Title
Recasting the Immigrant Health Paradox Through Intersections of Legal Status and Race

Journal
Journal of Immigrant and Minority Health, 23(5)

ISSN
1557-1912

Authors
Bacong, Adrian Matias
Menjívar, Cecilia

Publication Date
2021-10-01

DOI
10.1007/s10903-021-01162-2

Peer reviewed

HHS Public Access

Author manuscript

J Immigr Minor Health. Author manuscript; available in PMC 2023 March 17.

Published in final edited form as:

J Immigr Minor Health. 2021 October ; 23(5): 1092–1104. doi:10.1007/s10903-021-01162-2.

Recasting the Immigrant Health Paradox Through Intersections of Legal Status and Race

Adrian Matias Bacong[1], **Cecilia Menjívar**[2]

[1]Department of Community Health Sciences, UCLA, Fielding School of Public Health, Los Angeles, CA, USA

[2]Department of Sociology, UCLA, Los Angeles, CA, USA

Abstract

Immigrant health research has often noted an "immigrant health paradox", the observation that immigrants are "healthier" compared to their native-born peers of similar demographic and socioeconomic profile. This paradox disappears as immigrants stay longer in the host country. Multiple arguments, including migrant selectivity and cultural and behavioral factors have been proposed as reasons for the apparent paradox. Recently, the field has focused on immigrant legal status, especially its racialization. We review the literature on the immigrant health paradox, legal status, and racialized legal status to examine how this debate has taken a more structural approach. We find that immigrant health research has taken a needed intersectional approach, a productive development that examines how different markers of disadvantage work concurrently to shape immigrants' health. This approach, which factors in immigration enforcement practices, aligns with explanations for poor health outcomes among other racialized groups, and promises a fruitful avenue for future research.

Keywords

Immigrant health paradox; Hispanic health paradox; Immigrant health advantage; Race and racialization; Legal status; Immigration; Latinos/Latinas/Latinx

Introduction

Although the United States (U.S.) self-proclaims to be a "nation of immigrants", in May 2019 the Trump administration considered an expansion of the definition of "public charge" for immigrants [1]—specifically legal permanent residents who use government social services for subsistence—with the aim of discouraging immigration and expanding conditions of deportability for low income immigrants. Research indicates that immigrants are less likely to use government, social, and healthcare services [2–5], and that use of

✉Adrian Matias Bacong adrianbacong@ucla.edu.

Compliance with ethical standards

Conflicts of Interest The authors declare that they have no conflict of interests.

Ethical approval This paper is a literature review and not a study involving human subjects. As such, this paper did not require an Institutional Review Board approval.

welfare services has declined since the enactment of the 1996 Illegal Immigration Reform and Immigrant Responsibility Act [5]. However, debates about whether immigrants are "deserving" of admission or whether they are a "public charge" have been around since the country's foundation. [6, 7].

These debates on "deservingness" also have followed racialized lines. In our definition of racialization, we refer to Eduardo Bonilla-Silva, who outlined this concept as the stratification of people based on physical features and proximity to those who appear "white" [8]. We also look toward the work of scholars of Critical Race Theory [9, 10], such as Kimberlé Crenshaw and Richard Delgado, who emphasize that law and policy are not race-neutral. Finally, we look toward permutations of Critical Race Theory that are applied to health, such as Chandra Ford's and Collins Airhihenbuwa's Public Health Critical Race Praxis, [11–13] that center racialization and race relations at the core of qualitative and quantitative analysis.

Therefore, it is important to consider how race and racism have functioned in the proposal and passing of U.S. immigration policy. For example, the 1790 Naturalization Act required that only "free white persons" be allowed to become citizens after a two year residence in the U.S. and one year residence in their state [14, 15]. Although citizenship was later expanded to formerly enslaved people and to Native Americans, the U.S. has regularly enacted laws that deny certain groups citizenship (e.g. Chinese Exclusion Act of 1882), based on racism [15]. Moreover, policymakers used health as a justification to exclude immigrant groups, claiming that immigrants would bring disease and moral degeneracy into the U.S. [6, 16]. Today's alarms, however, are mixed with threats of invasions, terrorism, more veiled but still deeply rooted racist rhetoric, and embedded in vast technologies of surveillance and enforcement [17–20]. What is worth noting is that regardless of which political party is in office, these concerns continue to translate into restrictive laws; at least since the 1970s this trend has been amplified wide and deep [21]. Thus, although the Trump administration has notably drawn from anti-immigrant and xenophobic rhetoric to enact an unprecedented number of harmful immigration policies in just four years [6, 22], it has built and expanded on the enormous architecture of exclusion and punishment that each previous administration from the past three decades expanded [23, 24]. The racialization of immigration policies becomes evident when a spillover effect reaching various subgroups of a target group is detected [18]. For instance, a study showed that undocumented, lawful permanent resident (LRP), and U.S. citizen Latino/a/x residents reported feeling less safe and were less likely to go to an emergency room compared to non-Latino residents during the Trump administration's anti-immigrant campaign and rhetoric [25]. This situation contributes to impact their health negatively. Thus, Latino/a/x adolescents have been found to experience increased cortisol levels, a stress hormone, during and after the 2016 U.S. presidential election [26] and Latina immigrants also get sick under increased stress, a situation compounded by their fear of seeking medical care [27]. Thus, racialization, by its nature, has historically affected all races, though its manifestations have differed across time.

In contrast to popular narratives is a pervasive academic discussion about an "immigrant health paradox", the idea that immigrants have better health compared to the native-born, despite lower socioeconomic attainment [28]. The immigrant health paradox has been seen

in numerous chronic conditions [29] including hypertension [30], obesity, and heart disease [30], all major conditions that require medical management. Thus, popular and political accounts portray immigrants as social, public health, and economic liabilities [15, 31, 32] whereas academic research points to immigrants' greater need of social support [2, 4, 33, 34]. Despite these contrasting narratives, research today points to declining health among immigrants [27, 35, 36], particularly among those who are in vulnerable legal statuses (i.e. illegalized immigrants)[1] in the context of expanded enforcement [37–41]. Given this evidence, the foundational logics for the immigrant health paradox call for reexamination.

