

# Intersectoral Public Action between Immigration Policy and the Fight against Aids in France and Canada

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## Abstract

This article examines how two countries, France and Canada, with different political systems address a common problem that public migrants living with HIV/AIDS from countries where this disease is endemic. Public action in these countries is at the intersection of two public policies that may seem contradictory (immigration and the fight against AIDS). Despite three obvious differences: first in the fight against AIDS (constraint and control/cooperation and inclusion), then immigration policy (selective immigration/immigration generalized) and finally AIDS treatment among foreign (screening foreign/non-screening), the analysis of public action shows that there are common trends between the two countries on the direction of policy towards migrants living with HIV/AIDS. These are manifested in part by the reduction of the rights granted to the public due to the restrictions of immigration policies that affect the field of public health and secondly by humanitarianisation public action towards foreigners with serious diseases. Public management of this problem in countries thesis lies at the intersection of two public policies which may seem contradictory (immigration and fighting against AIDS). DESPITE three obvious differences: first in the fight against AIDS (coercion and control/cooperation and inclusion), Then in immigration policy (selective immigration/Widespread immigration) and treatment of AIDS Among Foreigners (non screening/screening aliens), the analysis of public Action That shows there are common trends Between the two countries in managing aids Among migrants. These Occur on the one hand by the reduction of the rights Granted to thesis hearings due to the restrictions of immigration policies affect the field of That public health and from the "humanitarianisation" of public policies targeting Foreigners suffering from serious illnesses: such as HIV/ aids.

**Keywords:** Public policy; Comparison; France; Canada; Health; Immigration

## Introduction

France and Canada have different political systems [1] but their policy approach they more? This article attempts to answer part of this question by taking the example of immigration policy, the fight against AIDS and public policy at the intersection between these two policies. The term "migrant" is used in this text as if it refers to foreign immigration policies in the field of the fight against AIDS, it is not suitable for public health issues around the immigration concerning immigrants (those arriving) than those already installed on the territory as well. This article is from the statement of a contrast between a strong associative mobilization around health of migrants in France during the 2000s and the relative weakness of the dynamics of community organizations around this problem in Canada during the same period<sup>1</sup>.

First, it seeks to analyze and compare public policy in both countries face the same public problem: HIV/AIDS among migrant populations from countries where HIV is endemic. The goal is then to analyze the diffusion process of public policy in a logical comparison of dyadic [2] to better identify the similarities and differences between the two states involved in the mechanisms of political competition on the management of public policies immigration and the fight against AIDS. This competition, it leads to closer public policy?

While it was obvious,<sup>2</sup> very little work of social scientists in France and Canada have discussed the link between AIDS and immigration in comparative perspective. In France, the publication of epidemiological

statistics on AIDS among foreigners in 1998 [3], as a science of government [4] led to specific programs targeting migrants from the end 1990s and early work on this issue [5]. The context of the arrival of HAART in 1996 and the fight against inequality in 1998 have encouraged further research: on the structural effects of immigration policies in the fight against AIDS [6] on HIV/AIDS among migrants in Dom/Tom on immigration policy and the fight against AIDS (Mbaye, 2009) on AIDS, migration and homosexuality [7] on migrant women and HIV/AIDS [8] etc..

In Canada, research on AIDS and immigration occurred in two phases: first, in the late 1980s with a series of works on AIDS and Haitian populations [9-12] However, because of the stigma that these people were the subject and the fact that these studies were likely to worsen, this theme has been temporarily abandoned by the researchers to return in a different approach to the early 2000s, following the decision to screen aliens before they enter Canada [13]. This work often involved have generally denounced the ethical, legal and medical effects of these measures on the health of migrants. While some comparative studies were already interested in this field, they have either compared immigration policies [14,15] or the political fight against AIDS [16,17] but did not address the public policy between the two.

