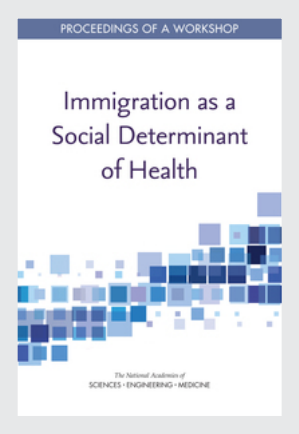

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Immigration as a Social Determinant of Health

PROCEEDINGS OF A WORKSHOP

Steve Olson and Karen M. Anderson, *Rapporteurs*

Roundtable on the Promotion of Health Equity

Board on Population Health and Public Health Practice

Health and Medicine Division

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This Proceedings of a Workshop was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the National Academies of Sciences, Engineering, and Medicine in making each published proceedings as sound as possible and to ensure that it meets the institutional standards for quality, objectivity, evidence, and responsiveness to the charge. The review comments and draft manuscript remain confidential to protect the integrity of the process.

We thank the following individuals for their review of this proceedings:

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Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the content of the proceedings nor did they see the final draft before its release. The review of this proceedings was overseen by **HARRY J. HEIMAN,** Georgia State University School of Public Health. He was responsible for making certain that an independent examination of this proceedings was carried out in accordance with standards of the National Academies and that all review comments were carefully considered. Responsibility for the final content rests entirely with the rapporteurs and the National Academies.

Contents

1

Introduction[1]

Immigrants make up a significant and growing population of the United States. Since 1965 the foreign-born population has swelled from 9.6 million or 5 percent of the population to 45 million or 14 percent in 2015. Today, about one-quarter of the U.S. population consists of immigrants or the children of immigrants (Pew Research Center, 2015). Given the sizable representation of immigrants in the U.S. population, their health is a major influence on the health of the population as a whole.

The process of immigration and the integration of immigrants into American society intersect with many of the social and economic factors that help determine health, including economic stability, access to health care, education, the impact of the built environment, and social and community context. On average, immigrants are healthier than native-born Americans. Yet, immigrants also are subject to the systematic marginalization and discrimination that often lead to the creation of health disparities. These complex interactions between immigration and health have not been well explored, but they are a significant determinant of differences in health and well-being between population groups in the United States.

To explore the link between immigration and health disparities, the

[1] The planning committee's role was limited to planning the workshop, and the Proceedings of a Workshop was prepared by the rapporteurs as a factual account of what occurred at the workshop. Statements, recommendations, and opinions expressed are those of individual presenters and participants and are not necessarily endorsed or verified by the National Academies of Sciences, Engineering, and Medicine. They should not be construed as reflecting any group consensus.

BOX 1-1
Roundtable on the Promotion of Health Equity

The Roundtable on the Promotion of Health Equity was established by the National Academies of Sciences, Engineering, and Medicine to promote health equity and eliminate health disparities by:

- Advancing the visibility and understanding of the inequities in health and health care among racial and ethnic populations;
- Amplifying research, policy, and community-centered programs; and
- Catalyzing the emergence of new leaders, partners, and stakeholders.

Roundtable on the Promotion of Health Equity held a workshop in Oakland, California, on November 28, 2017, titled Immigration as a Social Determinant of Health. (Box 1-1 lists the roundtable's mission and objectives.) The goals of the workshop, explained Winston Wong, medical director for community benefit at Kaiser Permanente, were to:

- Describe why immigrant health is important to the United States.
- Explain how the history of immigration in the United States connects to immigration, economic, and health policies today.
- Discuss the role of immigration as a social determinant of health.

The decision to hold the workshop in California was significant, said Wong. The Bay Area has been a hotbed of immigration issues. Angel Island, just a few miles from downtown Oakland where the workshop was held, was the entry point for immigrants coming from Asia, many of whom were incarcerated before they could even set foot into the United States. San Francisco and the Bay Area were a nexus of Japanese American incarceration during World War II, and they continue to be a center of discussion and debate for immigration issues. Many aspects of immigration "come into play in San Francisco and the Bay Area," said Wong.

MAJOR TOPICS OF THE PUBLICATION

In the final session of the workshop,[2] Melissa Simon, vice chair for clinical research in the Department of Obstetrics and Gynecology and professor

[2] Although Dr. Simon spoke in the closing session, her remarks are placed here in order to establish context for the workshop.

of obstetrics and gynecology/preventive medicine and medical social sciences at the Northwestern University Feinberg School of Medicine, presented a list of the major topics discussed at the workshop. Her list is presented here as an introduction to the workshop's scope.

First, the lesson of history is that immigration and integration are continuing to occur despite people's fears. "It's moving forward no matter what," said Simon. Second, health care is a human right, and no human is illegal. Now more than ever, services need to be expanded and supported, she said, despite the existence of stress and uncertainty. Third, immigrants need to know about their legal rights, regardless of their documentation status. Fourth, people who come to health care providers for care have rights by virtue of their being human. Fifth, the widespread misconceptions and misinformation that exist about immigrants and immigration need to be reversed. "We had some very brave people at this workshop sharing their stories. How do we amplify that?" she asked. Sixth, immigrants are not monolithic. On the contrary, they are extremely diverse. For example, being an immigrant does not mean being poor, no more than being a person of color implies poverty. Seventh, data matter. They inform policies for leaders at all levels. Eighth, immigrant and refugee cultures provide their communities with powerful support systems and networks that translate into hope and resilience.

Chapter 2 of this publication provides an overview of the history of immigration policy in the United States, the current state of immigration policy, and the effects of immigration on health and well-being. Also discussed are issues of data disaggregation and data security regarding immigrants. Chapter 3 looks more deeply at immigration as a social determinant of health,[3] examining the national, state, and local dimensions of this relationship. Chapter 4 presents the voices of several immigrants, both directly and through the organizations that work with and represent them. Finally, Chapter 5 revisits some of the major themes that arose during the workshop and points to unmet needs in the areas of research, policy, and practice.

[3] The social determinants of health are defined as "the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels" (WHO Commission on the Social Determinants of Health, 2008). Social determinants include access to good schools, availability of reliable transportation, high-quality housing, employment opportunities, and so on.

2

The Past and Present of U.S. Immigration Policy

Points Made by the Presenters

- Federal immigration policy, which was based on a quota system from the 1920s through the 1960s, has emphasized family reunification since passage of the 1965 Immigration and Nationality Act. (Villarruel)
- Cultural changes arising in part from increased immigration have contributed to a nativist backlash. (Ewing)
- Since 2009, Asians have constituted a larger percentage of immigrants to the United States than Latinos. (Ramakrishnan)
- Despite having less access to health care and insurance, immigrants have better health outcomes on average than do native-born Americans, although these better outcomes tend to diminish over time. (Ewing)
- The federal deadlock on immigration policy has led states to enact a confusing patchwork of rules and regulations related to immigration. (Ramakrishnan)
- Collection of disaggregated data in the U.S. Census and other surveys can contribute to policies that can improve the lives of immigrants. (Ramakrishnan)

NOTE: This list is the rapporteurs' summary of the main points made by individual speakers identified above. They are not intended to reflect a consensus among workshop participants.

"The U.S. immigration system is not ruled by logic," said Walter Ewing, senior researcher at the American Immigration Council. "It has been created from a long series of political compromises among U.S. lawmakers driven by all sorts of contradictory motivations, some of which have little if anything to do with immigration," he said.

In the first two sessions of the workshop, Ewing and two other presenters—Antonia Villarruel, Margaret Bond Simon Dean of Nursing at the University of Pennsylvania School of Nursing, and Karthick Ramakrishnan, associate dean of the University of California, Riverside, School of Public Policy, and professor of public policy and political science—provided a historical overview and a current snapshot of immigration policy in the United States. Debates over integration are not new, said Villarruel, adding that "they are part of a continual story of us as Americans." They emerge from "a juxtaposition of two diverging ideologies: nationalism and inclusion," she said.

ADVENT AND DECLINE OF THE QUOTA SYSTEM

The naturalization acts passed in the years shortly after the creation of the United States, which restricted citizenship to "free white persons," governed naturalization policy for much of the 19th century, Villarruel began. A series of Chinese exclusion acts in 1882, 1892, and 1902, borne partly out of economic concerns in the western United States, banned Chinese laborers from immigrating and barred Chinese immigrants who already resided in the United States from naturalizing.

The Emergency Quota Act of 1921 and the Immigration Act of 1924 established immigration quotas based on the existing population of the United States, Villarruel continued. Following passage of these acts, most of the immigrants coming to the United States were from Europe, with immigration from Asian countries still barred. These immigration acts generally did not deal with the Western Hemisphere, though a set of agreements around World War II were designed to bring primarily Mexican immigrants to the United States to meet labor shortages. As Ewing described the period after 1924, "Northern and western Europeans were in, and everybody else was effectively out—except for Mexicans and other inhabitants of the Western Hemisphere, who were left outside of the quota system due to their usefulness as easily exploited agricultural laborers."

The position of nativists gradually eroded after the 1920s for a number of reasons, Ewing said. The eugenic concept of white racial superiority on which the quota system was based was thoroughly discredited in scientific circles by the 1950s. "In addition," Ewing pointed out, "at the height of the Cold War, it seemed hypocritical of the U.S. government to decry communism but to not offer refuge to people who had fled communist regimes." The Civil Rights Movement was growing in the 1950s and 1960s,

BOX 2-1
Who Is an Immigrant?

Immigration lawyers use the word *immigrant* in a very narrow sense, referring only to legal permanent residents (or green card holders), However, most social scientists take it to mean any person born in a country other than the United States. This includes not only green card holders but naturalized U.S. citizens, undocumented immigrants, recipients of temporary protected status, refugees and asylum seekers, and workers on temporary visas.

SOURCE: Ewing presentation, November 28, 2017.

highlighting the racism that made African Americans second-class citizens even as race served as the foundation of the immigration system. "Finally," noted Ewing, "over the course of the 4 decades during which the quota system was in force, generations of immigrants had successfully integrated into U.S. society and given birth to very Americanized children." (Box 2-1 provides differing definitions of the term *immigrant*.)

1965 IMMIGRATION AND NATIONALITY ACT

The year 1965 was a major turning point in U.S. immigration policy. One year after the Civil Rights Act passed, the Immigration and Nationality Act of 1965 dismantled the national origins quota system. The new system allotted 170,000 visas to immigrants from the Eastern Hemisphere (with a 20,000 per-country limit) and 120,000 to the Western Hemisphere (with no per-country limit, although one was added in later years). Within these broad numerical caps, visas would go to the family members of legal immigrants (family members of U.S. citizens were—and still are—exempt from the caps), workers needed by U.S. employers, and refugees. "The authors of the bill did not expect it to have much of an effect on immigration overall, arguing that the benefits of the new system would flow primarily to Europeans with family members in the United States—not to Asians or Africans," Ewing said, adding that "in hindsight, the authors of the bill were obviously very wrong."

Growing economic inequality between the developed and less developed world made the developed world an attractive destination for people who wanted a chance for a better life. The forces of globalization rendered the nations of the world increasingly interconnected in terms of trade, transportation, and communication. "The end result was that, over the course of the decades following the 1965 immigration law, millions of people from Latin

America, the Caribbean, and Asia journeyed to the United States—some legally, some not," said Ewing. As a result of these trends, noted Villarruel, Mexicans became the nation's largest immigrant group, and by 2013 they were the largest immigrant group in 33 states.

As immigration in general, and undocumented immigration in particular, increased during the 1970s and 1980s, policy debates broke out over whether immigration was a net benefit to the United States or a threat. On one side of this debate, said Ewing, were organizations devoted to the advancement of rights for immigrants, refugees, Latinos, and Asians, which argued that immigrants were an economic and cultural asset to the nation. On the other side was a new generation of nativists who couched their anti-immigrant arguments in terms of immigration's contribution to the "overpopulation" of the United States, resulting in increased competition for jobs, housing, schools, and other public services. Ewing said:

> While these new nativists didn't use the terminology of eugenics and "racial betterment" that the prior generation of nativists had, the imagery provoked by their rhetoric was clear: the dark-skinned hordes of the developing world would overrun the light-skinned peoples of the developed world unless drastic action was taken.

