POPULATION HEALTH IS IMMIGRANT HEALTH IS WORKER HEALTH

The recent article by Ahonen et al. in *AJPH's* special section on work[1] emphasized the importance of incorporating work as a key concept in population health inequities research. We agree that the use of an ecosocial framework that encompasses work as a key concept to fully grasp health inequities and promote our nation's health is germane and long overdue. We appreciate the authors' acknowledgment of the role of intersectionality of social constructs such as socioeconomic status, race, gender, and immigration on the health of the working population, which echoes others' work.[2]

We further move the discussion to a specific group that remains at the core of population and occupational health disparities: immigrant workers. Immigrant workers constitute a large proportion of our invaluable yet vulnerable workforce,[3] notably in occupations that require low skills, pay low wages, and have job characteristics that increase their exposures to occupational hazards.[4,5] In light of the current climate in which population health, occupational health, and immigration policies are at the forefront of debates, this is the time to pay attention to our working immigrant population—specifically, how their experiences within and outside of work affect their health-promoting behaviors and overall health and well-being.

Different disciplines have documented various ecosocial stressors and protective factors associated with immigrant worker health. Stressors include language and cultural barriers, demands of their transborder relationships (also known as transnationalism,[6,7] whereby individuals maintain active relationships with friends and family in their home countries, including remittances), exposures to occupational hazards, and demands of acculturation. Protective factors include health insurance access, social support, and immigrant institutions and communities. We have yet to understand fully the dynamics of these factors and their short- and long-term effects on immigrant worker health. For instance, immigrants earning the exact or less than the federal minimum wage and send part of their income to care for family in their home country can be burdened. Yet these relationships also can be protective factors because social relationships and support have positive effects on health and well-being.

We have come a long way in terms of occupational health and population health inequities research in line with a culture of health for the nation. The article by Ahonen et al.[1] is proof of this evolution. Now that we know to include "work" in population health inequities research, a better integrated, interdisciplinary approach, especially for immigrant workers, will be vital to advancing the health equity agenda. AJPH

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AHONEN ET AL. RESPOND

We would like to respond to Rosemberg and Tsai's letter titled "Population Health Is Immigrant Health Is Worker Health." In their letter, Rosemberg and Tsai point out that immigrant groups are at the core of the experiences of both occupational and population-level health disparities, as well as at the forefront of the national sociopolitical conversation. This suggests that integrated approaches are needed to advance a health equity agenda. We could not agree more.

Recognizing that the health of immigrants, workers, and population in general are entwined, we must redouble our efforts to investigate work and immigrant experiences as drivers of population health. Work and immigrant experiences are intricately related to social identity and lived experience, as highlighted by Rosemberg and Tsai's examples of the financial hardship and social support that low-wage immigrant workers may experience. Such broadened perspectives would benefit our conceptualizations of both work and immigration, and could lead to innovative health promotion initiatives to inform agendas of international organizations that address labor, health, and development.[1] For instance, a life course perspective would recognize that work, the process of migration, and their interactions with health are embedded into lives and communities across time and place in both sending and receiving countries. In studies of migration and health, however, the premigration phase, continued contact with countries of origin, and return migration are often overlooked.[2–4]

Major challenges to such broadened approaches stem from the conceptual difficulty in separating and yet preserving the interconnectedness among relevant structural domains, such as immigration policies, local and national economies, employment practices, and individual and family needs. Separating such domains is necessary, at least initially, for scientific inquiries, but it diffuses both responsibility and the visibility of outcomes. The time and effort involved in developing synergistic views of the problem of health disparities across multiple, diversely focused stakeholders[5] are not insignificant.

Despite these challenges, we believe that the very intertwinement of the concerns of immigrant health, occupational health, and population health is the way forward. As we argued,[6] work is a potentially unifying experience to which many people can relate; the same is true for health. In fact, value differences can be narrowed if specific policies are framed by their health impact.[7] A renewed focus on what unifies us—as researchers, practitioners, and community members—may help us to move through divisions toward improved health status for all. AJPH

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E. Q. Ahonen drafted the letter and K. Fujishiro, M. Flynn, and T. Cunningham provided revision of its content.

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