In the context of this article, the national level is the context for

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<sup>1</sup>This work is the result of doctoral research on the French case between 2005 and 2009 and a postdoctoral research work on the Canadian case in 2013. Both land a series of interviews (over 100 interviews), observations and ethnographic studies were conducted with public stakeholders, associations and migrants. To see the methodological work [19]

<sup>2</sup>The issue of the link between AIDS and population mobility is at the very origin of the first programs of fight against AIDS: how to identify and master the "zero" in his patient mobility contributes to the dissemination and spread to San Francisco [20].

analysis and comparison. In the field of public policy analysis, it appears as one of the analytical frameworks most relevant [18], especially as the public problem to be solved is the same in both countries: prevalence rates of HIV/AIDS among high populations from areas where HIV/AIDS is endemic. While only 2.2% of the population living in Canada was born in these countries, 16.9% of new HIV infections in 2011 concern with a rate nine times higher than among other Canadians. In addition, the 71,300 people living with HIV in Canada in 2011, 14.9% are from these countries. In France, in the late 1990s “foreigners”<sup>3</sup> 6% of the population but accounted for 18% of AIDS cases. Of the 42,601 cases of new infections between 2003 and 2011, 26% from Africa and 2.5% of Haiti [21].

The sectoral analysis of “effects” and “collusive transactions” [22] between public policies in both countries face a problem required several mobilized based on theoretical approaches and issues stages of research. The approach by the political sociohistoire was sought to understand how the institutional path dependence and gambling taken by public policy actors is linked to the history of AIDS and the immigration in both countries. Another approach called structural [23] allows taking into account the determinants, economic, political and historical context, political, but also cultural factors in the vulnerability of these groups to HIV/AIDS. Geopolitical and geostrategic approaches [24] were also mobilized to understand their influence on both public actions because these migrants are not treated the same way because of colonial and geographic ties between France, Canada and these countries. The approach by the “policy problem [25] was requested because of its relevance in public policy analysis of health because health systems are not as “systematic” as headings the claim; they are often historical assemblies solutions adopted to solve public problems [26]. In addition, the problem of AIDS among migrants is more complex that it is not only a social or cultural medical problem, but all these problems at once.

This article first analyzes the influence of political systems and public health action against AIDS before to show the differences (on the role of community organizations) and similarities (restriction of rights and moral approach) between France and Canada in terms of management of the problem of HIV/AIDS among migrants.

## Effects of Political Systems and Public Health Action against Aids among Migrants

### Difference political systems and welfare state

If France has a unitary political system, Canada has a federal system where the division of powers is between the federal government and the provinces. Immigration policies are a federal level while health policies are under provincial jurisdiction<sup>4</sup>. Although there are interdependencies between national and federal policies, the policy of fight against AIDS in its missions prevention, education and research remains a federal prerogative. In France, the political system has a centralized health policy and immigration are purely national prerogative.

In both countries, political systems directly influence the political treatment of the issues around immigration. In France, the republican

and constitutional model assumes the unity of the Republic [27,28]. Racial or ethnic communities are not recognized and are part of a common set what the French nation. This unitary model and lessons learned for health policy in the colonies led since the late 1990s, following the political fight against exclusion, to a focus on socio-political determinants of migrant health policy approach. This approach assumes a transcendence of cultural and genetic which hitherto based health policies in countries colonized or with immigrant populations from these countries explanation. It is now no longer insist on the cultural dimension in the explanation of AIDS among migrants, as was the case for childhood lead poisoning which later was included on the public agenda because of culturalist explanations [29], but to demonstrate the importance of social and political determinants in the migrants’ vulnerability to HIV/AIDS. Policies to fight against immigration and their effects and serve as main reason for the particular vulnerability of foreign HIV/AIDS because they affect access to health services for people at risk or living with HIV/AIDS. However, the risk of overstatement of social determinants of health have delayed consideration of some relevant cultural determinants in the policies of fight against AIDS among migrants as language, instead of the woman, the symbolism of blood etc. [30]. In addition, the difficulty of producing ethnic statistics in France did not facilitate the identification of cultural issues of the disease in public migrants [31].