IMMIGRATION REFORM AND CONTROL ACT AND SUBSEQUENT LEGISLATION

In the face of large-scale undocumented immigration—and in an attempt to balance the demands of employers, immigrant rights groups, and nativists—Congress passed the Immigration Reform and Control Act (IRCA) in 1986. The act granted legal status to many of the undocumented immigrants already living in the country, opened the doors to hundreds of thousands of new agricultural guest workers from Mexico, and increased border enforcement. In addition, it created criminal penalties for employers who knowingly hired undocumented workers.

However, "the law ran aground for a couple of reasons," observed Ewing. First, it did not create flexible avenues for future immigration to the United States. As the economic integration of the Western Hemisphere increased—a process culminating in the North American Free Trade Agreement (NAFTA) of 1994—the movement of workers was not liberalized in the same way as the movement of commodities. "Ironically, NAFTA's supporters had predicted that it would decrease undocumented migration by creating more jobs in Mexico," said Ewing, adding:

> That didn't happen as planned. In fact, competition from U.S. multinational corporations drove many Mexican workers out of their jobs or off their farmland. And newly unemployed Mexicans knew that the best place to go in search of a new job was the United States.

A second reason for IRCA's long-term failure was the poor design and implementation of sanctions for employers who knowingly hired undocumented workers. "Proving whether someone knowingly or unknowingly hires an undocumented immigrant is not an easy task," Ewing observed. Criminal penalties against employers were rarely enforced, nor were labor laws, which might have diminished the exploitation of workers in general, regardless of where they were born. In addition, many of the numerous documents deemed acceptable as proof of legal residence in the United States were easily forged.

As the law proved ineffective, hundreds of thousands of immigrants and refugees from every corner of the globe came to the United States each year. "In the process, they created new neighborhoods or breathed life into old, decaying ones," Ewing pointed out. But, as a result, the cultural landscape of many regions in the United States shifted dramatically. "For instance, in some cities, Spanish-language media outlets now have more viewers than their English-language competitors," he said.

This transformation of U.S. society has provoked a nativist backlash, Ewing pointed out. Some native-born Americans are irate that their tax dollars might pay for the education of children whose parents are undocumented. Others are incensed that they have to "press one for English, two for Spanish" when they call their bank, he continued. This anger contributed to the passage of Proposition 187 in California in 1994, which would have denied virtually every public service (including education) to undocumented immigrants and their children. It also would have required every public employee, from teachers to doctors, to report undocumented immigrants to federal authorities. "Proposition 187 was struck down as unconstitutional in federal court and never took effect," said Ewing, adding:

> However, it did propel Republican Pete Wilson into the governor's mansion in 1994, thanks to his support for the initiative and a campaign based on nativist fears of an undocumented Mexican invasion of the state. Much to the chagrin of nativists, Wilson and Proposition 187 motivated tens of thousands of immigrants who were eligible to naturalize to actually do so and then register to vote—as Democrats.

During the early 1990s, the federal government began fortifying the U.S.–Mexico border against undocumented immigration with more Border Patrol agents, new technologies to detect unauthorized crossings, and hundreds of miles of fencing. "Yet, the end result wasn't fewer undocumented immigrants in the United States, but more," said Ewing, He added:

> True, more died while crossing the border in remote locations in an attempt to evade the Border Patrol. But, once they got here, they were more likely to stay. Whereas in the past they might have worked here for a few years and then gone home, perhaps later to return for a few more years of

> work, now they stayed permanently because crossing the border was so difficult. And they had their relatives join them in the United States rather than be forever separated from them.

The undocumented population grew from 3.5 million in 1990 to a high of 12.2 million in 2007 before dropping to about 11.3 million in 2016.

In 1996, Republicans in Congress authored the Illegal Immigration Reform and Immigrant Responsibility Act, the Antiterrorism and Effective Death Penalty Act, and the Personal Responsibility and Work Opportunity Reconciliation Act. These bills made sweeping changes to immigration law, making it easier to deport or deny federal welfare benefits even to lawfully present immigrants. "In the end, the goal of the immigration provisions of these laws was to make life as difficult as possible not only for undocumented immigrants but for green card holders as well," Ewing said.

IMMIGRATION TODAY

The United States today has a large number of immigrants in terms of absolute numbers, but it has not reached the previous high water marks of immigrants as a percentage of the U.S. population (see Figure 2-1). As of 2016, the United States had about 43.7 million immigrants, representing 13.5 percent of the population. Adding the first and second generation together, about one-quarter of the U.S. population is either an immigrant or a second-generation immigrant.

Before 2009, Latinos made up the largest share of U.S. migration; since then, it has been Asians (see Figure 2-2). In 2015, 36 percent of immigrants entering the country were from Asian countries and 31 percent were from Latino countries, and the number of Asian immigrants is likely to increase, said Ramakrishnan. In addition, the undocumented immigrant population has plateaued for a variety of reasons, including U.S. enforcement policy and demographic changes in Mexico. In recent years, more Mexican nationals have been going back to Mexico rather than arriving in the United States. "If there is a wall, it might keep people from returning to Mexico," Ramakrishnan pointed out, emphasizing a point made by Ewing. Greater border enforcement after 1996 had the same effect, Ramakrishnan pointed out, in that it "reduced the number of cross-border trips and, in many ways, kept unauthorized immigrants here."

As pointed out earlier, immigration since the 1965 Immigration Act has caused significant demographic changes in the United States. As one example, the United States does not currently have many second-generation Asian immigrants over the age of 50, because Asians only started immigrating to the United States around 1970. As another example, immigration

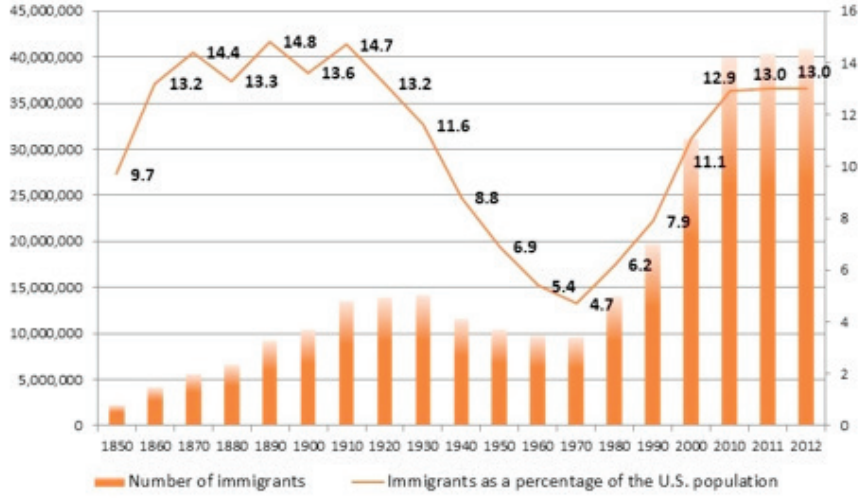

FIGURE 2-1 While the number of immigrants in the U.S. population (left axis) has grown, the percentage of immigrants in the U.S. population (right axis) is not currently as high as it was at the end of the 19th century and the beginning of the 20th century.
SOURCES: Ramakrishnan presentation, November 28, 2017. From NASEM, 2015.

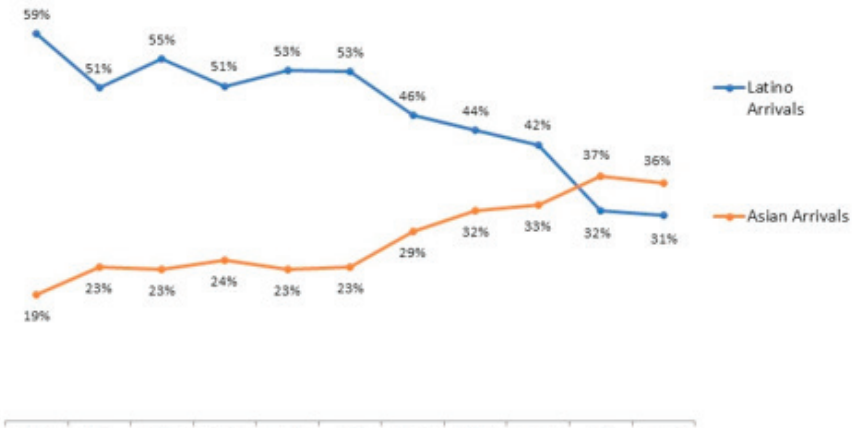

FIGURE 2-2 Since 2009 the number of Asians immigrating to the United States has exceeded the number of Latinos.
SOURCES: Ramakrishnan presentation, November 28, 2017. From NASEM, 2015.

has brought a significantly higher proportion of Hindus and Muslims to the U.S. population.

HEALTH AND WELL-BEING OF IMMIGRANTS

Legal status shapes many kinds of outcomes for immigrants, Ramakrishnan pointed out. In 2012, naturalized citizens made up 41.8 percent of immigrants, legal permanent residents accounted for 27.4 percent, undocumented immigrants made up 26.3 percent, and temporary and discretionary legal residents made up the remaining 4.5 percent. The number of deportations, which was below 50,000 before 1996, rose to almost 440,000 in 2012, before declining to about 240,000 in 2016 (though this number has been rising again since then), he explained. Immigration detention increased about 40 percent in the first year of the Trump administration, but the removal figures did not increase by similar amounts. "What that has meant is long detentions of immigrants in various facilities, public as well as private, and there are all sorts of public health and family health implications that flow out of that," Ramakrishnan said.

Undocumented status does not fully impede integration, but it does have intergenerational effects on the children of undocumented immigrants, he noted.[1] For example, 5.2 million children in the United States live in mixed-status families, and 4.5 million of these children were born in the United States. They are now living under "a regime of increased deportation, or at least increased fear of deportation," said Ramakrishnan, and these fears can contribute to negative health outcomes. Children of undocumented parents have lower levels of cognitive development in early and middle childhood, greater mental health issues in adolescence, and lasting negative effects on adult educational attainment and income, he explained.

Naturalization has major consequences for health and access to care. However, the United States lags behind other Organisation for Economic Co-operation and Development countries in the citizenship rates of working-age immigrants who have lived more than 10 years in a country—50 percent versus 61 percent, Ramakrishnan stated. Low levels of naturalization create barriers to political integration as well as other types of social integration. Based on the available survey data, most immigrants want to naturalize but do not do so because it is too complicated or expensive, he said.

In terms of political participation, first-generation immigrants are less likely to vote than are the second or third generations, Ramakrishnan explained. However, lack of experience with the U.S. political system and low

[1] For more information on the integration of immigrants into U.S. society, see NASEM, 2015.

levels of outreach and mobilization by political parties combine to produce lower participation. While many activities do not require citizenship, such as contacting officials, boycotting products, or expressing political views online, he noted that noncitizens are less likely to participate in these activities than citizens. This is true even for volunteers, which "should be a major concern," Ramakrishnan observed, "to the extent that volunteerism affects community dynamics and the ability of localities to be resilient in the face of budget cuts and economic shocks."

Ramakrishnan explained that the majority—85 percent—of first-generation immigrants speak another language, but half report speaking English well or very well. Children of immigrants and later generations are acquiring English and losing their ancestors' language at roughly the same rates as past immigrant waves, with the transition to speaking solely English usually occurring within three generations, he explained. Spanish is the one language that persists into the third generation, but the great majority of that generation is English dominant if not monolingual.

Immigrants have better health outcomes on average than native-born Americans even though they have less access to health care and insurance, Ewing said, adding that they have lower rates of adult and infant mortality and give birth to fewer underweight babies than natives, despite higher poverty rates and greater barriers to health care. They are less likely to die from cardiovascular disease and all cancers combined and have less obesity, depression, and alcohol and drug abuse. Over time these advantages decline and their health status converges with the native born. "Their health status—and that of their children—worsens the longer they live in the United States," Ewing pointed out, adding "As they adopt an 'American' diet high in fats, sugars, and processed foods, they experience sharp increases in obesity, diabetes, and high blood pressure." A decline in health status also occurs between the first and second generations.

Like their predecessors, modern nativists inaccurately stereotype immigrants as being prone to criminality and resistant to assimilation—both of which are demonstrably false, said Ewing. In addition, nativists have long blamed immigrants for spreading diseases into the United States from elsewhere, such as HIV, H1N1, Ebola, and Zika. "But viruses don't respect borders or care about nationality," observed Ewing. "International travelers to a country are just as capable of spreading a disease as the indigenous population. For that reason, border controls are not particularly effective at stemming the spread of epidemics," he said.

