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**Statement on Immigration**

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The exclusion of HIV-infected travelers and immigrants from the United States was initiated in 1987. It has resulted in serious discriminatory effects against people with HIV and has sent a misleading and distracting signal to the American people, since HIV-infected travelers and immigrants pose no threat to an informed public.

Since the first statement by the National Commission on AIDS on this topic in November 1989, a number of events have occurred:

1) The U. S. Public Health Service undertook and conducted a thorough review of the exclusionary list of "dangerous communicable diseases" and recommended formally that, from a public health vantagepoint, only active tuberculosis should remain on it. Secretary Sullivan has embraced and endorsed that recommendation.

2) The U. S. Congress reaffirmed the appropriateness of placing such judgment in the hands of the Secretary of Health and Human Services.

3) As the June 1, 1991, deadline neared for decision about what list of diseases constituted grounds for exclusion, a new debate apparently arose within the Administration around the proposition that travelers should be dealt with separately from immigrants. One view in this discussion was that the costs of medical care for people with HIV infection or AIDS made this disease a communicable disease of public health significance that should result in exclusion of immigrants. The Commission has reviewed that issue and found that present immigration law deals extensively and in detail with such economic concerns in the exclusion of persons who wish to immigrate if they are likely at any time to become a public charge. To single out HIV disease in this economic context seems irrelevant and highly discriminatory.

4) The issuance on May 31, 1991. of an interim rule that extends the same travel and immigration restrictions as "communicable diseases of public health significance" that previously were classified as "dangerous contagious diseases" defies public health knowledge. This action perpetuates the misleading and discriminatory effects of prior HIV inclusion on an outdated list of diseases. This has had the additional, serious side-effect of jeopardizing further important scientific meetings which are crucial to the efficient exchange of scientific information and progress in the midst of this accelerating pandemic.

Thus, we urge Secretary Sullivan to maintain his strong public health stance regarding this issue. We further urge Attorney General Thornburgh to accept the public health recommendation that concludes that HIV does not warrant exceptional treatment in travel and immigration policy. We further urge him to ensure that any revision of "public charge" conditions in such policy be made in an even-handed way that does not single out persons with HIV.

## BACKGROUND INFORMATION

## HIV DISEASE AND IMMIGRATION (INCLUDING PUBLIC CHARGE)

In its last revision of the immigration law (P.L. 101-649), Congress directed the Secretary of Health and Human Services to look to "current epidemiological principles and medical standards" in assessing the need to exclude immigrant applicants on the basis of illness or medical condition. Accordingly, the Public Health Service under the leadership of Secretary Sullivan reexamined the list of diseases to be used for purposes of exclusion. Of the eight diseases on the list, the Public Health Service determined that only infectious tuberculosis should be retained as it alone was transmissible through the air and by casual contact. The Commission unequivocally supports the proposed rule as put forward by the Secretary as it reflects our best and most current public health knowledge.

The Secretary's proposal has proved controversial due primarily to the elimination of HIV infection as a disease for which an individual may be excluded from entering the U.S. This is extremely unfortunate, as the removal of HIV infection from the list of diseases justifying the exclusion of aliens from the United States is an important step toward correcting false perceptions regarding the spread of HIV. The public health community has been united in its support of this action, having long recognized that regulations barring the immigration of HIV-infected individuals will have a negligible effect on the spread of HIV in the United States.

In the absence of a sound public health rationale, a United States government policy of continuing to restrict the entry of individuals who are infected with HIV would serve only to reaffirm inordinate and inappropriate fear of HIV infected persons, and to incite discrimination against these individuals. Such policies fail to recognize that it is not the immigrant or traveler, but rather risk producing behavior that transmits HIV. Restrictive policies, like this one, misdirect efforts toward aliens and away from those behaviors which do transmit HIV. In so doing, the policy does irreparable injury to our nation's best efforts to contain the spread of HIV by misleading the public regarding the risk and modes of HIV transmission.