Thus, if France has a socio-political approach to the health of migrants, Canada on multiculturalism model introduced in 1971 and enshrined in the Charter of Rights and Freedoms rubbed off on public health work with migrants. The “reasonable accommodation” of health structures to diversity [32] that results from this model institutionalizes a Community approach in targeted actions reasonable to ethnocultural communities in the field of health.

In the context of public action against AIDS among migrants in both countries, those in charge of public policies have different and sometimes conflicting standards. In Canada, there is a competition between the federal level in charge of immigration and provincial level in charge of the implementation of health policies. It is the same in France, where the reality of competition affects inter-governmental action. They are exacerbated when the logical sectoral coalitions in charge of public policy opposed as is the case of immigration and public health policies.

If the two political systems are different, France and Canada both have a mixed welfare state “bismarcko-Beveridge” [33] system. However, if the foundation of the French system is Bismarckian (based on insurance and for those who pay), that of Canada is historically Beveridge, but liberal trend, with differences between the provinces, financed from taxes and universal [34]. Instead of policies to fight against AIDS in Europe [35], the theory of welfare state models are relevant in the context of targeted public health policy because access to healthcare for migrants fits more easily into the framework contexts health system Beveridge type of insurance Bismarckian. At the same time, bismarcko Beveridge-mixed models of France and Canada contribute to strengthening the politicization of access to healthcare for migrants living with HIV/AIDS since the controversy about the values and principles that should underpin their management medical care: should they benefit from national solidarity? The public health principles they sufficient to grant them access to free care while national in precarious situations to pay their health insurance?

### Differences traditions policies to fight against AIDS and immigration

Apart from differences in political systems and health, France

<sup>3</sup>In France, this concept refers to those who do not have French nationality. They may be born in France and living in France for several years without requesting or obtaining naturalization.

<sup>4</sup>The refusal by the federal government to take over health care of rejected asylum applicants from countries designated “safe” will cost nearly \$ 6 million Canadian dollars to the Province of Quebec. (Cf. [http://quebec.huffingtonpost.ca/2013/03/01/gouvernement-soins-demandeurs-dasile\\_n\\_2793109.html](http://quebec.huffingtonpost.ca/2013/03/01/gouvernement-soins-demandeurs-dasile_n_2793109.html))

and Canada also have models of immigration and the fight against AIDS different. France and Canada seem to adopt, during the first years after the discovery of HIV, different policy responses. If France adopted the theoretical model of “cooperation and inclusion,” Canada has meanwhile chosen different from the “Contain and control”. The French model is to establish a solidarity vis-à-vis the sick, not to test foreign entry, to avoid discrimination and breach of confidentiality. Foreign patients can then receive free care and institutionalization of a right of residence for medical reasons if they do not receive appropriate care in their country of origin. However, in its logic, HIV testing has been mandatory since 2002 for permanent immigration to Canada, even though HIV is not in itself a barrier to entry.<sup>5</sup> According to the authorities, “if Canada wants to avoid becoming the medical clinic of the planet, it is justified to develop a selection system that makes distinctions based on personal characteristics such as health status”. Thus, according to Article 38 of the Law on Immigration and Refugee Protection Act of 2001, overseas living with HIV/AIDS may be inadmissible for medical reasons if he is a danger to the health and safety of Canada or when it may be a burden to the health and social services in Canada. The input request is denied and if the financial burden is higher than the average Canadian or demand may lengthen waiting lists of health or social services. In this procedure, the basic rules regarding listing of HIV counseling and post and pre-test are not met: the requirement for HIV without express and informed consent of the test person. In addition, once installed, certain categories of aliens are in the majority of the provinces of Canada to wait three months to receive health insurance.

Thus, unlike in the United States in the 1990s where foreigners diagnosed with HIV were not allowed to enter the territory, Canada, refusal of entry of HIV-positive immigrants, not a public health dimension, but primarily an economic dimension. The latest reforms of 2011 that put an end entirely to the protection offered by the Interim Federal Health (IFH) to failed asylum seekers, with the exception of products and services designed to protect the health or public safety will profit 300 million over five years (2012-2017). However, these two provisions (safety hazard and financial burden) does not apply to refugees, Canadians and permanent residents, as well as their spouses or children.