Finally, immigrants are overrepresented both at the bottom and at the top of the education scale. In addition, a racial dynamic is involved; for example, Asian immigrants tend to be overrepresented among those with bachelor's degrees or higher, and Latino immigrants tend to be overrepresented among those with less than a high school education. However, these

are very broad generalizations, Ramakrishnan observed, and all racial and ethnic groups contain people with a wide range of incomes and education. For example, refugee populations primarily from Southeast Asia, such as the Burmese, Cambodians, Hmong, and Vietnamese, tend to have levels of bachelor's degree attainment that are lower than those of Latino and African American populations in the United States, he explained.

CONTINUING INTEGRATION OF IMMIGRANTS INTO U.S. SOCIETY

Ramakrishnan was a member of the panel that produced the report *The Integration of Immigrants into American Society*. That report pointed out that integration occurs across multiple dimensions, including socioeconomic, political, sociocultural, spatial, familial, and health dimensions. In addition, the report observed that immigrant families are making strong intergenerational progress in educational attainment, including among Latino and black immigrants. Poverty rates among Asian Americans are lower than the overall U.S. rates, although Asian American senior poverty is higher than the average senior poverty rate. In addition, as immigrants are making their way to new destinations in states controlled by Republicans, this has led to new anti-immigrant laws.

The aging of the native-born population in the United States is rendering immigration a demographic necessity, Ewing stated. The retirement of the baby boomers will create a demand for new workers to take the place of those who retire from the labor force. The Social Security and Medicare programs also will be called upon to serve a rapidly growing number of older Americans, with immigration a potential way to reduce pressure on these programs.

In addition, demand will grow for both highly skilled and less-skilled health care workers to look after the growing ranks of elderly Americans, Ewing observed. Already, as of 2015, 28 percent of physicians and surgeons were immigrants, as were 24 percent of nursing, psychiatric, and home health aides.

ASIAN AMERICANS AND PACIFIC ISLANDERS

Finally, Ramakrishnan presented some of the data he and his colleagues have been collecting on Asian Americans and Pacific Islanders. Asian Americans have been the fastest growing racial group since 2000, with much of that growth fueled by immigration. In fact, Asian Americans are the only major racial group in the United States of which a majority are immigrants, Ramakrishnan pointed out, despite the misconceptions that most immigrants are Latinos and that Latinos are mostly immigrants. By

about 2050, according to projections from the Pew Research Center, the foreign-born population will include more Asian Americans than Latinos. Already, the share of registered voters who are foreign born is higher for Asian Americans than Latinos in California—44 percent compared with 33 percent—and it is approaching parity (30 versus 33 percent) for the United States as a whole.

The Asian American community is both one group and many groups, said Ramakrishnan. *Asian* is a single racial category in the United States built over many years of exclusion from citizenship. But the Asian American community also has tremendous diversity in terms of socioeconomic status, language, health, geographic ancestry, political activity, and other measures. As just one indication of this diversity, Ramakrishnan mentioned the political activity of recent Chinese immigrants using WeChat to exchange information, political messages, and rumors.

Another feature of the Asian American population that is often overlooked is the extent of undocumented immigration. Today, about 1.6 million Asian Americans are undocumented, representing about one in seven Asian immigrants. In addition, about as many Asian Americans as Latinos in the United States have limited English proficiency, Ramakrishnan observed. Large Asian groups such as the Chinese, Korean, and Vietnamese have significant language needs.

"Data like these can help make our conversation about immigration more complex," said Ramakrishnan. He said:

> When immigrant equals Latino and Latino equals immigrant, while that may be empowering for certain communities, what we saw in the last election is that there is a lot of harm that can also be done in terms of how these issues get visualized, especially with a majority white population.

Even within the Asian American community, the impression is widespread that Asian Americans are in the United States predominantly on employer-based visas. In fact, most Asian Americans are in the United States based on family sponsorships, and "any attempt to cut back on the family visa provision will affect Asian Americans and, importantly, will increase the undocumented population," said Ramakrishnan. He further explained:

> This notion that people just need to wait in line, well, tell that to the Filipino relative waiting over 20 years to reunite with their family members. Most people won't wait that long—for good reason—so we need to think about what these policy changes will mean not only for the Asian American community but for American society in general.

STATE-LEVEL POLICIES

A prominent topic in this session of the workshop and in other sessions was the role of state governments in immigration policy. With the federal government deadlocked on immigration reform since 1996, state and local governments have stepped in to fill the void. Some have voted to prevent police from inquiring about someone's immigration status. Others have joined the federal 287(g) program, which trains local police officers to act as immigration agents. Oakland, California, requires all municipal departments to have bilingual employees on staff. Prince William County, Virginia, denied all county services of any kind to undocumented immigrants, and Hazleton, Pennsylvania, passed an ordinance making it a crime to rent an apartment to an undocumented immigrant. The result has been "a complete mess," Ewing observed, "a patchwork of conflicting rules and regulations on topics that should have been decided at the federal level."

As did Ewing, Ramakrishnan pointed to wide variation in the states in enforcing federal immigration laws while also citing differences in areas such as adult education and workforce training, in-state tuition, financial aid, driver's licenses, professional licenses, and child health insurance. Ramakrishnan and other Californians have been writing and talking about state citizenship, a status that would not "threaten federal citizenship but that works in parallel and in many ways exceeds the standards set at the federal level." Though more research is needed on the policy effects of state laws, "Funders not just at the state level but at the national level can pay attention to the policy changes that are happening at the local and state level and look at their possible effects," he said.

Though opinions vary about the advantages and disadvantages of state-level policies on immigration, Ramakrishnan pointed out that experiments at the state level have often been the source of important innovations. Furthermore, the federal government remains so deadlocked on immigration that progress may only be available at the state level. Other states besides California, including Connecticut, Illinois, and New York, have been working on the issue, Ramakrishnan observed. Ewing, however, pointed out that "There are states in which the political reality may never allow enfranchisement of immigration populations.... It presents real operational challenges on the ground." Ramakrishnan agreed: "There are limits to state citizenship, especially in terms of providing health benefits at the state level—it's very expensive to do."

Nevertheless, Ramakrishnan pointed to the advantages of state-level innovations above a floor of federal immigration policies. The analogy would be the minimum wage in which the federal floor does not hold back states like California. "We cannot count on Congress or the presidency

to come through, and we've known this now for more than 15 years," he said, adding that "instead of waiting for funding, let's get on with it and do the work." Philanthropies in California have coordinated their efforts to work on specific issues, which has been effective, he said. "Any hope for federal reform will depend on building up the political case for it at the state level," he concluded.

DATA SECURITY AND THE NEED FOR DISAGGREGATED DATA

Another prominent topic in this and other sessions was whether any data provided to federal agencies by immigrants could be used against them. For example, both Ewing and Ramakrishnan acknowledged that immigrants may be reluctant to provide information to the census. "Census 2020 is going to be the perfect storm," Ramakrishnan predicted, citing his fear of what an undercount of the immigration population could mean to immigrants. "In many ways the nativists will have won, because representation [and] resources in all those districts will go down dramatically," he said. Similar issues arise when data are collected from immigrants in community health departments, college financial aid forms, or driver's license offices.

The 2015 National Academies report recommended continuing the practice of collecting the nativity of not only the respondent but also the father and the mother, as has been done in the past. "When you are trying to understand immigrant integration, we need to look across generations, and you can't do that if you don't have the nativity," he explained. Ramakrishnan also expressed the belief that such data will be held securely, "because otherwise you will never see anyone sign up for something like DACA [Deferred Action for Childhood Arrivals] again." Ewing, however, expressed his opinion that people in power today "are perfectly capable of misusing this information."

Ramakrishnan also pointed to the continued need to collect disaggregated data in the census and other surveys. As an example of the need for fine-grained data, Ramakrishnan pointed to the difference between Asian American and Latino populations in accepting DACA:

> There is a "coming out" dynamic within Latino communities, where it's not a stigma but in fact could be empowering for people to speak up and be visible, [whereas the] completely opposite dynamic is happening within the Asian undocumented communities. We wouldn't know the magnitude of that unless we have the data to show how low the participation of some of these Asian DACA-eligible populations are.

Another example involves rates of uninsured people among Asian Americans, which dropped substantially after enactment of the Patient Protection and Affordable Care Act. However, the numbers differ by ethnic group, again demonstrating "why data disaggregation is so critical," Ramakrishnan said.

3

Immigration and the Social Determinants of Health

Points Made by the Presenters

- Immigration is both a consequence of the social determinants of health and a social determinant of health in its own right. (Castañeda)
- The lack of dialogue between people working in areas involved with the social determinants of health and people working on immigration issues has resulted in missed opportunities for research, practice, and policy. (Castañeda)
- The California Health Interview Survey is a tool and potential model for understanding the health needs and inequities in health and well-being of immigrant populations. (Ponce)
- La Clínica del Pueblo in metropolitan Washington, DC, is an example of a community health organization that serves patients while also working on the social determinants of health. (Wilson)

NOTE: This list is the rapporteurs' summary of the main points made by individual speakers identified above. They are not intended to reflect a consensus among workshop participants.

Considering immigration as a social determinant of health may offer a new and valuable way of examining the linkages between immigration and

health. Investigating why the average health of immigrants is better than that of native-born populations can help reveal the mechanisms responsible for maintaining or degrading health. A framework based on social determinants of health can also illuminate the relationship between health and broad social and economic factors not only for immigrant populations but for all members of the population. Three presenters at the workshop looked at these mechanisms and relationships successively at the international and national, state, and local levels.

LINKING IMMIGRATION WITH THE SOCIAL DETERMINANTS OF HEALTH

In the past, research on immigrant health has been largely disconnected from the analytical framework provided by the concept of the social determinants of health, pointed out Heide Castañeda, associate professor of anthropology at the University of South Florida. Analyses and interventions of immigrant health have focused "on individual behaviors and purported cultural beliefs rather than on glaring patterns of inequality and pathogenic conditions produced by structures of poverty, immigration policy, and heavy-handed enforcement tactics," she said.

Throughout prehistory and history, migration has been a fundamental part of the human condition, and "no nation has remained untouched by human mobility," noted Castañeda. However, considering migration "natural" is misleading and dangerous, she continued, adding:

> There's nothing natural about human displacement. Global patterns of inequality that lead to migration are rooted in specific social, political, and economic conditions; they reproduce by specific structures, policies, and institutions; and to gloss over the root causes of population movements is an injustice to the people affected by them.

The world is currently witnessing the highest ever recorded number of international migrants at 244 million, though the percentage of the world's population who are migrants has remained fairly constant over the past several decades, at about 3 percent. In addition, migration occurs within countries, and many individuals have become trapped in third countries during transit from one country to another. About 66 million people worldwide have been forcibly displaced from their homes, although scholars are challenging the dichotomy between voluntary and involuntary migration, noted Castañeda. For example, they are arguing that people can also be forcibly displaced through poverty in their home countries.

The framing of the causes of migration is important, Castañeda said, because it affects a group's reception in a country, which in turn can affect the health status of immigrants. This is why a focus on structural factors is

important, such as the cost of health care, discrimination, racism, and poor access to transportation. Like gender or race, immigration status represents another form of everyday inequality that may be pervasive and inescapable.

Immigration can thus be both a consequence of social determinants and a social determinant in its own right, said Castañeda. Understanding this relationship may require going beyond the hold of individualism and behaviorism in scientific studies and interventions and instead tackling a wider sphere of upstream structural factors that affect health, including living and working conditions; income inequalities and poverty; access to care; immigration policies and enforcement practices; and gender, race, and ethnic hierarchies. This approach draws insights from political economy, critical race theory, structural violence, structural vulnerability, and intersectionality, but it tries to avoid strict delineations of variables upon operationalization. "The more we fix and make permanent the specific factors in our definitions, the more likely we are to lose the big picture and the radical reframing that needs to be done," she explained.