In this review, we examine the foundations of the immigrant health paradox as well as alternative perspectives to account for current developments. *First*, we review the origins, explanations, and critiques of the immigrant health paradox. *Second,* we turn to the literature on race and immigrant legal status and the effects of these factors on the health of immigrants. Finally, we explore applications of an alternative framework, *racialized legal status*, proposed by Asad and Clair [42], which incorporates historical and structural factors to understand mechanisms behind the immigrant health paradox. We argue for including legal status, but more precisely, its racialization, to modify the immigrant health paradox for today's context. Immigration enforcement has expanded dramatically and legal avenues for legalization have shrank significantly in the past two decades [17, 18, 43], and research has identified important effects of these shifts on a variety of health outcomes, including pre-term birth [44, 45], birthweight [46], psychological distress [47, 48] and self-rated health [41, 49, 50].

On its own, legal status is insufficient in understanding health outcomes among immigrants [29, 42]. However, its racialization, intertwined with "legality" as this intersection impacts immigrants' health and shapes their access to resources, plays a critical role [46, 42]. We end our discussion with implications for future research in examining how the racialization of legal status can expand or modify the immigrant health paradox.

Theories on the Immigrant Health Paradox

Despite the expansive scholarship on the relationship between socioeconomic attainment and health [51, 52] and stress and health [53, 54], the immigration literature has historically espoused the "immigrant health paradox" [55–57]. The immigrant health paradox is predicated on two main patterns. First, the statistical tendency showing that first-generation immigrants tend to have more favorable health outcomes compared to native-born individuals of the same age, gender, and race, despite having lower socioeconomic attainment on average [57]. This pattern has been found for numerous health outcomes, including cardiovascular disease [28], mental health [56, 58], and mortality [59]. It also emerges intergenerationally, specifically in low birth weight-term births [44, 60]. Moreover, immigrant children (1.5 generation) and the children of immigrants (2nd generation) have better mental health outcomes on certain measures compared to later generation (3rd and above) children [61, 62]. And second, this paradox disappears with longer time immigrants

[1]We use the term *illegalized immigrants* to convey the idea that immigrants *are made undocumented through law*. We also use this term to emphasize how government policies create scenarios where immigrants may not be protected under the same laws as lawful permanent residents or citizens.

spend in the receiving country, eventually converging with the health profiles of native-born residents of the same ethnic group [61, 63–65]. These trends have been mostly studied among Latino/a/x immigrants [55, 66, 67], with some studies including Asian [56, 68] and Black immigrants [65, 69, 70].

Why are Immigrants Healthier? Mechanisms of the Immigrant Health Paradox

Four mechanisms have been proposed to explain the immigrant health paradox: cultural and behavioral factors, migrant selectivity, a salmon bias, and data artifacts. Cultural and behavioral explanations posit that immigrants bring with them positive cultural values or behaviors that predispose them to eat healthily and engage in healthier behaviors, compared to native-born individuals [59, 71–73]. These explanations also suggest that immigrants are more likely to consume their "traditional" foods instead of more westernized foods [73]. And there has been some evidence that cultural and behavioral factors may be behind immigrants' better health compared to native-born people. Abraído-Lanza, Chao, and Flórez found that Latino immigrants were less likely to smoke and drink alcohol compared to native-born people. However, this healthiness was not seen for all health behaviors; Latino immigrants were less likely to be physically active and had higher body mass index (BMI).

However, these healthy behaviors are assumed to disappear over time as immigrants become more sedentary [74], eat larger amounts of fatty foods [75, 76], or adopt greater drug and alcohol use [77]. However, the larger historical and structural factors within which individual behaviors and cultural practices are enacted, and which could help us understand the roots of the health paradox, have remained largely underexplored.

Migrant selectivity, a competing explanation, assumes that only the healthiest and hardiest of migrants can overcome the immigration bureaucracy, the hardships of the migration itself, and the destabilization of the move. Once in the host country, immigrants' hardiness and resourcefulness allow them a health advantage when compared to native-born individuals of similar demographic profiles [57, 78]. However, selection is often based on higher educational attainment, regardless of whether immigrants came from poorer or wealthier countries; immigrants with higher levels of education tend to engage in less unhealthy behaviors (e.g. smoking) or have fewer chronic conditions compared to the average in their sending countries [78]. Immigrant selectivity need not be based on individual agency or personal level factors; it can also be based on structural and institutional factors. Selective visas (e.g., employment-based and fiancé visas), which reflect contextual inequalities at exit, has been found to impact immigrants' health [15, 73, 79]. Morey et al. found that Filipinos with marriage visas had fewer health conditions compared to non-migrants who remained. Interestingly, Filipinos with family reunification visas or employment visas had a similar number of health conditions compared to non-migrants.

The "salmon hypothesis," accounting for immigrants' home country, posits that the population health advantage observed when comparing immigrants to non-immigrants is the result of return migration—less healthy immigrants return to their countries of origin. Because data on health outcomes are often collected in cross-sectional studies, they may

not fully capture those who have returned to their country of origin and thus may bias the results. Originally a speculative idea, the literature on the salmon hypothesis is relatively mixed. Though the hypothesis still holds for some groups, some scholars note that the contribution of the salmon hypothesis is relatively minimal [59, 80–82]. For example, using the National Longitudinal Mortality Study, Abraido-Lanza et al. found little evidence of the salmon hypothesis in differences in morality among Latinos when compared to non-Latino whites. However, in a recent study using data from the Mexican Migration Project, Cheong and Massey find that health status did not predict return migration. Instead, migrants who had multiple roundtrips to the U.S. had poorer health, especially those who were illegalized immigrants. Thus, it appears that while health itself may not account for the salmon bias, return migration certainly warrants consideration.