These two different traditions of struggle against AIDS directly influence public policy and the extent of public problem solving in France and Canada with (logically) on the one hand, France, import conditions and Moreover, Canada, pathologies acquisition.

Political choice not detect foreigners entering French territory should lead to a major wave of immigration therapeutic. However, statistics and studies have shown that the rate of therapeutic immigrants is between 5 and 10% of foreigners who discover their HIV status in France [36,37]. Moreover, Canada, several categories of foreigners (asylum seekers, spouses of Canadians or permanent residents) pass between the cracks and can enter without being detected or not to be affected by both Article 38. This reality demonstrates the limits of the two models in the epidemiological reality of AIDS in France and Canada.

### Action between two competing public policy

A comparative project is more complex than the objects of comparison are areas of public action [38] different (Table 1) in two different political contexts (France, Canada).

<sup>5</sup>In 2006, at the International AIDS Conference in Toronto, steps have been taken to facilitate the entry of applicants short-stay visa in Canada

In both countries, sectoral boundaries are not the same and the actors involved vary from one country to another. Public action is at the crossroads of two autonomous but interdependent public policies that influence each other. Unlike political sectors that are organized in a vertical sense, policy towards migrants living with HIV/AIDS in both countries a horizontal and population public action. Because of its cross, it comes from the classical logics of regulation of public policies and lies between logic of inclusion and exclusion.

It is the scene of at least two belief systems, two advocacy coalitions [39] that clash: a sector-specific immigration and the health sector. Both systems are supported by coalitions of causes which sometimes competing interests. The area of the fight against AIDS is borne by public health stakeholders from the public and private sector, committed to the principles of non-discrimination, equality, accountability and therefore inclusion, while the area of the Immigration is clean in both countries logical selection, restrictions made by the authorities to fight against illegal immigration. These sector-specific [40] corporatism, by dint of immobility, confinement and sectoral strategies, identify forward the sector to which they belong. The sector confinement can lead to the conclusion that the sectoral weight overrides the global action adopted by a political superior [41,42]. Each jurisdiction within the state and acts as an advocate for the sector, leaving even go against the public interest. These actors undertake to act according to their sectoral logic failing to discredit inside or outside their area. Administrations are willing to negotiate, provided that their corporate interests are not affected: The *not in my backyard* “collusive transactions” between these two systems determine the modes of definition, institutionalization and development of public *action!* daily in both countries as well as the actors.

### Collective mobilizations around AIDS in France and Canada

Despite these differences models, public action against AIDS among migrants in both countries led to political realities and treatment increasingly tending to a similar approximation of traditionally different models of public action: the trend common to the relationship between government and community organizations and the exceptional treatment of AIDS in the field of immigration.

### State community organizations toward recentralization?

Public action against AIDS towards migrants is also marked by the traditions of public action and relations between the government and various community organizations. In Canada, public action rather then centrifuged in France, it is traditionally centripetal. In Canada, the government is trying to nationalize the actions of Community by imposing through public subsidies standards of public action in the fight against AIDS, while in France, actors powerful community in the field of the fight against AIDS and sometimes direct influence prevention policies and support for people living with HIV/AIDS.

	Immigration	Health
Instruments	Legislative/regulatory/coercive	Informative/participatory
Political efficacy	Uncertain	Possible effective
Target groups	Concentrate (foreigners)	Diffuse (all), universal
State and degree of institutionalization	Sovereign, legitimate violence, "command and control"	Governance, Health democracy, negotiation: State/doctors/associations
Forms of legitimation	Respect for the law, state sovereignty	Public health, solidarity, pragmatic adaptation
Implementation	Tax, use of police	Cooperation, public action
Type of control	Discretion, top down	Bottom-up perspective

Table 1: Difference in two different political contexts (France, Canada).