In a meta-analysis that appeared in the *Annual Review of Public Health* (Castañeda et al., 2015), Castañeda and her colleagues reviewed articles on immigration and health published since 2000 and found that most focused on behavioral and cultural factors. Consideration of structural factors was more limited, focusing most often on access to care. Access to care varies among immigrant populations, with undocumented immigrants typically having extremely limited access to care, which "impacts well-being significantly," Castañeda said. Study of federal policies from a social determinants of health perspective can help reveal policies that have constrained access to care for immigrants, as well as the broader effects of immigration status. For example, how does exclusion from certain labor protections, which affects other low-income populations of color, uniquely affect immigrants? How do the direct consequences of immigration enforcement activities, such as detention, deportation, and family separation, affect health? She concluded that a lack of dialogue between people working in areas involved with the social determinants of health and people working on immigration issues has resulted in missed opportunities for research, practice, and policy.

As an example of this broader approach, Castañeda cited her work on immigrant communities in South Texas. Rates of diabetes are extremely high in this region, which had attracted researchers interested in genetic or dietary causes of diabetes. But this research has tended to overlook the roles of policies that have limited the economic opportunities, dislocated communities, and affected housing, all of which contribute to pathogenic conditions. "The rates of diabetes there are no coincidence," said Castañeda.

She concluded by listing several research priorities and gaps that are based on this broader focus on structural factors. New anti-immigrant policies and heightened enforcement are affecting the health of commu-

nities, she said. For example, she has been looking at the developmental implications for children when a family member is detained or deported. The effects of uncertain legal status should be better understood, she said, as should the ripple effects of legal status on family members, including U.S. citizens. An issue that needs to be examined, for example, is the rising mental health toll for DACA recipients since the program was rescinded.

The effects of local immigration, health, labor, and education policies have also been underexplored, Castañeda noted. Many states have adopted policies involving farm worker organizing, higher minimum wages, identification cards, and driver's license eligibility for immigrants, and the effects of these changes could be further explored. Finally, she emphasized studying resiliency despite factors that affect individual and community health. "This represents a strength-based approach as opposed to the more common deficit focus in health research," said Castañeda, which is a trap into which even a social determinants approach can fall. Resiliency studies could include analyses of social capital, informal care networks, community organizing, and practices that preserve healthy communities. For example, not all DACA recipients are experiencing mental stress when confronted with the possibilities of becoming undocumented again. Castañeda noted, "I would say half are [stressed] and the other half are saying, 'You know what, we got this, we've been there before, and now we have more skills and better networks.' That's a resiliency perspective."

A social determinants of health approach can be difficult to employ because it is political—"and by political, I don't mean partisan, but that it requires the buy-in of policy makers to create change," she stated. Change based on this approach may require inclusive health care practices, engagement with immigration communities, and advocacy for fair immigration economic and health policies. Castañeda concluded with "it requires commitment and a true desire for change."

A STATE SURVEY OF HEALTH

California is home to about 4 percent of the 240 million people worldwide who live outside their countries of origin, noted Ninez Ponce, professor in the University of California, Los Angeles (UCLA), Fielding School of Public Health's Department of Health Policy and Management, associate center director of the UCLA Center for Health Policy Research, and director of the UCLA Center for Global and Immigrant Health. More than one in four Californians is an immigrant—amounting to more than 10 million people—compared with less than one in seven for the United States as a whole.

The California Health Interview Survey (CHIS), which was launched in 2001 and interviews more than 20,000 adults, teenagers, and children

each year, is the largest continuous state-based health survey in the United States and the most comprehensive source of data on California's diverse population. It was designed from the ground up to provide data that are used for governance, health systems, and wider system accountability at the local and statewide levels and also to provide new knowledge. It seeks to understand the social determinants of health not just at a policy level but at an individual level, with geocoding allowing for linkages with measures of neighborhood context such as pollution, health care supply, or local policies. It is funded by a variety of state and local agencies, Californian and national foundations, and others. This mix of public and private funding facilitates the nimble inclusion of hot topics, said Ponce, while also ensuring a population-based perspective. "Getting at an emerging crisis could avert a costly burden on the health system," she added.

CHIS uses a random digit dial telephone survey—including cell phones since 2007—to provide statistically reliable estimates. Response rates have been going down, but the sample is still representative of the California population, said Ponce. It is conducted in seven different languages—Chinese (Cantonese and Mandarin), English, Korean, Spanish, Tagalog, and Vietnamese—and new languages are considered following the release of census data. Some ethnic groups are oversampled, including Alaskan Natives, American Indians, Japanese, Koreans, and Vietnamese. Adults speak for their minor children and give permission to collect information on teens. Interviews can take 35 minutes for adults, 20 minutes for adolescents, and 15 minutes for children.

For immigrant populations, CHIS is a tool for understanding their health needs and inequities in health and economic well-being. It looks at social factors, health care access, health behaviors, and health conditions (see Figure 3-1). It also includes information on language, race and ethnicity, citizenship and immigration status, and how long a family has been in the United States, including country of birth and the mother's and father's country of birth. Since the launch of CHIS in 2001, it asks:

- Are you a citizen of the United States?
- Are you a permanent resident with a green card? Your answers are confidential and will not be reported to Immigration Services.
- About how many years have you lived in the United States?

In 2015–2016, specific questions on immigration were added:

- In what year did you become naturalized?
- Tell me if you are currently here on any of the following: a tourist visa, a student visa, a work visa or permit, or another document that permits you to stay in the U.S. for a limited amount of time?

- Was this visa or permit through Deferred Action for Childhood Arrivals or DACA?
- Is this visa or document still valid or has it expired?

These are sensitive and complicated questions, Ponce acknowledged. For example, being a noncitizen could mean a person is not lawfully present, is in the DACA program, or is waiting for a green card. "There's some fuzziness in that," she said, which is reflected in different ways of calculating the number of undocumented people in California, with estimates ranging from 1.2 million to 1.4 million. As a result of the sensitivities, nonresponse rates for these questions could be higher than most questions, but not as high as other sensitive survey questions such as income. The questions since 2001 post relatively low nonresponse rates (less than 5 percent), but questions on visa type in 2015–2016 register higher nonresponse rates, about 20 percent.

In 2011 the National Council of La Raza, along with more than 200 other civil rights and consumer groups, recommended to the U.S. Department of Health and Human Services that CHIS be used as a model for the collection of data on immigrants and mixed-status families in data collection related to federal health care reform. CHIS has been used to study the effects of language, citizenship, and U.S. tenure on health, health access,

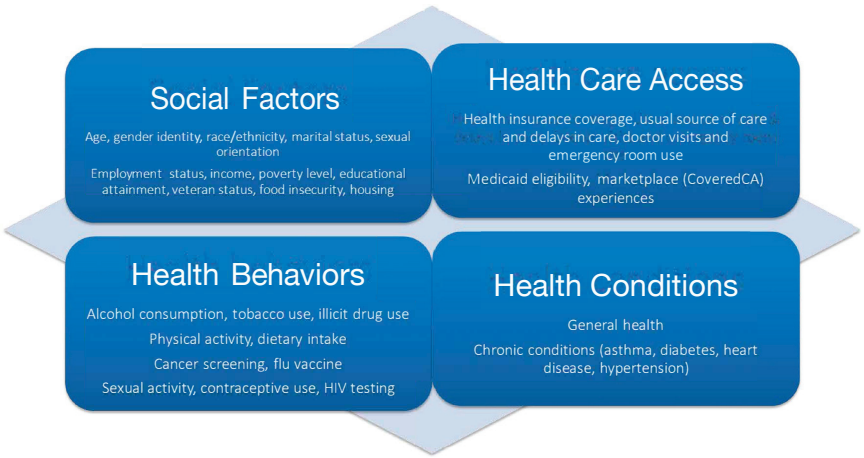

FIGURE 3-1 The California Health Interview Survey (CHIS) examines not only health conditions and behaviors but the social and economic factors that can affect those conditions and behaviors.
SOURCES: Ponce, 2017. Figure created based on CHIS information: http://healthpolicy.ucla.edu/chis/design/pages/survey-topics.aspx (accessed July 19, 2018).

and perceived discrimination. It has significantly affected state policy, including laws on health care language assistance, children's health, and medical interpretation services. The survey provides not just numbers but relationships, Ponce concluded, which make its results a particularly valuable social science data set.

COMMUNITY-BASED RESPONSES

La Clínica del Pueblo is a federally qualified health center in the Washington, DC, metropolitan area focused on building a healthy Latino community through culturally appropriate health services, with a particular focus on those most in need. It was founded in 1983 on the concept that health care is a human right. "It still blows me away that we have to say that out loud, but we do," said the organization's executive director, Alicia Wilson.

In the primary area the clinic serves—Washington, DC, and Prince George's County, Maryland—84 percent of the clinic's patients are limited English proficient and 92 percent are Hispanic. Much of the Latino population in the DC metropolitan area is from Central America, Wilson said, adding "It's one of the few places where you can really see the salient characteristics of Central American migration, as opposed to a broader Latino migration or a smaller subset of Mexican migration." About 40 percent of the clinic's patients are uninsured, and 26 percent are covered under Medicaid. Washington, DC, has an insurance product called the DC Health Care Alliance, which provides an insurance-like product to anyone under 200 percent of the federal poverty level regardless of immigration status, although it does not provide behavioral health care. About 20 percent of the clinic's patients are covered by this program.

The clinic's patients lack access to health care for a variety of reasons, including exclusion from government programs, the Patient Protection and Affordable Care Act enrollment barriers, the complexity of navigating eligibility for mixed-status families, and language access. In particular, many patients are worried about applying for programs given new concerns about their immigration status. "For the enrollment period that started right after the election, every single patient who came in said, 'Should I really apply? Is it worth it? Am I safe applying?'" she explained.

In the clinic, providers see many conditions caused by lack of preventive health care, including obesity, hypertension, diabetes, HIV infection, and late prenatal care entry. In the area of behavioral health, the clinic sees many cases of depression and other mood disorders, post-traumatic stress disorder, and alcohol-related disorders. For example, rates of post-traumatic stress disorder among Central American refugee patients range from 33 percent to 60 percent. "We have significant unmet need across the

region in terms of behavioral health," said Wilson. "It's more how many therapists can we afford to pay, not what's the need in the community," she added. In addition, the DC metro area has had an enormous influx of unaccompanied minors, including an estimated 7,000 of the 60,000 children from El Salvador, Guatemala, and Honduras who were detained at the southern border in 2014–2015.

As an example of the ways in which immigration acts as a social determinant of health, Wilson mentioned gender-based violence. The clinic does many screenings for intimate partner violence, resulting in one to two referrals per week. "We see significant immigration fears that prevent women from getting to safety," she said, adding "we see significant challenges in navigating the complexities of civil concerns and immigration concerns." For example, taking a child to school "while you're trying to be safe from an abusive partner demands intensive support and can have dramatic effects on our patients," she explained.

Another example is the association between fear of deportation and HIV risk behaviors among nonpermanent residents. In general, Hispanics in Washington, DC, get tested for HIV infection later than members of other ethnic groups. Homophobia, transphobia, and past traumatic experiences drive economic instability, social instability, and risk behaviors, including substance use, commercial sex work, and depression.

La Clínica del Pueblo works on all the social determinants of health, said Wilson, including social and economic factors and health behaviors. "We look at our patients not just as individuals but as members of communities—and members of communities that are affected by not only policy but also by culture and by history and economics," she said. As such, the clinic's approach to reducing health disparities includes the following:

- Ensuring access to affordable, culturally competent, and linguistically appropriate health services, including prevention, care, and treatment
- Recognition of the key role of mental health on health outcomes
- Support to reduce barriers to care
- Creating safe spaces in which the Latino immigrant community can critically explore and discuss the effect of immigration on physical and mental health
- Enhancing feelings of belonging and social support, particularly from family, friends, caseworkers, and health care providers
- Community health promotion
- Providing opportunities for social action, including volunteerism and activism

In general, said Wilson, "The community is our patient, not just each individual." The clinic trains 40 to 60 *promotores de salud* each year to work in the community. It also seeks to inform patients about advocacy, participation in local issues, and immigration issues, such as language access laws and access to other health services. The clinic has been leading a campaign based on the idea that "no human being is illegal," she explained.

Immigration and health care are linked, Wilson concluded. "We are not an immigration services organization. We are a health care organization that serves immigrants.... We can't address one without addressing the other," she said. For that reason, pursuing comprehensive immigration reform is a public health strategy, she said. Wilson concluded:

> Looking locally but also looking nationally is a public health imperative. We have to look systemwide and structurally if we're going to have an impact on what happens in the exam room with our patients.