Finally, the “data artifact hypothesis” purports that immigrants, as a potentially marginalized community, may be less likely to participate in major surveys for fear of outing themselves [83]. Moreover, there may be some misclassification error with respect to one’s racial or ethnic identity or age [59]. However, in a study of linked mortality data with the National Health Interview Survey (NHIS), Palloni and Arias found inconsistency with the data artifact hypothesis.

A Critique of the Immigrant Health Paradox

Several studies have noted the fallibility of the paradox, of both of its key assumptions.[2] Regarding the tendency for immigrants to be healthier when compared to native-born individuals of the same demographic profile, studies have found discrepancies in infectious [28] and chronic disease [56, 68]. Moreover, using a nationally representative sample of Mexican immigrants, Goldman et al. found that recent Mexican migrants experienced an overall health decline within the first two years of migration when compared to non-migrant Mexicans and earlier migrants. Importantly, when factoring in legal status, one study found that undocumented immigrants, regardless of time spent in the United States, continued to have higher blood pressure than recently documented immigrants [84]. Thus, regardless of some paradoxical outcomes, the immigrant health paradox has been found to be generally inconsistent across health outcomes and within specific racial and ethnic groups [30, 41, 85]. Recent findings hint at the need for additional nuance, particularly regarding the changing legal and enforcement context for immigrants, in examining immigrant health. The immigrant health paradox may not capture current realities, as it was developed at a different historical moment of immigration law and enforcement. By generally not attending to structural factors, the immigrant health paradox may fall short in explaining the health outcomes of contemporary immigrants who face an enhanced enforcement context where legal status has become a new axis of stratification [86, 87].

Finally, issues remain with respect to assumptions of healthiness of behavior. One study of Mexican–American women found that they viewed traditional Mexican foods as “unhealthy” and preferred American foods as “healthier” alternatives [88]. Others [89] note

[2]Although most work on the paradox is U.S.-based, the discrepancies found in the U.S. also have been observed in other countries, especially in Europe (see Speciale and Regidor [60] and Villaonga-Olives et al. (2017)).

that food behaviors could be more than perceptions of healthiness. Instead, adjustments to living in the U.S. (i.e. busier lifestyles, greater stress) and, especially food insecurity could lead immigrants to consume diets high in fat and sugar and low in fruits and vegetables.

Placing the Immigrant Health Paradox in an Institutional and Structural Context

The structural conditions in the place where immigrants arrive could alter the picture depicted through the immigrant health paradox. First, an implicit assumption in the paradox is that the socioeconomic gains that can accrue with integration/assimilation could be harmful for health. Second, the paradox relies on a unidirectional lens, focusing on the experiences of immigrants who are already in the host country, and assuming that immigrants bring with them behaviors and cultural practices from home to affect their current lives. Both expectations are premised on immigrant health as being primarily an individual phenomenon that can exist independently of larger social and political structures. However, considering broader structural factors of the context where immigrants arrive can disentangle both the seeming paradox and processes of immigrant integration that are accompanied by wellbeing.

A focus on individual and cultural factors veils an understanding of how racialized immigration policies, structural racism, and discrimination may ultimately contribute to declining health among immigrants [15, 42, 71]. It follows then that the longer immigrants are exposed to racist structures and experiences, individually or as a group, the more their health will tend to decline [90–92]. Even the racism embedded in immigration policies may alter the selectivity process [15]. Moreover, the context of the sending country matters [77, 93], as policies that encourage emigration have created globalized workforces [94–97]. However, the introduction of temporary work visas in regions such as the Middle East and countries such as the U.S. have created precarious working conditions for temporary immigrants [96, 98, 99]. These workers may not be entitled to the same protections as lawful permanent residents or citizen workers, making them targets for exploitation [96, 99].

Additionally, the paradox is based on the notion that immigrants adopt an “American-like” lifestyle only upon arrival which does not consider that with globalization immigrants were already practicing U.S. consumption lifestyles, foods and behaviors, before arrival. Indeed, some have suggested that acculturation occurs prior to migration [100–102]; however, given extensive communication and exposure to U.S. lifestyles, immigrants today may not necessarily arrive to the U.S. as “blank slates” [77, 93, 103]. Immigrants’ ties in the receiving country allow for easier transitions during the migration and integration process but are also sources of knowledge and information before immigrants arrive [77, 104].

Finally, assumptions behind the immigrant health paradox often do not consider the historical context that propels people to migrate [93], especially from contexts where the U.S. has played a key role through military intervention, such as the large-scale U.S.-bound migration from Central America [105]. More importantly, the process of formal immigration to the U.S. has historically required that immigrants be medically screened both prior to migration and upon entry, which may contribute to the healthy trend seen

in the paradox [106]. Physicians who screen immigrants for admission to the U.S. act as immigration brokers, one of the final bureaucratic steps in a long journey [106]. Above all, immigration enforcement policies and the legal landscape for immigrant health have changed dramatically from the time when the health paradox was conceptualized (see Markides and Coreil [28]). Immigrant legal status today determines access to resources, including health care [2, 107, 108], shaping immigrants' trajectories in similar ways as other axes of stratification [17, 86, 105], and immigration enforcement has been found to negatively affect immigrant mental and emotional health, especially among Latinos/as/x [38, 40, 109–112]. The dramatic change in this legal context, and especially its racialized nature, calls for a reevaluation of the main assumptions behind the immigrant health paradox to reflect the health care outcomes that today's immigrants, particularly Latinos/as/x, are likely to experience.