Actors such as Aids, ActUp the TRT5 have particularly influenced the decisions of the French authorities in screening, prevention and treatment of AIDS patients in the 1990s and 2000s [43]. In the field of the fight against AIDS among migrants, community organizations have gained legitimacy through their knowledge of the public, their tradition in treating health precarious and difficult and illegitimacy of government support public health illegally established on the territory. Although there is no consensus and homogeneity between members of association's traditional fight against AIDS on this issue, the leaders were able to politicize AIDS among migrants and to impose government repository that determines policy.

However, in both countries, the "normalization of AIDS" [44] seems to lead to a common trend recentralization of public action around government. Community actors lose their more human and financial resources, are becoming more professional and open to new fields such as international. They are also victims of the spread of neoliberal framework in the social field and must mobilize to face new constraints as the new public management that determines their working hours, access to grants and human resources. Access to treatment in the South and professional politicization of issues around immigration make their advocacy more complex. In addition, the institutionalization of "humanitarian State" allows public to use the same registers powers arguments to legitimize the right to care and stay of foreigners living with HIV/AIDS and occupy the space that previously was reserved for humanitarian NGOs.

### Differential treatment of AIDS immigration

In both countries, AIDS receives special treatment in immigration compared to other pathologies that affect migrants. In Canada, the treatment of AIDS policy in the field of immigration remains bound to the image of the epidemic in the early years marked by uncertainty. These years of uncertainty continue to rub off on the policies towards foreigners living with HIV/AIDS. Canada immigration services gave him early on, a particular treatment [45] as a separate disease that refers to sexual deviance and risk [46,47]. This image of AIDS is often at the expense of foreigners living with HIV/AIDS because it can jeopardize their access to land. During these early years of AIDS, the disease came to bring a new stigma to an immigrant population, often Haiti, already highly stigmatized [48]. This treatment gives exceptional HIV/AIDS, politically treated in a diffusion approach and spreading fear of immigrants, contrary to international provisions that specify that this separate treatment should not be limited to HIV/AIDS compared to similar pathologies: the exclusion of immigrants with HIV-AIDS for economic reasons is justifiable only if the same requirements apply to immigrants suffering from other diseases such as cardiovascular disease.

France, meanwhile, has changed its political treatment of AIDS among migrants. Community mobilization has contributed to change the image of AIDS among authorities in charge of immigration. Apart from the fact that patients are not detected at the input, the discovery of HIV/AIDS does not preclude the entry into the country and instead may facilitate the integration of foreigners living with HIV/AIDS in the territory. More than other diseases, AIDS is treated as a "humanitarian" exception in favor of migrants living with HIV/AIDS. If in the early years of AIDS, migrants appeared under the sign of danger and fear, this logic has evolved into a focus on social inequalities in health [49] approach and a political commitment to dealing with this vulnerability particular migrants to HIV/AIDS. It is no longer a priority to protect against the national "AIDS foreigners", but assume this condition in a focus on the social determinants of health that

determine the vulnerability of migrants to HIV/AIDS approach. This paradigm shift will lead to legislation to facilitate the installation and regular residence of foreign AIDS patients and effective access to health care and rights. In this perspective, AIDS can be a means of integration in France.

Unlike Canada, the exceptionality of HIV/AIDS for the benefit of foreigners in France. In Canada, AIDS may pose a risk of refusal to stay while in France, it can allow access to a regular residence permit. While in France, changing the right of residence for care given to foreign patients in 1998 received major restrictions in 2011<sup>6</sup> for all patients with serious illnesses who can no longer benefit from the stay provided that treatment is available in their country of origin, those living with HIV/AIDS continue to enjoy this right even if the treatment is available at home. They benefit through a 2007 circular from the Directorate General of Health (DGS) additional provisions that take into account not only the availability but the actual accessibility to treatment in the country of origin.

