Immigrant Health: Anchoring Public Health Practice in a Justice Framework

See also Young and Wallace, p. 1171; Allen, p. 1177; Rothstein and Coughlin, p. 1179; and Sundwall, p. 1184.

The nexus between policy actions and immigrant health is central in this issue of *AJPH* in two articles by Young and Wallace (p. 1171) and Rothstein and Coughlin (p. 1179), serving as a reminder of the need for public health practitioners to adopt a framework that explicitly connects the dimensions of social determinants of health with population health outcomes. Such a framework incorporates a root cause analysis to elucidate the factors contributing to observed health results, including the centrality of economic, social, and environmental conditions.

EFFECTIVE PRACTICES

Young and Wallace show how policies that marginalize and criminalize immigrants can minimize the effect of actions taken to ensure access to health-affirming resources. Their essay provides a critical discussion of the public health implications of states' complex, contradictory contexts in which immigrants may, for example, simultaneously benefit from public programs while living under the specter of immigration enforcement. Their research points to the need to account for interactions across the broad dimensions that affect both individual and community well-being.

Rothstein and Coughlin note that for a quarantine to succeed, there must be a set of protections in place that minimize the legal, economic, and social effects on vulnerable individuals who need to be quarantined. One strategy for dealing with the unintended consequences of public health actions is to enact as few regulations or practices as possible that restrict individual liberty. Rothstein and Coughlin offer an alternative to this approach in their notion of "safe harbor provisions," which can complement actions and regulations enacted to protect population health; such provisions make it both more likely that individuals will comply with public health directives and more likely that compliance will not cause additional harms. The concept of safe harbor provisions can be broadened, creating the strategic imperative to ensure that community members have access to the resources and opportunities that prevent transmission of an infectious disease; this allows policies related to quarantine to align with a much deeper set of actions that ensure economic well-being, protect from discrimination, and attend to social connections. In Los Angeles County, California, this includes creating safe and welcoming places for immigrants (regardless of citizenship status) to access a full range of free health services (including vaccinations), establishing a legal assistance fund for immigrants, and decriminalizing economic activities such as street vending.

MULTIPLE FORMS OF OPPRESSION

Health-affirming policies are always limited in their effectiveness by practices and systems that perpetuate discrimination, maintain exposure to hazards, and continue grave injustices. For immigrants, the intersectionality of race, language, citizenship status, and economic position create, for many, exposures to multiple forms of oppression and marginalization that can negate the many benefits of inclusionary policies. Public health success depends on acknowledging this complexity and addressing the fundamental need for social, economic, and racial justice to ensure optimal health and well-being. Offering sanctuary policies at Los Angeles County health clinics is not sufficient if the possible change in the public charge rule can penalize immigrants who receive government services.

Health departments and public health practitioners will need to ensure that local, state, and federal officials enact laws and regulations that improve the conditions that shape immigrant health. The foundation of excellent public health practice recognizes our interconnectedness with one another and our environment. Effective disease control, prevention of chronic diseases, and promotion of health-affirming actions demand approaches that are comprehensive and rooted in an understanding of the social determinants of health. Nowhere is this clearer than in our obligation to ensure that public health policies and practices do not unfairly advantage or disadvantage some community members based on social hierarchies including race/ethnicity,

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sex, sexual orientation, gender identity, social class, and immigration status.

SOCIAL MOVEMENTS

Our history illustrates that a commitment to improving health means incorporating health practices in a justice framework that defines health as a social good belonging to everyone and as a human right. Many of our major advances in health status have occurred because of key social movements that resulted in significant reforms such as abolishing child labor, passing factory regulations, establishing housing codes, mandating an eight-hour workday and a guaranteed minimum wage, extending civil rights, and investing in community infrastructure such as sanitation, clean water, and a safe food supply. It is not possible to address immigrant health and well-being without connecting to current social movements across the United States tackling the fundamental issues that interfere with our public health mandate to ensure health and well-being for all. As for other vulnerable populations, immigrants are at the crossroads of these fundamental issues. AJPH

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CONFLICTS OF INTEREST
The author has no conflicts of interest to disclose.

Health in All (Competing) Policies: The Case of Furniture Flammability Standards

See also Rodgers et al., p. 1205.

The concept of "Health in All Policies," promoted through agencies such as the World Health Organization, the American Public Health Association, and the Robert Wood Johnson Foundation, recognizes the importance of health for a thriving society and specifically addresses the need for all sectors to consider health implications when introducing new policies.[1,2] Achieving the goals of Health in All Policies requires an understanding of the broad health implications of individual policies and groups of policies, which is a complicated issue. The article by Rodgers et al. (p. 1205) brings up one complication in considering the health impacts of policies: namely, that policies are likely to have both positive and negative health impacts that must be weighed to determine the net health impact.

FURNITURE FLAMMABILITY

Rodgers et al. examine furniture flammability standards, which aim to reduce fires and fire-related mortality from residential fires that involve upholstered furniture. The standards require that upholstery material be treated with flame-retardant chemicals, which reduce the likelihood that the material will ignite. The conundrum is that exposure to the flame-retardant chemicals has health consequences—which, as cited by the authors, include poor attention and cognition in children.

The article thus brings up a conflict in many, if not all, policy decisions, which is the need to pit positive against negative consequences. The direct conflict addressed by Rodgers et al. is whether treating upholstery to reduce the risk of a fire, which is a relatively rare but devastating event, outweighs the ubiquitous exposure that occurs when upholstery is treated with flame-retardant chemicals. This issue alone is complex, but the question becomes more complex as the authors posit that upholstery-related fires have two main initiation sources: open flames and smoking-related material. The chemical treatment of upholstery is most impactful for open flame-initiated fires, and many other policies, such as requirements for fire safe cigarettes, exist to reduce the risk of fires from smoking materials.

THE CASE OF MASSACHUSETTS

Using data from Massachusetts from 2003 through 2016, Rodgers et al. found that upholstery fires resulted in the highest proportion of deaths of all residential fire types, but that the vast majority of these fires were from smoking materials rather than open flames. The authors therefore conclude that fire safety regulations should focus on smoking materials rather than open flames. Given the trauma, both physical and psychological, that results from burn injuries, most burn prevention researchers and professionals argue that we should move toward a goal of zero burn deaths.[3] The concept of Toward Zero Deaths has been widely adapted in road safety, where currently many countries (e.g., Sweden) and all of the US states have Toward Zero Death road safety campaigns.[4,5] Under this concept, any policy that reduces the incidence of burn injuries would be a priority. However, for road safety or fire prevention, we need to define at what cost we are willing to achieve this goal, and what other consequences we are willing to experience. We have few resources or conceptual frameworks that help guide these decisions.

Although this work by Rodgers et al. provides help in developing an argument for prioritizing a policy strategy—that is, that policies to reduce fires caused by smoking material

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