The Role of Race and Legal Status in the Immigrant Health Paradox

A burgeoning scholarship explores the role of *legal status* as a critical factor affecting immigrants' health. [29, 82, 113–116]. Previous work has emphasized the effects of legal status on access to health care, flexible resources for health, and exposure to immigration enforcement [18, 115–118]. But we argue that it is the *racialized* nature of legal status, that is, the concentrated targeting of Latinos/as/x for enforcement today and their narrower avenues to regularize their legal status, that is key to factor in. The larger groups of Latino/a/x immigrants have higher chances to fall out of status and be detected in a context that targets them for enforcement. For instance, the overwhelming majority of immigrants in detention and deportation are Latinos/as/x (90%). However, Latinos/as/x make approximately 60% of the undocumented population, making this group a disproportionately targeted [119]. Public opinion has greatly contributed to this anti-Latino/a/x bias of immigrants. A report by the Pew Research Center found that although public views of immigrants have grown more positive since the 1990s, there are racial differences. Asian and European immigrants are viewed more favorably than Latino/a/x immigrants [120]. Interestingly, the same report found that immigrants from Africa and the Middle East were also viewed just as unfavorably as Latino/a/x immigrants [120].

Considerations of Race

Much of the impetus behind restrictive of immigration policy has been influenced by a preoccupation with maintaining a white nation and other racist tendencies [15, 43]. Thus, some of the most telling in the nascent literature exploring the racialized nature of immigration has focused on the experiences of Black immigrants [30, 85]. In the U.S. context, understanding the experience of Black immigrants can provide a deeper understanding of how race and immigration intersect. For example, Read et al. [30] using the 2000–2001 National Health Interview Survey found that U.S.-born and European-born Black people had worse health due to hypertension compared to U.S.-born white people. In contrast, African-born Black immigrants had better health than all groups. A similar, more recent study by Commodore-Mensah et al. [85] found that African immigrants had higher prevalence of diabetes compared to European immigrants. Both studies point to how the

racialization of certain immigration streams today contributes to poorer health when racial classifications are taken into account.

In Read et al., we see an initial immigrant health advantage, where immigrants have a positive outcome compared to U.S.-born people. However, in the second study, we see racial disparities among immigrant groups, such that Black people from majority non-white regions had the least hypertension while Black people from majority white regions had most hypertension [30]. It is possible that the since racialization of legal status affects: almost exclusively on Latinos/as/x, that it might not have had a large effect for Black immigrants. In the second study however, the effects of racialization of Latinos becomes clearer. For instance, the study [85] found that immigrants from Mexico and Central America had higher prevalence of overweight/obesity and diabetes compared to European immigrants. Thus, these discrepancies by the intersection of race and immigration status warrant further exploration.

Considerations of Legal Status

Examining the immigrant health paradox from a racialized legal status standpoint could provide greater clarification on the structural mechanisms that either facilitate or hinder immigrant health. How does legal status affect immigrants' health? The Theory of Fundamental Causes of Health Inequality has remained a popular explanation for why immigrants in less protected legal statuses (e.g. illegalized immigrants) may have worse health compared to those with more protected statues (e.g. lawful permanent residents) or citizenship [29, 42]. Legal status acts as a fundamental cause of health inequality because it limits access to health promoting/health protecting resources [115, 121, 122]. It also affects health directly, the association between less protected legal statuses and health has been found in numerous health outcomes including mental health [111, 121, 123, 124], self-rated health [41, 125], and some chronic conditions [84, 124].

One important consideration is to observe legal status before and after migration to provide a nuanced, broader picture of immigrant health incorporation [15, 93]. Immigration via visas ("lawful" migration) make up the majority of migration to the U.S. [37, 126]; three fourths of the foreign-born population are either lawful permanent residents or naturalized citizens [107]. However, as immigrants go through the process of obtaining lawful permanent residence (LPR), they spend increasingly longer times waiting for their status, and about half of those adjusting to LPR status already reside in the U.S. [127]. Thus, longer waiting times delay access to resources but also place additional stress as processes of integration are delayed [128, 129]. And because the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 made even lawful permanent residents ineligible for a host of benefits in their first five years in the U.S., these immigrants have narrow access to most forms of assistance, except emergency medical care. The legal incorporation of immigrants has been further threatened as the Trump administration considered expansion of situations under which immigrants can become a "public charge," placing additional bureaucratic hurdles to access resources.

Furthermore, while citizenship (by birth or naturalization) may appear race neutral, the rights and benefits of this status may depend on political and sociohistorical contexts. In the

case of immigrants of color in the U.S., laws have historically restricted their immigration [15] and continue to target their access to goods and resources [2, 7] so that they become excluded or marginalized legally and institutionally.

The growing literature exploring the association between legal status and health, especially among Latinos/as/x, has produced mixed results. Some studies report that illegalized immigrants are more likely to have poorer health in self-rated health [130] and mental health [47] compared to citizens and documented persons. Illegalized immigrants may also delay care until absolutely necessary [115]. Other studies report no association [113] or even a health advantage among non-citizen or illegalized persons [29, 131]. Recently, Hamilton et al. found that illegalized Latino farmworkers were less likely to have self-reported chronic disease and musculoskeletal problems than documented immigrants, legal permanent residents, and naturalized citizens. Hamilton et al.'s finding conforms to the immigrant health paradox. However, these researchers conclude that this observation could be due to hyperselectivity for health among illegalized immigrants.

Though the work of Hamilton et al. sheds light on why the association between precarious legal statuses and health may not exist, a structural and intersectional perspective may elucidate the importance of *racialized* legal status on health. Van Natta et al. [115] suggest that the study of the association between legal status and health should consider intersections of legal status with other structural determinants, such as poverty, housing, and especially racism. Immigration law and the legal statuses it produces are not race neutral, nor do they occur in a social vacuum; they are intimately intertwined with race and other structural determinants.