In Canada, HIV/AIDS is one of the only diseases to receive treatment from the authorities to fight against the burden on health and social services. Its treatment is especially compared to other diseases: doctors Citizenship and Immigration Canada (CIC) and the administrative authorities give it more attention than other diseases in the application to enter the territory.<sup>7</sup>

These two political treatment of HIV/AIDS among immigrants in Canada and France are related to the place of community stakeholders in advocacy for patients. If in France, community actors gathered around the Observatory of the right to health of foreigners (ODSE) are political entrepreneurs behind public action against AIDS among migrants in Canada, their place is marginal in the normative production and experimentation that often precedes political fight against AIDS. However, as in Canada, these associations are increasingly taken in managerial, professional and financial logic dependencies à-vis public authorities that require them to sort out the various problems that deserve their mobilization. Due to its political and legal complexity, the issue of foreign patients undergoing increasingly these constraints community organizations for the benefit of public authorities in the two countries engage in a recentralization of public action in requesting the repository humanitarian NGOs and submitting this field to the logic of struggle against immigration.

New policy guidelines for public action between health and immigration in both countries

Political decisions taken in recent years in both countries show common trends in addressing issues around health of migrants in France and Canada. They are increasingly affected by the paradigm of the "unwanted" immigration which at the same time leaves a window of opportunity for those who can raise a moral dimension of state action.

### Consensus on Action against "immigration suffered" and its effects on health

It is, in a dyadic approach to public policy to show how the mechanism of competition between states leads to the diffusion of public policies. In other words, how the reduction of the rights of

<sup>6</sup>The Immigration Act of 16 June 2011 amended section 313-11-11 CESEDA replaces the concept of "availability" to that of accessibility "of treatment in the country of origin, which significantly reduces the number of contenders for this legislation.

<sup>7</sup>In the manual for DMPs responsible for providing medical certificate, specific details are given accurate HIV test compared to other tests, see the manual DMP <http://www.cic.gc.ca/francais/ressources/publications/md-manuel/annexe-03.asp>

foreign patients is considered a rational strategy to avoid attracting new patients immigrants fight against medical tourism and prove the defense of the gains of a health system threatened by the arrival of foreigners. The proximity of the tongue between Canada and France (La Francophonie) that facilitates formal and informal arenas of distribution, origin countries of emigration, the resemblance between public problems, their salience and their politicization, contribute to the dissemination of public policy between the two countries in this field and mimicry on certain aspects.

Immigration policies in both countries are increasingly marked by phenomena of politicization [50]. While in Canada, it does not exist, in the image of France, far-right parties have gained political capital through exploiting the discourse around issues of immigration; in both countries, the issue of immigration is at the center of political debate. The electoralisation health of immigrants directly affects their rights and access to care where politicians are accused of “playing politics with the health of migrants rather than health policy.”

Several arguments registers occupy the political debates around access to health care for immigrants in both countries, “medical tourism”, “call for air”, “rider”, “cost higher than the national ownership”. Due to the professionalization of political actor [51] the field of AIDS among migrants is increasingly sought. Even powerful public actors such as doctors undergo this diffusion logic of immigration in the field of public health. This situation is linked to the social and political sensitivity of the two topics that are of public action and economic crisis regularly sought to justify the restrictions of rights means for governments to demonstrate their concern for the health of their population and protection against danger from the outside.

The fight against “immigration suffered” is the basis of immigration policy in Canada. In France, between 2002 and 2011, “chosen immigration” to the Canadian was introduced in French legislation and the three laws on immigration. The health costs of immigration are among the foundations of policies against immigration suffered. In 2001, France and Quebec (who decided to follow other provinces such as Ontario, New Brunswick and British Columbia) established at the same time a waiting period of three months<sup>8</sup> during which medical care is not provided to newcomers (Canada) and undocumented (France). This is according to the authorities in both countries to fight against the “pull factor” and “medical tourism” that these too attractive health systems may be.