DATA AND POTENTIAL POLICY CHANGE

During the discussion period, the presenters focused on the use of data to drive policy change. Wilson pointed out, for example, that data on whether the DC Health Care Alliance reduces preventable emergency room visits could help make the case for wider access to health insurance:

> The more that we can have data that backs up what we see on the ground and policy statements from respected nationwide organizations, the more we can make our case that funding and support for these concepts make a big difference.

Ponce made a similar observation. Could data on increased detection of prediabetes rates as a result of CHIS results, for example, reduce overall health care costs? Though CHIS is expensive, costing $8 million to $10 million per year, it has affected health care, such as increased rates of cancer screening, that could yield major savings, though so far these effects have not been quantified.

In Florida, Castañeda noted, researchers rode along with families as they were trying to access dental coverage under Medicaid for children and discovered that fewer than 20 percent of the dentists in the region were accepting dental Medicaid for children. "That was information that policy makers at the state level weren't aware of," she said. "Going through the experiences of the family and then trying to portray that to policy makers can be a powerful way to bring up these sorts of issues," she explained. In this case, both hard data and stories "about how one event can have ripple effects on other parts of people's lives" were important, Castañeda said.

4

The Voices of Immigrants

Points Made by the Presenters

- Community health centers are particularly close to the immigrant populations they serve and can be particularly attuned to their needs and challenges. (Quach)
- Recent policy changes have made the military less welcoming to immigrants and have resulted in the deportation of thousands of immigrant veterans. (Hinojosa)
- Capturing the voices and impressions of immigrant youth can convey their challenges, struggles, and triumphs. (Baltazar-Molina)
- Involving members of immigrant populations in community-based research can clarify research questions and heighten effects on policy. (Gómez)
- Immigrant communities have resources and resiliency that can enable their members to overcome obstacles to success. (Cordova)

NOTE: This list is the rapporteurs' summary of the main points made by individual speakers identified above. They are not intended to reflect a consensus among workshop participants.

Several sessions at the workshop emphasized the voices of immigrants, whether directly or indirectly through organizations that serve them. In describing their experiences, these presenters clearly demonstrated the many effects that immigration has on health.

SERVING A DIVERSE ASIAN AMERICAN COMMUNITY

Asian Health Services, a community health center located just a few blocks from where the workshop was held in downtown Oakland, serves 28,000 patients, most of whom are limited English proficient. It provides comprehensive care, including dental care, behavioral health care, and preventive services, in English and 12 Asian languages. It also has a dual advocacy mission to address the structural factors that prevent people from getting the care they deserve. "Health care is only part of your right to have a healthy life," said Thu Quach, the organization's director of community health and research. Asian Health Services works in communities not just to ensure that people get access to care but to assert their right to access care. "I myself am an immigrant," said Quach; "I came here as a refugee from Vietnam at the age of 5 with my family and experienced a lot of that."

Quach recounted several stories from the clinic that highlight how immigration affects health. The first was of a Chinese patient who came from a small village in China and became HIV positive, after which he was shunned by his community because his HIV status revealed his sexual orientation. He went to New York but could not get care there, and someone said that he should seek out Asian Health Services. He moved to the Bay Area, came to Asian Health Services, and got the care he needed. Quach said that last year he wrote to our staff and said:

> Thank you, because at the time I came to you I had almost given up. But you wouldn't let me give up, you kept pushing and pushing, and finally I got into care. Not only am I healthy but I joined a church choir, I'm singing, I'm part of a network, and I got a job.

The second story involved a teenage Cambodian girl who came to the clinic where Asian Health Services provided confidential care. There, the clinic's providers saw patterns coming together that eventually led to the uncovering of a commercial sexual exploitation operation in Oakland.

The third story involved a Vietnamese detainee who had committed a crime when he was a minor, had been tried as an adult, and served 20-plus years in prison. He was released and started a new family, but then he was detained by Immigration and Customs Enforcement (ICE). "He was the sole breadwinner, and his wife was pregnant and about to deliver. What

happens when you take away economic opportunity not just for that one individual but for the entire family?" Quach asked.

Finally, she mentioned environmental justice. When immigrants arrive, they often lack choices of where to live and have to move to highly polluted areas. "They are all factors that affect people's health," she explained.

From its founding in 1974, Asian Health Services has recognized the intersection of immigration with health. "It's nice to see the science finally catching up with us, because community health centers have always recognized that social factors impact health," said Quach. Asian Americans have faced health disparities that go unrecognized, in part because they struggle with the modern minority myth that Asian Americans do well in school. But the myth obscures hidden disparities. Asian American populations consist of more than 50 ethnic groups and speak than more 100 languages. "You don't see the disparities that exist within certain groups because it's being masked," she said.

Asian Health Services is staffed by people from the community, which is important, reported Quach, because "those who are closest to the problems are often closest to the solutions." Health care providers are on the front lines of immigration issues, and they need to be able to take stories to higher levels and organize for change. Also, asking about immigration status in a clinic generally requires a relationship between provider and patient, because it is not like asking other questions. "There are so many stories behind it," she added.

Immigration status is a politically driven issue, Quach observed. She came to the United States from Vietnam with her family, where she received refugee status and eventually became a lawful permanent resident. That status entitled her to public assistance that she would not have received with a different immigration status. "What that sets up is the dichotomy of the good versus the bad immigrant," that some immigrants are more deserving than others, she said, adding that "we need to push back on that framing." She asked how her experience was different than that of a child who needs to leave Latin America to survive. "Yet, the statuses given to each of us [establish] barriers, both in terms of political barriers and social barriers," she explained.

She raised three issues for the Asian American immigrant community. First, undocumented status is usually associated with Latinos, but "there are actually a lot of Asian Americans who are undocumented as well," Quach said. These undocumented immigrants are afraid not only of persecution but of the stigma they would receive from their own community if their status were known. For example, Asian Americans have a low rate of applying for DACA. "When we talk to those individuals, they have many reasons—not fear that they're going to now be known by the government, but they're afraid they'll be shamed in their churches and such," she noted.

The second issue she raised involves the issue of public charge. The law requires that decisions about naturalization consider whether someone is going to rely on public benefits, including cash assistance and long-term care. If it is determined that a person will be a public charge, that person will not be allowed to enter. If they are allowed to enter, for the first 5 years they are not allowed to use public benefits. A leaked executive order that was not enacted expressed the intention to investigate immigrants who were using public benefits. "Even though that has not been signed, it has had a chilling effect among our patients," said Quach. "They're afraid to sign up for things like food stamps. [But] by not seeking health care, by not having access to healthy food, that is going to affect not just them but also their family members," she said.

The third issue she raised involved detention deportation. Individuals who have served their time in prison and have been released are being detained because they are not citizens, said Quach, adding:

> We are hearing stories of ICE rounding up Cambodians and Vietnamese and detaining them and working with their country to try to deport them. And these are not people who committed a recent crime. It's individuals who have gone into prison, have served their time, have been paroled, and have been released. Some have started families again and are now being ripped from their families. You can imagine all the different health implications that go with that.

THE PLIGHT OF VETERANS

One missing voice in the immigration debate is the veteran's voice, said Octavio Hinojosa, the Veterans for New Americans Coordinator on behalf of the National Immigration Forum. "We are a nation of immigrants," he said, and "so are our armed forces." In each major conflict in the nation's history, immigrants have played an integral role in the military, whether the Revolutionary War, the Civil War, World War I, World War II, or the Iraq and Afghanistan conflicts. Today, immigrants continue to add to the military's cultural competency in global operations.

However, parts of the military are still not welcoming to immigrants, Hinojosa observed, and this stance is reflected in recent policy changes at the Pentagon. One issue is enlistment and recruitment. Currently, any legal permanent resident can go to any recruiting offices and enlist and he or she will be allowed to serve. In addition, after 9/11 President Bush signed an executive order allowing for expedited naturalization, "which basically meant that if I got my green card today and went to the recruiter's office this afternoon and I enlisted, then within a year I should have my citizenship by serving in the military," Hinojosa said. Of the 511,000 immigrant veterans in the United States, 84 percent have become naturalized citizens. The other

16 percent have not, representing approximately 98,000 veterans, with approximately one-third of those living in California.

The expedited nationalization policy was rescinded 1 month before the workshop took place (October 2017). Now, legal permanent residents are required to go through additional screenings, which will delay their naturalization by 2 years or more. Also, the U.S. Army Reserve and National Guard are no longer allowing legal permanent residents to enlist in the reserves as a way of obtaining citizenship. Yet, all five branches of the military are struggling with recruitment, Hinojosa observed, leading them to offer increasing enlistment bonuses and higher benefits. "Instead of looking at the potential talent in the population of undocumented youth, such as the Dreamers, we're missing out on a great opportunity to allow them to serve in exchange for residency and eventually citizenship," he explained.

It is not known if the health of immigration veterans is better or worse than average, though that would be useful information to have, Hinojosa said. He reiterated that the immigration population tends to be healthier than the native-born population and that, according to an analysis from the Center for Naval Analysis in 2015, less than 20 percent of the 18- to 29-year-old population in the United States is qualified to serve because of health issues, predominantly obesity. "Obesity needs to be seen as a national security threat," Hinojosa noted.

Following the failed effort to pass immigration reform in 2014, the National Immigration Forum has been seeking to engage with conservative constituencies. Through an initiative called BBB, for Bibles, Badges, and Businesses, it has been seeking to engage the evangelical community, the law enforcement community, and the business community, "and by doing that we have made tremendous headway in changing hearts and minds when it comes to immigration," Hinojosa said.

The other issue Hinojosa cited is that of deported veterans. Legal permanent residents who have served in the military and commit a crime are being automatically put into deportation proceedings. The government is not tracking the number of deported residents, but guestimates range up to 3,000 or more. These veterans qualify for benefits from the Veterans Health Administration, but they cannot access those benefits because the U.S. Department of Veterans Affairs is not in their home countries. They are not being allowed to return to the United States until they have passed away, after which they have a right to be buried in a U.S. cemetery. "Think about those types of injustices," Hinojosa said.

When veterans are deported back to their countries of origin, they are at the mercy of their home country's health system. They may not even speak the language of their home country, and they may not be able to get the health care they need in that country, even in countries with universal health care. "If you deport a veteran who does not have the job skills or

the language skills to readjust to Mexico City life, then he's basically out of luck," noted Hinojosa.

One recommendation Hinojosa made is for medical professionals to go to the countries where deported veterans are living and provide them with the health screening and medications that they need. But to achieve such a goal, he stated:

> We need to raise awareness that we have men and women who have served in uniform, who have risked their lives and sometimes have even earned the Purple Heart, and unfortunately are now living in exile.

Hinojosa was not optimistic about making progress with the Congress as it existed at the time of the workshop. The fault was the 1996 immigration laws, which increased the number of crimes that are triggers for automatic deportation without the possibility of judicial discretion. The states are more active. For example, the governor and legislature of California have pardoned several deported veterans, "but now we have to deal with the federal laws." Many high-ranking people in the military understand the issue, said Hinojosa, and want to do something about it. "They understand and appreciate that they fought alongside immigrants and they're willing to go bat for them. I find that reassuring," Hinojosa concluded.

PHOTOGRAPHS OF IMMIGRANTS' LIVES

Alejandra Baltazar-Molina, who came to the United States as a child from Mexico City, works as a community health advisor at a community health center in Tucson, Arizona, in an area with a largely Mexican population. "I love what I do," she said. She added that "it's amazing how one person can change the life and health care of a person who doesn't know that I can ask for help even though I'm undocumented."

Baltazar-Molina has been one of seven young people represented in the project DACAmented Voices in Healthcare (Gómez and Castañeda, 2018). The organization arose out of the interest of Sofia Gómez in state-level immigration policy, which in Arizona has turned strongly against immigrant communities. To learn how these policies were affecting the immigrant community, she turned to youth that qualified for DACA, "because who else can speak to this but those who live that experience?" she asked. DACAmented Voices in Healthcare provides a platform for discussion and identification of health care experiences and needs. DACA youth addressed their experiences in health care using PhotoVoice, which combines photography and prose to enable people to tell their own story.[1] PhotoVoice additionally enabled the youth to have critical conversations with each other and with policy makers

[1] More information about PhotoVoice is available at https://photovoice.org.

at the local level. "It provides a flashlight in a very dark corner, because we have no idea of the lived experiences of immigration communities in Arizona," said Gómez.