In addition, the exclusion policy interferes with our public health objectives by discouraging members of immigrant communities in the U.S. from seeking testing, counselling and treatment due to fear of adverse immigration consequences. Through misinformation, misdiagnosis and breaches in confidentiality, HIV exclusionary policies exacerbate the ignorance, fear, prejudice and discrimination surrounding HIV. Such policies undermine both private and public outreach and education efforts that encourage voluntary, anonymous and confidential HIV testing. This is of considerable concern since almost half of all applicants for permanent residence are legalization applicants who have lived in the U.S. continuously since 1982. They are therefore not new migrants and if infected were almost certainly infected here in the U.S.

It has been argued that HIV infected individuals should be barred from immigration into the United States on the basis of the financial cost they will pose to the nation. It should be noted that U.S. immigration laws are very detailed and complex. Individuals seeking to come to the U.S. for a temporary visit or to reside here permanently must meet stringent visa eligibility criteria. Applicants who are HIV positive, like every other applicant, will be obliged to satisfy all other immigration requirements, including financial requirements.

Public charge provisions of the Immigration and Nationality Act administered by the Department of State and the Immigration and Naturalization Service require all applicants for immigrant and nonimmigrant visas to demonstrate that they are not likely to become public charges. Anyone who does not do so is denied a visa and precluded from either visiting or immigrating to the U.S. This is based on a "totality of circumstances" test which considers an applicant's health, financial resources, and their ability to earn a living in the future. As an added safeguard, the regulations provide that an alien who becomes a public charge within five years of entry be deported. Elimination of HIV exclusion will in no way lessen these restrictions on individuals who wish to immigrate to this country.

In fact, present protections are sufficient and are less discriminatory than exclusionary schemes that would arbitrarily classify certain illnesses as presenting an economic threat to the nation. Assessing costs means much more than simply adding up the average life time cost of treating an individual with HIV disease. The following are only a few of the costs which will weigh heavily on the nation in both economic and social terms: the cost to states and cities of lost revenues from taxes, tourism and commerce, such as the estimated $20 million in spending expected during the upcoming VIII International AIDS Conference in Boston; the costs of operating testing facilities, such as the estimated $4 million per year to maintain the testing program for refugees; the cost to those fields with a desperate need for skilled and educated employees; and, the cost to scientific progress through the serious side-effect of jeopardizing further important scientific meetings which are crucial to the efficient exchange of scientific information and progress in the midst of this accelerating pandemic.

In the long term, it is likely that the social costs associated with admission of HIV infected immigrant applicants will be minimal. U.S. immigration law gives preferential immigration status to aliens with a family relationship with a U.S. citizen or legal permanent resident, aliens with needed job skills or aliens who qualify as refugees. Aliens in other categories amount to relatively few admissions. Thus, immigrant applicants who are approved for permanent residence status are not indigent -- in fact, most are gainfully employed and many work in those very occupations where the U.S. suffers from shortages of staff and expertise.

Others immigrate to this country to be reunited with families who are able to provide them with financial support. A 1981 study of U.S. census data found that immigrant families to the U.S., from the time of entry to twelve years later, take substantially less funding from public services than do U.S. national families. After twelve years immigrant families' usage of public services becomes about average. The study also found that within two to six years immigrant families pay an average amount of taxes, and eventually pay more than U.S. national families. Overall, it was found that immigrants contribute more economically than they take in terms of public services. Individuals with HIV infection are still likely to be employed and self sufficient during the estimated 10 or more years from infection to development of clinical AIDS. Their economic contribution to our society over the course of those many years will far outweigh the estimated lifetime cost of treating HIV infected individuals.

The Commission must voice its deep distress over the encroachment of extraneous issues into a decision that should be science-based and focused solely on public heath concerns. We should not allow arguments based on misinformation, fear or discriminatory agendas to triumph. To do so is to betray the heart and the integrity of the federal government's role in protecting and advancing the health of all its people. The Administration's indecision makes it appear that the nation's public health process is to be governed by political pressure and not sound science.