An Increasing Focus on Racialized Legal Status

The seemingly contradictory findings to which we point in the previous section create an opportunity to consider *racialized* legal status as a key factor to shed light on the immigrant health paradox. Just as race and socioeconomic status are inextricably linked, so too are race and legal status. In the U.S. context, most of the immigration streams today come from Asia and Central America [132], where the U.S. has played a key role in military interventions and colonization. The predominance of immigrants of color originating in formerly colonized or invaded countries therefore has significant implications for how U.S. society sees and receives them, as these immigrants arrive to a context that has historically been stratified along racial lines [8]. Thus, as with domestic minorities whose health is poorer than the general population [66, 133], when legal status is racialized immigrant health becomes intertwined with experiences of race and racism [15, 42, 71]. But unlike the case of domestic minorities, immigrants also face the structural constraints imposed by legal status, which for many immigrants today translates into exclusion and expulsion by design.

Though legal status appears to be race neutral (because "law is neutral"), it is a racialized system that disproportionately places groups like Latinos/as/x at risk of exclusion, through legislative procedures in the application process to obtain visas and to regularize one's status [6, 126] and through the enforcement system that overwhelmingly targets Latinos/as/x [18, 38, 109, 134]. However, rather than treating race as a "control variable", we propose that

race should serve as a lens to examine the association between immigration and health. As Asad and Clair observe, the racialized nature of legal status can negatively impact health [42]. Racialized associations with legal status (e.g. being undocumented with being Latino) makes legal status a racialized *identity*, which, based on the experiences of racialized minorities, can lead to greater discrimination and to greater stress and poorer health [53, 91, 134–138].

Garcia [140] highlights the importance of context in upholding racialization processes. Racialized illegality unfolds in the workplace, educational and health institutions, and in the criminal justice system. Garcia [104] finds that a climate of anti-immigrant hostility and xenophobia exacerbate ideologies that underpin racialization processes that homogenize Mexicans, and other Latinos, regardless of nativity or legal status, as "illegal".

How do race and immigrant legal status intersect? As immigrants become familiar with the U.S. racial hierarchy and are exposed to greater discrimination and nativist backlash, they experience greater stress that can lead to deteriorating health over time [71, 142]. Importantly, discrimination and racism are not only an interpersonal issue; they are structural and systemic [15, 71, 143–145]. The immigration system is itself racialized, based on seemingly neutral laws that target Latinas/os, making them synonymous with being undocumented [18]. This is the result of the disproportionate criminalization and policing of Latinas/os [20, 21, 134], carried out through state institutional practices and aided by the media. This institutionalization and structural racism negatively affect these immigrants' health and wellbeing [15, 71].

Using the Latino/a/x population as an example, the conflation of "Latino/a/x" with being undocumented has been associated with greater stress, discrimination, and social rejection [21, 140, 146] in addition to feeling unsafe [25]. These experiences translate into delays in seeking medical care among undocumented immigrants, documented immigrants, and even U.S.-born Latinos [25, 115, 140, 147, 148]. In contrast, because narratives about illegalized Asians are few, many assume that there are few illegalized immigrants among Asians, even when they are the fastest growing group of illegalized immigrants in the U.S. [149]. As a result, many illegalized Asians may be deterred from seeking healthcare and social services for fear of outing their legal status or because they believe that there may be no resources catering their community [121]. Therefore, the intersections of race and legal status may function differently depending on the axis of stratification.

The racialization of legal status for Latinos/as/x is so strong that a spillover effect has been detected. Even though immigration law and enforcement target the undocumented, all Latinos/as/x subgroups beyond "undocumented immigrants" are affected, including LPR, naturalized citizens, and even the native-born [138, 150–152]. At the same time, vulnerably legal immigrants with lighter skin tone, which in the U.S. context may be white passing, may not experience the same detrimental effects that legal status may have for immigrants with darker skin tone [138, 151, 153, 154]. Such experiences evince the racialization of legal status for Latinos, for whom disadvantages may manifest as increased discrimination in employment and wages [150, 155] in addition to interpersonal discrimination [156]. Research has found that poor health among Latinos, documented and U.S.-born citizens

alike, is likely related to disadvantage based on their racialized position rather than to their legal status [138]. This finding may partially explain why we continue to see an "immigrant health paradox" despite accounting for the role of legal status. Indeed, others have observed similar mechanisms regarding the role of race in understanding immigrant health [136, 154, 157].

Racialized legal status also manifests at community and policy levels [49, 118, 154, 157] U.S. immigration and welfare benefit policies since the 1990s have teetered between hindering all immigrants' access to social services through the Personal Work and Responsibility Act [2] and narrowing eligibility criteria for legalization by identifying immigrants who use social services as "public charges" [7] to policies expanding protections to support illegalized youth [50, 158]. However, even policies intended to support all Americans, such as President Obama's Affordable Care Act of 2012, specifically exclude illegalized immigrants, who are predominantly Latina/o/x, from protection.

Finally, enforcement or the threat of enforcement of immigration policies can have profound effects on the wellbeing of immigrants, especially Latinas/os/x, at all contextual levels. At the local level, Novak et al. found that an immigratoin raid of a meat processing plant in Potsville, Iowa with a predominantly Latino workforce was associated with lower birthweight for babies of both immigrant Latina and U.S.-born Latina mothers, a finding not observed among white mothers [46]. At the state level, threats of punitive immigration policies, such as Arizona State bill 1070 (SB 1070), have also been associated with poorer birth outcomes among Latina mothers in Arizona [45]. Though SB 1070 was declared unconstitutional, Torche and Sirois observe that the mere signing of the law and initial discussions about implementation became a traumatic stressor for both immigrant and U.S.-born Latinas [45]. The effects of anti-immigrant policies are also seen at the national level. More anti-immigrant laws [159] and greater restrictiveness of immigrant laws [157] have been associated with worse health and reduced healthcare access. Overall, the anti-immigrant climate of today may have profound effects on the targets of immigration enforcement and those who belong to the same ethnoracial group.

Conclusion

Much progress has been made in the study of immigration and health. However, a pervasive focus remains on individual-level factors, behaviors and cultural change as primary explanations for shifts in health with time in the U.S., and why immigrants initially have better health compared to the native-born of the same demographic profile. Though such explanations, encapsulated in the "immigrant health paradox," may have been valid earlier, they do not hold up as in the past in today's context of increased immigration enforcement, racialization of legal status, and greater globalization [17, 18].