Each of the seven youth in DACAmented Voices in Healthcare was unique, yet they had a collective voice in what they wanted to recommend, Gómez observed. They identified health literacy, navigating the health care system, and cost of care as major barriers. They also identified resiliency and strength in their community. Gómez said that "I always compared the people to the desert. It's a harsh environment, but there's still life and beauty in it." However, some issues she did not expect, such as those associated with the undocumented lesbian, gay, bisexual, transgender, and questioning population. "The process became the product for me, because as the project unfolded I learned from them," she said.

Gómez noted that health care providers might miss an opportunity to address health care needs if they do not take into account their patients' immigration status. The youth in her project felt that providers should consider this, because otherwise how can they understand their patients' needs? "What if I come from a mixed-status family and my dad just got deported or is in detention? Or I don't have any income because of my immigration status?" she asked. Gómez observed that is important for researchers to include the voices of community members in developing their projects. People from the community, including young people, want to be more than just token representatives on an advisory board. They want to be actively engaged in defining what is needed and how those needs should be met. "That's definitely a lesson I heard loud and clear: include the youth voices in health research and policy development," she said.

Baltazar-Molina said that she has struggled at times as her parents have worked hard to provide for their family. Being part of DACAmented Voices in Healthcare taught her that she was not alone. "Being part of this project was a break in my life," she said, adding, "we were able to open up and say, 'This is me, this is my story, and it's okay to talk about it.'" The voices and images captured through the project also have broader applicability, she said. "This is our struggle as immigrants. . . . Health care is a right that everyone should have no matter their immigration status," she explained.

Baltazar-Molina pointed to the need for continued advocacy for immigration reform and health care for all. Immigrant youth can help make this case by working with public health departments and local community organizations. She explained that "We wanted to be given a seat and be able to say, 'This is what our community needs, because we're the ones who are going through that struggle.'" She advocated for greater training for health care workers and for mental health clinicians who are bilingual and bicultural, because "we need to relate to someone who's able to speak our own language—someone who can really understand what you're say-

ing instead of going from a translator who might not be able say how you really feel," she concluded.

FROM MEDICAL SCHOOL TO COMMUNITY

Emmanuel Cordova,[2] a medical student at the University of California, Los Angeles, David Geffen School of Medicine came to the United States from Mexico when he was 4 years old because his mother was suffering domestic abuse and wanted a better life for her family. Cordova spent much of his childhood in Chicago as an undocumented immigrant where he experienced firsthand the social determinants of health associated with immigration. His family's biggest fear was not deportation, he said, but not having health insurance or access to health care. Once when he was 8 his mother had an aneurism and they had to drive 30 minutes to a public hospital for her to get care. After they waited their turn at the emergency department, the doctor told him that no Spanish speaker was available, so Cordova had to act as a translator for his mother and the doctor. "Through that moment of chaos there came clarity," he said; "I realized that I wanted to be a doctor so I wouldn't have to rely on a child to deliver culturally and linguistically appropriate care."

Watching his mother work 12-hour shifts and barely make minimum wage taught him about resiliency, he said, adding, "I learned what it means to have a hard work ethic and to provide for your family despite all the obstacles." He also learned the value of community. "There was a lot of social cohesion and social capital that helped us get accustomed to the United States," he noted.

Cordova said that he always loved to learn and took challenging classes in high school. But as an undocumented immigrant he was not eligible for financial aid to attend college. However, a high school counselor was dedicated to getting him into college. "With her help, I was able to go to the University of Illinois, Chicago," he said, although to pay his college fees he had to work 20 hours a week at a fast-food restaurant. "Be nice to people who serve you food," he said. "They're human beings, too."

After 2 years at the University of Illinois, budget cuts eliminated his scholarship, but his advisor at the university told him that top-tier universities offered scholarships to students like him, and he was able to transfer to the University of Pennsylvania. Getting his degree there was a moment of great pride and accomplishment, but he was also frustrated by how few students like him got that opportunity. "There were a few dozen of us in

[2] Although Emmanuel Cordova spoke on a different panel, his comments are presented here for continuity of the topic of immigrant voices.

that school who received aid, but there were thousands of undocumented immigrants who didn't get the privilege that I did," he noted.

After college, he worked for 2 years with Melissa Simon at Northwestern University as a research assistant. One of the highlights of that experience, he said, was a meeting where members of the community were invited to the university to talk with top-level administrators about their concerns. "To see community members sitting next to people who are at the top of their field was breathtaking," he explained. "I'm very thankful for all the things I went through," he said, "because they gave me a lot of resiliency. They made me realize the power that our communities have, not only in overcoming social obstacles but in terms of the power and influence and wisdom they have," he said.

Now a legal resident, Cordova emphasized the diversity of the undocumented population. Immigrants come from many different places and have many different statuses. Health care providers need to be aware that these differences exist, he said, and not assume that all immigrants have the same backgrounds or experiences. Inequities magnify the problems that communities face in terms of health outcomes, he said. But the power and resiliency communities have is often overlooked, and this resiliency could be used to leverage sustainable interventions and policy change.

He also emphasized the importance of communication in doing research on the immigration population. "It isn't enough to reach out to a community organization and expect them to give back the resources you need," he said. Rather, he said,

> You need to invest a lot of time and effort and passion in making sustainable relationships with the community members. A lot of community members are socially conflicted by being undocumented and are going to be secretive unless they know that they can trust somebody.

To gain that trust, researchers need to treat community members with dignity and not as research subjects, he said, adding "Understanding their life stories is probably the best way to do that. Before you even get to the research, ask them where they came from, their life stories, and what they want out of this research."

Grassroots efforts have great potential to change policy, he concluded. "DACA was born out of that movement, out of the civil disobedience people did, basically putting their lives on hold to make sure that DACA passed," he concluded.

5

Reflections on the Workshop

In the final session of the workshop, two presenters—Hal Yee, chief medical officer for the Los Angeles County Department of Health Services, and Tiffiany Howard, associate professor of political science and director of the Center for Migration, Demography, and Population Studies at the University of Nevada, Las Vegas—along with various members of the Roundtable on the Promotion of Health Equity, briefly commented on the main messages emerging from the workshop and pointed to remaining unmet needs.

GRAPPLING WITH THE COMPLEXITIES OF IMMIGRATION

Immigration is a very complicated subject with many views and many stakeholders, said Yee, and "unfortunately, in some areas, there is not going to be agreement." Yet, health care providers need to provide care to the patients they see despite the complexities and challenges they may encounter. "Each individual, regardless of immigration status or any other determinant of health, deserves equity of medical care," he said.

Yee also called attention to the underlying problem of the cost of health care. "In America we spend 17.5 percent of the entire GDP [gross domestic product] on health care," he observed. As a result, the nation cannot invest what it needs to invest in other areas, even though such investments may prevent health problems that contribute to the cost of health care. "We need to focus more on how we provide the right care at the right time in the right place by the right person, because only by freeing up resources can we invest in all of the social determinants in health," he said. If health

care were more efficient, more resources could be devoted to alleviating the social issues that lead to many health disparities, including those associated with immigration.

Howard emphasized that immigration as a social determinant of health goes beyond immigration status and encompasses the entire process of immigration. As an example, she mentioned working with Syrian refugees who needed to establish a credit history to secure an apartment. But they had no history of using credit in their home country and did not see the value in doing so. "We don't think about the nuances that immigrants confront or the challenges that they face when they come here. These cultural barriers are often overlooked, [but they] affect all facets of their existence," she said.

Roundtable member Uchenna Uchendu pointed out that everyone can do something within their area of influence to help immigrants deal with the complex issues they face. "What can I do in my own space, in my own community? What awareness can I create? What energy can I develop?" she asked. She has written letters to the electric company saying, "This person can't be without power because there's an oxygen tank in their home, and you pretty much sign their death warrant if you turn off their power."

Uchendu recalled the "double battle" that some groups have to undertake because they are immigrants while also dealing with another issue. "In health equity, we talk about the intersection of vulnerabilities," she explained. For example, immigrants can have mental health disabilities or be dealing with other issues. "Again, it comes back to that connection about the holistic individual," she noted.

Gillian Barclay called attention to the link between immigration and racism. Both are linked to difficulties in accessing health care, and feelings about immigration can be difficult to separate from racial discrimination, she said. Francisco García made a similar point, raising the issue of the association between immigrant status and poverty. For example, the Afro-Latino diaspora communities and Native American communities are both diverse populations, but they are also relatively poor populations. Therefore, addressing health care also means addressing issues of equity, economic fairness, and justice. "The solution is not always in the doctor's office. It is in the economic opportunities that we create in our communities," García said.

UNMET NEEDS

Reflections on the complexity of the issues associated with immigration led several roundtable members to comment on the conversations that need to take place regarding immigration. One involves the basic definition of health equity. Uchendu remarked that health equity means lifting everyone

as a result of taking care of the differences among people while recognizing that some people "are standing so far behind that even equal treatment will always leave them behind." Melissa Simon said that the metaphor she uses is an apple orchard. For everyone to get an apple from the tree and not settle for a rotten or half-eaten apple from the ground, everyone needs a stool, but some people need a taller stool than others. "That's the visual I use for teaching about health equity versus equality, which would be the same size stool for everybody," she explained.

Another is the definition for a social determinant of health. The planning committee approached the topic of immigration from this perspective: Immigration and the integration of immigrants into American society intersect with many of the social and economic factors that help determine health, including economic stability, access to health care, education, the effect of the built environment, and social and community context.

Simon also observed that more discussion is needed about what the word *determinant* actually means. "*Determinant* can have a negative connotation," she said, adding that "it can imply that you are destined for this, that if you are an immigrant you are destined for poverty or you are destined to not have any chance or hope or resilience."

More broadly, said Cara James, the United States needs to have a conversation about the nature of health care. The social determinants of health framework emphasizes the many interconnections between health and other aspects of life, including immigration. Without knowing exactly what health care encompasses, people are talking past each other in policy discussions, she said.

Patricia Baker said that even after immigration is accepted as a strong determinant of health, the question becomes, "Then what?" What policies, practices, and actions need to be taken to produce equitable health care for immigrants? Some of these policies will involve short-term change, some intermediate-term change, and some long-term change. Culture, for example, "cannot be changed overnight, and it is very different in red places and blue places," she noted.

Octavio Martinez pointed to the need for a cohesive set of core values, including respect for human life. "If we respect each other, then obviously we will respect and give prominence to keeping healthy regardless of what your status may be. If you're within the borders of the United States, we ought to be looking to each other to take care of each other," he stated. Treating health care as a right would influence many other ways of looking at things, including the other social determinants of health, he said. The nation spends more than $3 trillion on health care annually, and if some of that money could be spent more effectively to deliver health care to everyone, many people would be healthier than they are today.

Another conversation that needs to be happening, said Uchendu, is

with people who are opposed to immigration and the provision of services to immigrants. "How do you bridge those gaps? How [do we] get everybody on board to see what a difference it could make to them as well?" she asked. Uchendu added, "there is a lot of heart in this country." People are willing to help others, which is why so many work in health care, emergency services, or other service professions, she stated, adding, "the truth is that the innate human wants to help other people. We can harness and harvest a lot from that."

James made a similar point in emphasizing the importance of raising awareness of immigration issues among people whose families have not recently immigrated to the United States. Conversations about immigration play out very differently in more and less diverse regions, she noted. In addition, the power of narratives can work against honest and informed conversations, because, she said, "when people get a firm hold on those narratives, it's hard to get them to hear information contrary to what they believe."

One of the greatest impediments to these conversations is the amount of misinformation that exists with regard to immigration, said Howard, adding, "the first step is providing quality information."

Eve Higginbotham recalled the historical dimensions of the immigration issue. During the Civil Rights movement, people hoped and believed that things were going to change, and some things did change. "What was different about the Civil Rights movement that allowed for policy changes? Why were more people in the U.S. population allowed to enter the majority space during that period?" she asked. People do not change their thinking or behavior just because of an increase in awareness. Data are important, Higginbotham observed, but the conversation needs to be framed differently to enlarge the issue.