In both countries, but also in other immigration countries in Europe, the authorities are *committed* “in a race to the bottom in terms of social rights granted to foreigners” [52]. This is minimize social rights that are granted to them may appear in the eyes of other countries or candidates for immigration as “medical paradise” of immigrants and thus attract the “misery of world”.<sup>9</sup> To avoid this picture, all countries at the same time restrict care rights granted to immigrants. This policy is in practice the transfer of norms, ideas and policies [53], where political decisions are conditioned by the political choices made in other territorial entities. National policies on health of immigrants are then established according to the rights that other countries provide foreign.

<sup>8</sup>The waiting period does not apply to temporary workers from countries having concluded an agreement with Quebec on social security, Mexican or Caribbean Seasonal Agricultural Workers who participate in a program for workers from Mexico and the Caribbean, women pregnant, victims of violence or infections that could threaten public health.

<sup>9</sup>Referring to the now famous statement by Michel Rocard, former French minister in 1990, “France can not accommodate all the misery of the world, but it must faithfully take his hand”.

While the entry of foreign patients is increasingly restricted, the foreigners living and living with HIV/AIDS are not exempt from these new measures. Deportation and expulsion of foreigners living with HIV/AIDS are common in both countries. In France, the right to stay to care is restricted due to the availability of treatment in the country of origin. In Canada, the application for permanent residence on humanitarian grounds foreigners living with HIV/AIDS can less be based on an “irreparable harm” if returned to the country of origin. As asylum, lists of safe countries of origin in health are produced by governments in both countries to facilitate the return in the countries of origin of foreign patients. In 2012 this list was extended following the reforms of the federal program Interim Health (IFH).<sup>10</sup>

And more than policy transfer, it is for these countries to adopt the same responses to the same public issue. The harmonization of policies towards foreign patients is less determined by the political mimicry by competition and by the structural effect of the global market repository that serves as an explanation of social rights restrictions faced by the all these countries.

### **Moral approach to the rights of migrants living with HIV/AIDS: the government “humanitarian”**

The social representation that companies still have AIDS more than 30 years after its discovery, it continues to be considered politically, despite its “normalization” and advances in medicine, an incurable disease which refers to death, especially in the case of Canada. This representation helps make sick people deserving of national solidarity. Both in France and Canada, access to healthcare for migrants raises moral issues, which lead to political debates around the responsibility of rich countries to take their share of the world’s misery. What is the magnitude of the sacrifice that national morality can reasonably require in respect of foreign nationals? In Canada under the Immigration Act may be admitted “persons belonging to a declared inadmissible class [...] in accordance with its humanitarian tradition followed by Canada with respect to the displaced and persecuted”.<sup>11</sup> It is also the moral duty that asylum seekers with HIV are not subject to the principle of “undue burden” for Canadian health care system. In France, the right of residence for foreigners with serious diseases cannot be supported in their country of origin established by Chevènement Act 1998 and is politically defined as a humanitarian device.

In both countries, there has been a shift towards a humanitarian approach to health policy in respect of seriously ill foreigners. Through action and administrative experience of senior officials, the welfare state is one of the few areas of public action to escape, until the late 1980s, the triumph of neoliberalism and focus on the fight against poverty and exclusion. Develop together new forms of solidarity vis-à-vis the populations in precarious situations. Social inequalities in health are unacceptable for actors and public opinion, even in the context of immigration policy more and more restrictive. Public opinion is often expressed support for the deportation of illegal aliens, but generally opposes restrictive access to care for the most vulnerable measures. While it expels more and more illegal aliens in France, are granted residence permits more and more foreigners with serious diseases such as AIDS. Residence permits for medical reasons increased from 1,045 in 1998 to 9,149 in 2001 and 18,572 in 2005 [54]. At the same time, the expulsion of illegal immigrants rose from 9,227 in 2001 à 23,831 in 2006 and 36,822 in 2012.<sup>12</sup>

<sup>10</sup>On 30 June 2012, the Canadian federal government introduced new restrictions on access to the Interim Federal Health (IFH), which covers basic health care for refugees, asylum seekers and certain other non-citizens.