To address these limitations, we examined the origins, explanations, and critiques of the "immigrant health paradox"; and explored an alternative framework, focusing on *structural constraints*. We specifically underscore *racialized legal status* as a lens to better understand the association between immigration and health. Overall, the "immigrant health paradox" was explained through a lens of acculturation, which can partially account for the paradox

but ignores critical historical and structural contexts of migration (i.e. migrant legal stratification and structural racism) and an ever-globalizing world. Moreover, the scholarship on the "immigrant health paradox" has been limited by the absence of longitudinal studies to infer causality as well as the common use of inappropriate comparison groups (i.e. native-born persons instead of non-migrants). And although recently the *legal status* and *health* nexus have been included, it has produced mixed findings.

To move this research forward, we argue that the analytical lens to be used should be the *racialization of legal status*, not simply including the *variable* legal status. Legal status unfavorably structures opportunities for immigrants of color, especially Latinos/as/x, undermining their integration process. A racialized legal status lens allows us to capture structural forces, their effects on the racialized group, and the consequent spillover effects for native-born Latinos/as/x, as they face greater stigmatization despite holding protected legal statuses or even U.S. citizenship. Thus, future research on immigrant health should engage the growing body of work examining the intersections of race and immigrant legal status, especially among Latinos/as/x [138, 147, 160], with attention to mixed methods approaches to more deeply and holistically explore this phenomenon [71, 140, 161, 162]. Indeed, contemporary scholarship has incorporated Critical Race Theory (CRT) and discussions of legal status and immigration [12, 139, 160] with CRT providing solid theoretical ground to understand racialized legal status [42]. Indeed, some of the successors of CRT, such as "Lat-Crit", have integrated discussions of how immigration law racializes Latinos/as/x and disrupts assimilation paradigms in an ever globalizing world [163, 164]. Racialization of legal status has resulted in the internalization of borders, with greater bureaucratic barriers (e.g. Green Cards) which creates obstacles for the racialized immigrants to obtain the same rights as citizens [19, 163]. When incorporating a racialized legal status lens, future research should attend to changes in racial classification over time, as who is "white" versus "non-white" has shifted with immigration regimes [8, 71, 161]. Racialization processes are never static; laws, racial classifications, and the immigrant groups have differed at various historical moments.

A significant expansion of available datasets and research now address these questions. We should caution however, that inserting an interaction term with race and immigrant legal status does not necessarily constitute examining immigrant health through a racialized legal status lens. Indeed, quantitative scholars have cautioned against this practice as it can be mistaken for intersectionality [165]. Instead, it is the racial context of immigration that matters. López et al. examined people's "street race", that is, what people would say a person's race would be "on the street" [146]. This study can serve as a model for studying the effects of racialized legal status on health outcomes by substituting legal status for race, thus examining others' perceptions of a person's legality. This distinction is important, as it addresses the spillover effect posited by Asad's and Clair's [42] framework and the effects such perceptions may have on one's mental and physical health.

Recent iterations of the California Health Interview Survey (CHIS) provide valuable data on both race and immigrant legal status [166, 167]. Some waves of the Survey of Income and Program Participation (SIPP) also provide data on legal status [168] and involve national level data. The SIPP has been used to evaluate insurance coverage by documentation status

[169]. However, more can be done to understand the intersection of race and legal status with respect to insurance coverage.

Researchers can also consider using data fusion or multiple imputation methods to apply datasets with data on immigrant legal status to larger sample datasets that lack these variables [168–170]. While the process itself is complex, this work has been done using legal status data from the SIPP to impute the American Community Survey [168] to provide an overview of the population of immigrants who are illegalized. We should caution on the utility of this technique, however, as it relies on a number of assumptions, similar to all imputation techniques. For example, given that some immigrants can fall in and out of "documented" status, this technique cannot identify these transitions. Instead, it provides a probability that someone is in a certain documentation status at a certain time.

Finally, we should note that focusing solely on race and legal status should not be the only approach incorporated in studying immigrant health. It is also important to consider additional factors such as gender, language, region of origin, immigrant level of education, characteristics of immigrant parents, and generational status. These variables function both independently and concurrently with race and legal status. Because they are so intertwined, we encourage researchers to take a comprehensive approach including such factors, as the data allow.

While individual agency and selectivity are still important in understanding the relationship between immigration and health, our review suggests that research can be strengthened by accounting for the historical and structural factors within which immigration decisions are made. Like race and socioeconomic status, race and legal status are inextricably linked, and the impact of their intersection on health cannot be ignored. Therefore, as both policymakers and researchers examine the links between health and migration, it is imperative to consider that the processes of migration and integration are inherently racialized, and that racialization structures opportunities not only for migrants, but for the native-born as well.

Acknowledgements

Adrian Bacong was supported by the UCLA Graduate Research Mentorship Fellowship and the Eugene V. Cota-Robles Fellowship.

References

1. Torbati Y Trump administration proposal would make it easier to deport immigrants who use public benefits. Reuters https://www.reuters.com/article/us-usa-immigration-benefits-exclusive/exclusive-trump-administration-proposal-would-make-it-easier-to-deport-immigrants-who-use-public-benefits-idUSKCN1S91UR. (2019). Accessed 18 Nov 2019.
2. Derose KP, Escarce JJ, Lurie N. Immigrants and health care: sources of vulnerability. Health Aff (Project Hope) 2007;26(5):1258–68.
3. Hacker K, Anies M, Folb BL, Zallman L. Barriers to health care for undocumented immigrants: a literature review. Risk Manag Healthc Policy 2015;8:175. [PubMed: 26586971]
4. McBride K, Bacong AM, Reynoso A, Benjamin AE, Wallace SP, Kietzman KG. Healthcare decision-making among dual-eligible immigrants: implications from a study of an integrated medicare-medicaid demonstration program in California. J Immigr Minor Health 2019;22:494–502.