Several roundtable members emphasized the importance of gathering additional data about specific issues. "If we don't have the data, then you don't know what you're dealing with," said Uchendu. However, data need to be collected in ways that do not threaten people who are already threatened, she added. Thus, data on immigration should be collected through what she called "the equity lens."

Refugees, specific immigration groups, and the effects of culture on resiliency are other areas members cited where data gathering needs to be intensified. In its first year in office, for example, the Trump administration cut the number of refugees admitted to the United States to the lowest level since the Refugee Act was passed in 1980. This is a small set of people who come to the United States and enter the health care system, but they have many of the same barriers in terms of language, culture, and other barriers as other immigrants.

Howard said that she would have liked to hear more about Afro-

Latinos who have immigrated to the United States. They face a number of hurdles, including discrimination because of their ancestry and language barriers. She also pointed to the problem of access to nutrient-rich foods in immigrant communities, adding, "when immigrants are relegated to certain neighborhoods and do not have access to quality food, that has implications for their health outcomes."

CARING FOR THOSE IN THE SHADOWS OF LIFE

Roundtable member Winston Wong cited a quotation from Hubert Humphrey that is engraved on the U.S. Department of Health and Human Services building in Washington, DC, that bears his name: "The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy, and handicapped."

To that quotation, said Wong, "I would add 'the newest Americans.'" Health care in the United States is characterized by a mentality of scarcity, as if the only ones who can pursue health are those who can afford it. But the new narrative about health care, especially as it relates to immigration, should not be about scarcity, Wong said. "It's about seeking the productivity and the promise of what America is. It's about capturing the pursuit of health and all the investments made in people on their journeys to wellness," he concluded.

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Appendix A

Workshop Agenda

Immigration as a Social Determinant of Health: A Workshop

Tuesday, November 28, 2017

Cal State East Bay Oakland Conference Center
Trans Pacific Centre
1000 Broadway, Suite 109
Oakland, CA

Grand Lake Conference Room

8:30–8:45 am	**Welcome and Opening Remarks** Antonia M. Villarruel, Ph.D., R.N., FAAN, *University of Pennsylvania School of Nursing; Chair, Roundtable on the Promotion of Health Equity* Winston F. Wong, M.D., M.S., *Kaiser Permanente*
8:45–9:45 am	**Keynote Speaker Panel: Historical Framing and a Snapshot of Immigration Today** *Moderator:* Winston F. Wong and Francisco García, M.D., M.P.H. Walter A. Ewing, Ph.D., *American Immigration Council* **A Current Snapshot of Immigration in the U.S. Today** Karthick Ramakrishnan, Ph.D., *University of California, Riverside*
9:45–10:15 am	**Moderated Q&A with Audience**

10:15–10:30 am	BREAK
10:30–11:30 am	**Panel 1: Immigration as a Social Determinant of Health** *Moderator:* Samantha Sabo, Dr.P.H., M.P.H., *Northern Arizona University* Heide Castañeda, Ph.D., M.P.H., *University of South Florida* Ninez A. Ponce, Ph.D., M.P.P., *University of California, Los Angeles, Center for Health Policy Research* Alicia Wilson, *La Clínica del Pueblo*
11:30 am–12:00 pm	Moderated Q&A with Audience
12:00–1:30 pm	LUNCH: World Café—Montclair Conference Room Alameda Health Consortium Asian Pacific Islander Legal Outreach Center for Empowering Refugees and Immigrants Centro Legal de la Raza Culturally Responsive Care, Regional Health Education, and the Permanente Medical Group Filipino Advocates for Justice
1:30–3:00 pm	**Panel 2: Voices of Immigrants** *Moderator:* Uchenna S. Uchendu, M.D., *U.S. Department of Veterans Affairs* Thu Quach, Ph.D., *Asian Health Services* Sofia Gómez, Dr.P.H., M.P.A., *DACAmented Voices in Healthcare; University of Arizona* Alejandra Baltazar-Molina, *DACAmented Voices in Healthcare; University of Arizona* Octavio A. Hinojosa Mier, M.P.A., *Veterans for New Americans*

3:00–3:15 pm	BREAK
3:15–4:15 pm	**Reactor Panel and Moderated Discussion** *Moderator:* Melissa A. Simon, M.D., M.P.H., *Northwestern University* Emmanuel Cordova, *University of California, Los Angeles, David Geffen School of Medicine* Hal F. Yee, Jr., M.D., Ph.D., *Los Angeles County Department of Health Services* Tiffiany Howard, Ph.D., L.L.M., *University of Nevada, Las Vegas*
4:15 pm	ADJOURN

Appendix B

Speaker Biographical Sketches

Alejandra Baltazar-Molina is a DACAmented Voices in Healthcare participant. Currently employed as a Community Health Advisor at El Rio Community Health Center in Tucson, Arizona, Ms. Baltazar-Molina graduated from the University of Arizona in 2015 with a bachelor's degree in Spanish and a minor in Portuguese. She is currently a graduate student pursuing a dual degree in Mexican American Studies (Spring 2018) and Public Health (Fall 2018). Ms. Baltazar-Molina has been active in her community since August 2010, when she started volunteering as an English as a Second Language teacher for adults with the nonprofit organization Literacy Connects in Tucson and for various organizations that are pro-immigrant.

Heide Castañeda, Ph.D., M.P.H., is an Associate Professor of Anthropology at the University of South Florida. Her research combines medical anthropology and public health perspectives and focuses on migrant health and health policy in Germany, Mexico, and the United States. She is the co-editor of *Unequal Coverage: The Experience of Health Care Reform in the United States* (New York University Press, 2017) and the author of two forthcoming books, one titled *Migrant Health: Cross-Disciplinary and Critical Perspectives*, as well as an ethnography of mixed-status families in the U.S.–Mexico borderlands. Dr. Castañeda has published dozens of articles on health care access for immigrant and minority populations. Her research has been funded by the National Science Foundation, the National Institutes of Health, the Fulbright Program, the German Academic Exchange Service, and the Wenner-Gren Foundation for Anthropological Research.

Emmanuel Cordova is a first-year medical student at the University of California, Los Angeles (UCLA), David Geffen School of Medicine. His interest in medicine comes from having lived as an undocumented immigrant and experiencing health inequities for most of his life. He studied at the University of Pennsylvania where he double majored in Health and Societies and Hispanic Studies with a minor in Latin American and Latino studies. Mr. Cordova is interested in conducting health equity research as a physician and using community-based research to incorporate voices from the community. Before medical school, he worked at Northwestern University on a randomized controlled trial focused on increasing smoking cessation rates among low-income patients attending federally qualified health centers.

Walter A. Ewing, Ph.D., is a Senior Researcher at the American Immigration Council. Dr. Ewing has authored numerous reports for the council, including *The Criminalization of Immigration in the United States* (co-written in 2015 with Daniel Gonzalez and Rubén Rumbaut), which received considerable press attention. He has also published articles in the *Journal on Migration and Human Security*, *Society*, the *Georgetown Journal of Law and Public Policy*, and the *Stanford Law and Policy Review*, as well as a chapter in *Debates on U.S. Immigration*, published by SAGE in 2012. Dr. Ewing holds a Ph.D. in Anthropology from the City University of New York.

Sofia Gómez, Dr.P.H., M.P.A., obtained her doctorate in public health at the University of Arizona's Mel & Enid Zuckerman College of Public Health. Dr. Gómez's doctoral research examines immigrant families' health care experiences in Arizona's comparatively restrictive political climate. Her dissertation work titled DACAmented Voices in Healthcare examines DACAmented youth's experience in Arizona via documentary photography. Importantly, the DACAmented Voices in Healthcare project promotes participatory research methods that engage community members in addressing their own health concerns.

Dr. Gómez served as the Executive Director of Humane Borders, a human rights organization addressing migrant deaths along the U.S.–Mexico border. In addition to her work with Humane Borders, she served as a Research Associate with the University of Arizona's Binational Migration Institute (BMI). She was part of the research team that investigated the deaths along the U.S.–Mexico border. Her work contributed to BMI's publication of *Protocol Development for the Standardization of Identification and Postmortem Examinations of UBC Bodies Along the U.S.–Mexico Border: A Best Practices Manual*.

Her scholarly work provides scholars, policy makers, and health practitioners with information on the effects of restrictive immigration on

immigrant health and strategies to overcome them. Because of the importance and relevancy of her work, she has been recognized with awards and scholarships that include the Marshall Foundation Dissertation Fellowship Award, the Hispanic Women's Corporation Scholarship, the Zuckerman Family Foundation Public Health Student Scholarship, BMI's 2017 Excellent Migration Research Graduate Student Award, and most recently her dissertation was nominated for the 2017 Council of Graduate Schools and ProQuest Dissertation Award.

Tiffiany Howard, Ph.D., L.L.M., is an Associate Professor of Political Science and the Director of the Center for Migration, Demography, and Population Studies at the University of Nevada, Las Vegas (UNLV). Earning her dual doctorate in Political Science and Public Policy from the University of Michigan, Dr. Howard's teaching interests reflect her dual expertise and training in policy and politics and she has taught courses on international security and foreign policy, terrorism and political violence, immigration and refugee policy, race and gender, and research methods and statistics. Since joining the UNLV faculty in 2008, she has been awarded several prestigious and nationally recognized research fellowships and visiting scholar positions, including the Ford Foundation Postdoctoral Scholar Fellowship (University of California, Los Angeles, 2013–2014), the American Political Science Association Centennial Center Visiting Scholar Position (2014), the U.S. Department of Defense Advanced Research Projects Agency-VIPCAT Research Fellowship (University of Georgia, 2008), and most recently, the Black Mountain Institute–Faculty Research Fellowship (UNLV, 2015). Dr. Howard is also the 2013 recipient of the Marjorie Barrick Faculty Scholar Award for distinguished research and the 2011 Faculty Diversity Award for Excellence in Research and Scholarship. Lastly, Dr. Howard has published extensively in her areas of expertise and is the author of three books: *The Tragedy of Failure* (Praeger/ABC-CLIO, 2010), *Failed States and the Origins of Violence* (Ashgate, 2014), and *Sex, Power, and Politics* (Palgrave, 2016).

Octavio A. Hinojosa Mier, M.P.A., is the Veterans for New Americans Coordinator on behalf of the National Immigration Forum. He is responsible for leading and managing the growth of veterans networks at the state and national level. He also oversees the day-to-day operations in coordination with the Forum's Field Director; the Bibles, Badges, and Business (BBB) Campaign Manager; and the Veterans for New Americans Co-Chairs. Mr. Hinojosa Mier has extensive national security and public policy expertise gained from his years at both the U.S. Department of State and the U.S. Congress. He holds a Bachelor of Arts degree in Political Science and Latin American Studies from the University of Kansas and a Master of Public

Administration degree from the Syracuse University Maxwell School of Citizenship and Public Affairs. He is also a former Graduate Fellow of the Maxwell School National Security Studies Program. In April 2013, Mr. Hinojosa Mier was decorated with the Officer's Cross of the Order of Civil Merit by the Spanish Ambassador to the United States on behalf of His Majesty King Juan Carlos I and the Ministry of Foreign Affairs and Cooperation for "extraordinary services" in benefit of the Kingdom of Spain. He is a 2017 Elected Fellow of the National Academy of Public Administration.

Ninez A. Ponce, Ph.D., M.P.P., is a Professor in the University of California, Los Angeles (UCLA), Fielding School of Public Health's Department of Health Policy and Management; Associate Center Director of the UCLA Center for Health Policy Research (CHPR); and Director of the UCLA Center for Global and Immigrant Health. She is the Principal Investigator for the California Health Interview Survey, the largest state health survey in the nation, housed at CHPR. She led pioneering efforts in the measurement of race/ethnicity, citizenship status, generational status, the implementation of the Asian ethnic oversamples, and the cultural and linguistic adaptation of the survey. A health economist, her research contributes to the elimination of racial, ethnic, and social disparities in health and health care in three areas: multicultural survey research, social penalties in health access, and global and immigrant health. Dr. Ponce has worked at the Asian and Pacific Islander American Forum, RAND, Catholic Relief Services, and the World Bank. She has served on the board of the National Health Law Program, the California Pan Ethnic Health Network, and the New Heights Charter School in South Los Angeles, and is a current member of the multicultural advisory board for Nielsen, Inc. She served on a National Academy of Sciences (NAS) subcommittee and on the National Quality Forum's (NQF's) expert panels. She currently co-chairs the NQF's Disparities Standing Committee. Her service for the NQF and the NAS committees focused on setting guidance for health systems in the use of social determinants of health and standardized race/ethnicity collection as tools to eliminate health disparities. Recently, Dr. Ponce was appointed to the Board of Scientific Counselors, National Center for Health Statistics, Centers for Disease Control and Prevention.

