter, "Natives and Newcomers: Moving Forward Together," we employ the 2014 Ebola outbreak as a case study to show the continuing relevance of the fear of strangers and resulting irrational health policy. But we also look at how international actors galvanized in the end to help the people of West Africa.

We note that the willingness of nations and international agents from around the globe to come to the aid of the people of West Africa, at some cost to themselves, should give rise to a sense of optimism about the future. Norms about our obligation to help strangers seem to be in the midst of radical change: mainstream *Time* magazine honored the international Ebola workforce as its Person of the Year in 2014. Leadership is critical to norm change. In December 2015, Justin Trudeau, prime minister of Canada, welcomed Syrian refugees to Canada with the words, "You are home. . . . You're safe at home now." Newcomers were then given health insurance cards, demonstrating solidarity with them. This example, we believe, offers the hope that respect for the health of others can create a virtuous cycle that is able to override our bias, find shared humanity, and create trust and solidarity that will spill over to other domains.