<sup>11</sup>An Act respecting immigration to Canada, RSC, 1985, Article 6 (3).

While the disease was a denial of the immigrant worker, she became a part of the fight against illegal immigration, a means of recognition and integration of immigrants. If people of immigrant experience more forms of discrimination, ill foreigners receive a new biological citizenship [55]. This humanitarian State allows the government to take advantage of the benefits of the humanitarian field and at the same time in a centripetal logic nationalize the actions of traditional humanitarian actors have invested the area of immigration.

However, the admission of immigrants for humanitarian reasons is the exception rather than the rule. This arrangement further allows electorally beneficial politicians in both countries use a double discourse: first to demonstrate protective image of the health system like Canada where the obstacle of “undue burden” is to prevent the entry into the territory of populations, patients often undesirable. At the same time, the generosity of the company allows them to demonstrate the solidarity of society vis-à-vis the poor. If HIV testing on entry may seem contrary to the ethical and moral dimension of public policy, IFH in its current version to support all people with serious diseases has a strong humanitarian dimension.

Generally if those in charge of the defense of foreign base their arguments in international conventions of human rights [56], the health of migrants is marked by the peculiarity of this argument based not on human rights man but as a humanitarian dimensions approach the Human Rights assess the burden that some public health measures (such as the denial of entry of some AIDS patients in Canada) may have on the rights of person immigrants. However, the humanitarian rights often ignore certain basic rights that people can claim to the host society, not because they are granted a privilege or special favor but because they have the right [57]. One of the perverse effects of this approach is that the extension of rights to certain categories of foreigners (such as AIDS), to the detriment of other categories (non-diseased); the opening of these new rights is accompanied by the exclusion of other migrants of their basic rights [58-60]. This thus leads to create new legitimacy through suffering. Thus, the legitimacy of immigrants into the host society is its workforce at its suffering, as if to be seriously ill to benefit from national solidarity [61-73].<sup>13</sup>

## Conclusion

Despite the differences in traditional models of political systems, welfare states, of immigration and the fight against AIDS policy, public action against AIDS among migrants in France and Canada shows that these two states developed eventually adopt the same policy and even tend to align. The case for public action between AIDS and immigration shows two trends of harmonization: the first is a restriction increasingly important rights to a foreign health insurance. This limitation is part of a broader context of restrictions of rights of entry and residence of foreigners in Europe [74] and North America, but also reductions in health spending. The second, related to the first, is a moral treatment of foreigners with “very serious” diseases. This allows them, for humanitarian reasons, or public health benefit of” special treatment that gives them a right of residence in the host country and to receive free care. However this right for foreigners “seriously sick” at the expense of those “healthy” that cannot benefit from this “exceptional favorable” treatment. Both results show that these states are sensitive to privacy when directly threatened, but less so for those who cannot

benefit from this suffering visible and urgent care. These links between public policies in developed countries are not confined to the field of immigration and health, they affect more social policies (housing, employment, retirement) and beyond environmental policies linked without doubt the impact of increasingly marked the neoliberal global repository on the action of all States. Intersectoral approach to the problem of AIDS among migrants showed that increasingly, we are seeing construction arenas more or less consensual resolution of this public issue. This cross-government action tends more and more to empower traditional sectors to create new “types” of focus either on intervention in a particular field but on a pragmatic approach to solving public policy problems. This is the case of other interdepartmental programs such as the rights of women, the struggle for recognition of LGBT (Lesbian, bisexual, gay and transgender), environmental policies and policies of the city. These new forms public policy change on the one hand the government work traditionally organized on a sectorial approach and the other called the analysis of public policies based on the sequential approach Jones to readjust [75,76].

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<sup>12</sup>Le Figaro of 22 January 2013, record expelling undocumented 2012 <http://www.lefigaro.fr/actualite-france/2013/01/22/01016-20130122ARTFIG00577-record-d-expulsions-de-sans-papiers-en-2012.php>

<sup>13</sup>Some community organizations in France, some paperless contaminate voluntarily to have the right of residence granted



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