Thu Quach, Ph.D., came to the United States as a refugee from Vietnam. Her lived experiences during immigration and resettlement have grounded her and motivated her commitment to addressing disparities that affect underserved communities. She is currently the Director of Community Health and Research at Asian Health Services (AHS), a federally qualified health center in Oakland, California, providing culturally competent health care to more than 28,000 patients in English and 12 Asian languages. In this role, she oversees community outreach, patient engagement, and health

policy advocacy efforts. In addition, she leads research projects on clinic-based interventions, quality improvement, and payment reform analyses. As an epidemiologist, she has focused much of her work on examining the influence of environmental and sociocultural factors on the health of the Asian Americans and Pacific Islanders population. In addition to AHS, she previously worked at the Cancer Prevention Institute of California as a Research Scientist, where she led research studies on environmental health issues affecting disadvantaged populations, including occupational chemical exposures for Vietnamese nail salon workers. Dr. Quach is involved in local, statewide, and national research and policy efforts to promote health equity, including data warehouses, community-based participatory research, civic engagement, and health policy. She received a Master's in Public Health from the University of California (UC), Los Angeles, and a Ph.D. in Epidemiology from UC Berkeley.

Karthick Ramakrishnan, Ph.D., is the Associate Dean of the University of California, Riverside, School of Public Policy, and a Professor of Public Policy and Political Science. He is also a Board Member of The California Endowment, Chair of the California Commission on Asian and Pacific Islander American (APIA) Affairs, and an Adjunct Fellow at the Public Policy Institute of California. He received his Ph.D. in Politics from Princeton University and has held fellowships at the Russell Sage Foundation and the Woodrow Wilson International Center for Scholars.

Dr. Ramakrishnan's research focuses on civic participation, immigration policy, and the politics of race, ethnicity, and immigration in the United States. He directs the National Asian American Survey and is the Founder of AAPIData.com, which features demographic data and policy research on Asian Americans and Pacific Islanders. He has published many articles and six books, including *Framing Immigrants* (Russell Sage, 2016) and *The New Immigration Federalism* (Cambridge, 2015). Dr. Ramakrishnan has received many grants from sources such as the National Science Foundation, James Irvine Foundation, and Carnegie Corporation, and has provided consultation to public officials at the federal and local levels.

In addition, Dr. Ramakrishnan is the founding Editor of the *Journal of Race, Ethnicity, and Politics*, an official section journal of the American Political Science Association; the Director of the University of California–wide program on AAPI policy; and an Assembly appointee to the California Commission on APIA Affairs (2014–2017). He has written dozens of op-eds and appeared in more than 1,000 news stories, many in major news outlets such as *The New York Times*, *The Economist*, *Los Angeles Times*, National Public Radio, *PBS Newshour*, MSNBC, *CBS Evening News*, and CNN.

Alicia Wilson is the Executive Director of La Clínica del Pueblo, a federally qualified health center serving the immigrant Latino community in and around Washington, DC. La Clínica was founded in 1983 as a direct response to the linguistic and cultural barriers to health care experienced by Central Americans who had come to the DC area fleeing war, human rights violations, and poverty. Today the clinic provides primary care, behavioral health, interpreter services, comprehensive chronic disease care with particular focus on diabetes and HIV, community health promotion and education, advocacy, and outreach for men, women, and children throughout the DC metropolitan area. La Clínica's mission is "to build a healthy Latino community through culturally appropriate health services, focusing on those most in need."

Ms. Wilson received her B.A. in Religion and Sociology/Anthropology from Swarthmore College and began working in the social services field immediately after graduating. She first served as a case manager working with the homeless and working poor in and around Washington, DC, then shifted to working with HIV positive Latinos at La Clínica del Pueblo. In 2001, Ms. Wilson joined the development department of La Clínica and in 2002 became the Director of Grants and Contracts Administration. After playing an increasing role in the leadership of the clinic, Ms. Wilson was selected to be La Clínica's Executive Director beginning in January 2009. Ms. Wilson currently sits on the Board of Directors of the DC Primary Care Association and the Institute for Public Health Innovation, and she serves on the DC Department of Health's Bureau of Cancer and Chronic Disease Community Leadership Team. She has played an active role in local health care advocacy through her frequent testimony in front of the DC City Council, as well as her work in coalitions across the region. Ms. Wilson was named a 2015 Disruptive Woman to Watch by Disruptive Women in Healthcare. In 2017, Ms. Wilson was appointed to DC's Health Equity Commission by the City Council.

Hal F. Yee, Jr., M.D., Ph.D., is the Chief Medical Officer for the Los Angeles County Department of Health Services, the nation's second largest metropolitan health system, which includes four academic medical centers; a large ambulatory care network; affiliations with the University of Southern California (USC); the University of California, Los Angeles (UCLA); and Charles Drew Schools of Medicine; approximately 20,000 employees; and a $5 billion budget. He serves on the Board of the California Association of Public Hospitals and Health Systems, and the advisory boards of the USC and UCLA Clinical Translational and Science Institutes. Dr. Yee was the Rice Memorial Distinguished Professor of Medicine at the University of California, San Francisco (UCSF); founding Director of the UCSF-San Francisco General Hospital (SFGH) Center for Innovation in Access and

Quality; and Chief Medical Officer and Chief of Gastroenterology at the SFGH and Trauma Center. He has more than 20 years of extramural grant funding and has authored more than 80 publications. He made fundamental discoveries in the understanding of the molecular signals controlling cellular contraction and motility, and the pathogenesis of hepatic and intestinal fibrosis. Over the past decade his research has evolved to focus on development and implementation of disruptive interventions to improve the effectiveness and efficiency of health care delivery. Most notably he (1) conceived of and designed the implementation and evaluation of an award-winning electronic specialty care consultation management system in both San Francisco and Los Angeles; (2) developed and implemented a novel approach, the Expected Practice, that effectively standardizes clinical decision making and behavior; and (3) transformed the Los Angeles County Health System into a model for testing disruptive health care innovations that improve the quality and efficiency of clinical care.

Appendix C

World Café Organizations

During the lunch break, workshop attendees participated in a World Café event, which is a technique designed to encourage large group dialogue.[1] Each organization hosted brief discussions of their organization's work. Attendees moved among six tables, each hosted by a representative of a local organization involved in immigration issues. Brief descriptions of the organizations follow.

ALAMEDA HEALTH CONSORTIUM

The Alameda Health Consortium (AHC) is a regional association of eight federally qualified health centers in the East Bay of the San Francisco Bay Area.

AHC advocates for high-quality health care for the underserved. Each center believes in a universal right to accessible, affordable, and quality health care that empowers individuals to participate in maintaining their health and well-being. The 8 independently operated health centers in the consortium operate at more than 95 locations across the East Bay. Together, the health centers provide primary medical, behavioral, and dental care, as well as supportive services to more than 250,000 patients in Alameda, Contra Costa, and Solano Counties, nearly half of which are from immigrant families. AHC collaborates with lawmakers, government officials, and health care and immigrant advocacy organizations to inform, shape,

[1] This was not the typical World Café process, as noted by one reviewer.

and implement positive policy changes that benefit the patients and communities it serves.

ASIAN PACIFIC ISLANDER LEGAL OUTREACH

Asian Pacific Islander Legal Outreach is a community-based, social justice organization serving the Asian and Pacific Islander communities of the Greater Bay Area. It provides culturally competent and linguistically appropriate legal representation, social services, and advocacy for the most marginalized segments of the community, including low-income women, seniors, recent immigrants, and youth. Particular areas of focus include violence against women and family law, immigration and immigrant rights, senior law and elder abuse prevention, the rights of people with disabilities, anti-human trafficking, youth violence prevention, affordable housing preservation and tenants' rights, and other social justice issues. The organization takes a holistic approach by offering legal, social, and educational services in more than a dozen languages. Its offices in Oakland and San Francisco provide free legal services through one-on-one representation, legal intake and referrals, community-based clinics, educational workshops, building community partnerships and collaborations, and raising funds for legal services that benefit the most vulnerable sectors of society.

CENTER FOR EMPOWERING REFUGEES AND IMMIGRANTS

The Center for Empowering Refugees and Immigrants is a nonprofit organization with the mission of improving the social, psychological, and economic health of refugees affected by war, torture, genocide, or other forms of extreme trauma. The center works with underprivileged and traumatized refugees and immigrants from Afghanistan, Bosnia, Cambodia, and Iran to address their complex and differing needs, offering them direct services as well as linking them to appropriate outside agencies. The majority of the organization's 200 clients are Cambodian refugees who escaped guerilla warfare between 1978 and 1993 and currently live in Oakland, California. Founded by a small group of bilingual and bicultural mental health professionals in 2005, the organization provides both traditional services, such as clinical mental health counseling and medication management, and culturally and spiritually tailored intervention strategies, such as a meditation group co-facilitated by a Buddhist monk.

CENTRO LEGAL DE LA RAZA

Centro Legal de la Raza seeks to ensure access to justice for low-income and immigrant communities. Founded in 1969, the agency offers com-

prehensive legal services to protect and advance the rights of immigrant, low-income, and Latino communities through bilingual legal representation, education, and advocacy. It combines rights education, quality legal services, and youth development to empower, lead, and defend vulnerable populations. Specific legal services and policy advocacy focus on immigrant, tenant, and workers' rights. In the past year, the agency has provided legal services to more than 7,000 underserved and underprivileged people throughout Northern and Central California. In addition, the agency makes the 3-year Youth Law Academy available to Oakland high school students, enabling them to build confidence, understand the path to college, and increase diversity in legal professions.

CULTURALLY RESPONSIBLE CARE, REGIONAL HEALTH EDUCATION, THE PERMANENTE MEDICAL GROUP

Diversity and inclusion are the foundation of Kaiser Permanente's integrated care model. The Permanente Medical Groups, along with the Kaiser Foundation Health Plan and Hospitals, work to deliver culturally responsive care by providing care in multiple languages, educating doctors and other care team members about racial and gender biases, addressing the social determinants of health, closing care gaps for underserved populations, staffing call centers with employees fluent in more than 140 languages, and translating member communications into different languages. Several Kaiser Permanente medical facilities have separate Culturally Competent Care clinics that specifically serve African American, Armenian, Chinese, Latino, Vietnamese, and lesbian, gay, bisexual, and transgender communities. In 2011, Kaiser Permanente Southern California received the Multicultural Health Care Distinction award from the National Committee for Quality Assurance for its exemplary health care service to minority populations.

FILIPINO ADVOCATES FOR JUSTICE

Filipino Advocates for Justice (FAJ) was founded in 1973 by students and community leaders in response to the discrimination and alienation faced by the influx of immigrants from the Philippines to the United States. For more than 40 years, FAJ has sought to build a strong and empowered Filipino community by organizing constituents, developing leaders, providing services, and advocating for policies that promote social and economic justice and equity. Its programs are rooted in Bayanihan principles, a Filipino demonstration of social justice values where a community comes together to help those in need. FAJ works particularly with middle school and high school students at risk, low-wage workers vulnerable to exploitation, newly arrived immigrants, and the undocumented. Its programs

include youth leadership development, immigrant services, worker support and empowerment, and community organizing. Two current goals are to increase community knowledge of tenant rights and Filipino voter registration and turnout. FAJ currently serves more than 130,000 Filipinos in the East Bay Area through its Oakland and Union City offices.

Appendix D

Statement of Task

An ad hoc committee will plan a 1-day, interactive public workshop exploring issues related to the role of immigration as a social determinant of health. The public workshop will feature invited presentations and discussions that will consider the history of immigration laws and policies and how these laws and policies affect not only immigrant health, but population health more broadly.

The committee will plan and organize the workshop, select and invite speakers and discussants, and moderate the discussions. A proceedings of the presentations and discussions at the workshop will be prepared by a designated rapporteur in accordance with institutional guidelines.