5. Borjas GJ. Welfare reform and immigrant participation in welfare programs. Int Migr Rev 2002;36(4):1093–123.
6. Young JG. Making America 1920 again-nativism and US immigration, past and present. J Migr Hum Sec 2017;5:217.
7. Perreira KM, Yoshikawa H, Oberlander J. A new threat to immigrants' health—the public-charge rule. N Engl J Med 2018;379(10):901–3. [PubMed: 30067441]
8. Bonilla-Silva E We are all Americans!: The Latin Americanization of racial stratification in the USA. Race Soc 2002;5(1):3–16.
9. Crenshaw K Critical race theory: the key writings that formed the movement New York: The New Press; 1995.
10. Delgado R, Stefancic J. Critical race theory: an introduction New York: NYU Press; 2017.
11. Ford CL. Public health critical race praxis: an introduction, an intervention, and three points for consideration. Wis L Rev 2016;2016:477.
12. Ford CL, Airhihenbuwa CO. Critical race theory, race equity, and public health: toward antiracism praxis. Am J Public Health 2010;100(Suppl 1):S30–5. [PubMed: 20147679]
13. Ford CL, Airhihenbuwa CO. The public health critical race methodology: praxis for antiracism research. Soc Sci Med 2010;71(8):1390–8. [PubMed: 20822840]
14. Cohen EF. The political economy of immigrant time: rights, citizenship, and temporariness in the post-1965 era. Polity 2015;47(3):337–51.
15. Gee GC, Ford CL. Structural racism and health inequities: old issues, new directions. Du Bois Rev 2011;8(1):115–32. [PubMed: 25632292]
16. Barkan E, Diner H, Kraut AM. From arrival to incorporation: migrants to the US in a global era New York: NYU Press; 2007.
17. Menjívar C, Kanstroom D. Constructing Immigrant' Illegality': critiques, experiences, and responses Cambridge: Cambridge University Press; 2013.
18. Menjívar C, Simmons WP, Alvord D, Valdez ES. Immigration enforcement, the racialization of legal status, and perceptions of the police: Latinos in Chicago, Los Angeles, Houston, and Phoenix in comparative perspective. Du Bois Rev 2018;15(1):107–28.
19. Menjívar C Immigration law beyond borders: externalizing and internalizing border controls in an era of securitization. Annu Rev Law Soc Sci 2014;10(1):353–69.
20. Menjívar C, Gómez Cervantes A, Alvord D. The expansion of "crimmigration", mass detention, and deportation. Sociol Compass 2018;12(4):e12573.
21. Cervantes AG, Menjivar C. "Bad Hombres": the effects of criminalizing Latino immigrants through law and media in the rural Midwest. Migr Lett 2018;15:182–96.
22. Pierce S, Bolter J. Dismangling and reconstructing the US immigration system: a catalog of changes under the Trump presidency Washington DC: Migration Policy Institute; 2020.
23. Menjívar C Commentary: Will the outcome of the 2020 election reshape US immigration policies? Int Migr 2020;58(5):277–80.
24. Garrett TM. The security apparatus, federal magistrate courts, and detention centers as simulacra: the effects of trump's zero tolerance policy on migrants and refugees in the Rio Grande Valley. Polit Policy 2020;48(2):372–95.
25. Rodriguez RM, Torres JR, Sun J, et al. Declared impact of the US President's statements and campaign statements on Latino populations' perceptions of safety and emergency care access. PLoS ONE 2019;14(10):e0222837–e0222837. [PubMed: 31665147]
26. Zeiders KH, Nair RL, Hoyt LT, Pace TWW, Cruze A. Latino early adolescents' psychological and physiological responses during the 2016 US presidential election. Cult Divers Ethnic Minor Psychol 2020;26(2):169–75.
27. Cervantes AG, Menjívar C. Legal violence, health, and access to care: Latina immigrants in rural and Urban Kansas. J Health Soc Behav 2020;61(3):307–23. [PubMed: 32772577]
28. Markides KS, Coreil J. The health of Hispanics in the southwestern United States: an epidemiologic paradox. Public Health Rep 1986;101(3):253. [PubMed: 3086917]

29. Hamilton ER, Hale JM, Savinar R. Immigrant legal status and health: legal status disparities in chronic conditions and musculoskeletal pain among Mexican-born farm workers in the United States. Demography 2019;56(1):1–24. [PubMed: 30519846]
30. Read JNG, Emerson MO, Tarlov A. Implications of black immigrant health for US racial disparities in health. J Immigr Health 2005;3:205–12.
31. Fox C Three worlds of relief: race, immigration, and the American welfare state from the progressive era to the new deal Princeton: Princeton University Press; 2012.
32. Bansak K, Hainmueller J, Hangartner D. How economic, humanitarian, and religious concerns shape European attitudes toward asylum seekers. Science 2016;354(6309):217–22. [PubMed: 27708060]
33. McBride K, Reynoso A, Alunan T, et al. Cal MediConnect enrollment: why are dual-eligible consumers in Los Angeles county opting out Los Angeles: UCLA Center for Health Policy Research; 2017. p. 1–8.
34. Clough J, Lee S, Chae DH. Barriers to health care among Asian immigrants in the United States: a traditional review. J Health Care Poor Underserved 2013;24(1):384–403. [PubMed: 23377740]
35. Goldman N, Pebley AR, Creighton MJ, Teruel GM, Rubalcava LN, Chung C. The consequences of migration to the United States for short-term changes in the health of Mexican immigrants. Demography 2014;51(4):1159–73. [PubMed: 24788391]
36. Lee S, O'Neill AH, Ihara ES, Chae DH. Change in Self-reported health status among immigrants in the United States: associations with measures of acculturation. PLoS ONE 2013;8(10):e76494. [PubMed: 24098515]
37. Baker B, Williams C. Immigration enforcement actions: 2015 Washington, DC: Department of Homeland Security; 2016.
38. Hacker K, Chu J, Leung C, et al. The impact of Immigration and Customs Enforcement on immigrant health: perceptions of immigrants in Everett, Massachusetts, USA. Soc Sci Med 2011;73(4):586–94. [PubMed: 21778008]
39. Perreira KM, Pedroza JM. Policies of exclusion: implications for the health of immigrants and their children. Annu Rev Public Health 2019;40(1):147–66. [PubMed: 30601722]
40. Wang JS-H, Kaushal N. Health and mental health effects of local immigration enforcement. Int Migr Rev. 2011;53:970–1005.
41. Bacong AM. Heterogeneity in the association of citizenship status on self-rated health among Asians in California. J Immigr Minor Health 2020;23:121–36.
42. Asad AL, Clair M. Racialized legal status as a social determinant of health. Soc Sci Med 2018;199:19–28. [PubMed: 28359580]
43. Horton SB, Heyman J. Paper trails: migrants, documents, and legal insecurity Duke: Duke University Press; 2020.
44. Villalonga-Olives E, Kawachi I, von Steinbüchel N. Pregnancy and birth outcomes among immigrant women in the US and Europe: a systematic review. J Immigr Minor Health 2017;19(6):1469–87. [PubMed: 27553259]
45. Torche F, Sirois C. Restrictive immigration law and birth outcomes of immigrant women. Am J Epidemiol 2018;188(1):24–33.
46. Novak NL, Geronimus AT, Martinez-Cardoso AM. Change in birth outcomes among infants born to Latina mothers after a major immigration raid. Int J Epidemiol 2017;46(3):839–49. [PubMed: 28115577]
47. Gee GC, Morey BN, Walsemann KM, Ro A, Takeuchi DT. Citizenship as privilege and social identity: implications for psychological distress. Am Behav Sci 2016;60(5–6):680–704.
48. Torres JM, Wallace SP. Migration circumstances, psychological distress, and self-rated physical health for Latino immigrants in the United States. Am J Public Health 2013;103(9):1619–27. [PubMed: 23865667]
49. Vargas ED, Ybarra VD. US citizen children of undocumented parents: the link between state immigration policy and the health of latino children. J Immigr Minor Health 2017;19(4):913–20. [PubMed: 27435476]
50. Patler C, Hamilton ER, Meagher K, Savinar R. Uncertainty about DACA may undermine its positive impact on health for recipients and their children. Health Aff 2019;38(5):738–45.

51. Phelan JC, Link BG, Tehranifar P. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. J Health Soc Behav 2010;51:S28–40. [PubMed: 20943581]
52. Robertson T, Watts E. The importance of age, sex and place in understanding socioeconomic inequalities in allostatic load: evidence from the Scottish Health Survey (2008–2011). BMC Public Health 2016;16:126. [PubMed: 26856976]
53. Hicken MT, Lee H, Morenoff J, House JS, Williams DR. Racial/ethnic disparities in hypertension prevalence: reconsidering the role of chronic stress. Am J Public Health 2014;104(1):117–23. [PubMed: 24228644]
54. Geronimus AT, Hicken M, Keene D, Bound J. "Weathering" and age patterns of allostatic load scores among blacks and whites in the United States. Am J Public Health 2006;96(5):826–33. [PubMed: 16380565]
55. Goldman N Will the Latino Mortality Advantage Endure? Res Aging 2016;38(3):263–82. [PubMed: 26966251]
56. John DA, de Castro AB, Martin DP, Duran B, Takeuchi DT. Does an immigrant health paradox exist among Asian Americans? Associations of nativity and occupational class with self-rated health and mental disorders. Soc Sci Med 2012;75(12):2085–98. [PubMed: 22503561]
57. Markides KS, Rote S. Immigrant health paradox. In: Emerging trends in the social and behavioral sciences New York: Wiley; 2015.
58. Farley T, Galves A, Dickinson LM, Perez MDJD Stress, coping, and health: a comparison of Mexican immigrants, Mexican-Americans, and non-Hispanic whites. J Immigr Health 2005;7(3):213–20. [PubMed: 15900422]
59. Palloni A, Arias E. Paradox lost: Explaining the hispanic adult mortality advantage. Demography 2004;41(3):385–415. [PubMed: 15461007]
60. Speciale AM, Regidor E. Understanding the universality of the immigrant health paradox: the Spanish perspective. J Immigr Minor Health 2011;13(3):518–25. [PubMed: 20614183]
61. Salas-Wright CP, Kagotho N, Vaughn MG. Mood, anxiety, and personality disorders among first and second-generation immigrants to the United States. Psychiatry Res 2014;220(3):1028–36. [PubMed: 25223256]
62. Jackson MI, Kiernan K, McLanahan S. Immigrant-native differences in child health: does maternal education narrow or widen the gap? Child Dev 2012;83(5):1501–9. [PubMed: 22966919]
63. Ro A The longer you stay, the worse your health? A critical review of the negative acculturation theory among Asian immigrants. Int J Environ Res Public Health 2014;11(8):8038. [PubMed: 25111874]
64. Ro A, Geronimus A, Bound J, Griffith D, Gee G. Cohort and duration patterns among Asian immigrants: comparing trends in obesity and self-rated health. Biodemogr Soc Biol 2015;61(1):65–80.
65. Nwankwo EM, Wallace SP. Duration of United States residence and self-reported health among African-born immigrant adults. J Immigr Minority Health 2020. 10.1007/s10903-020-01073-8.
66. Beydoun MA, Beydoun HA, Mode N, et al. Racial disparities in adult all-cause and cause-specific mortality among us adults: mediating and moderating factors. BMC Public Health 2016;16(1):1113. [PubMed: 27770781]
67. Martinez JN, Aguayo-Tellez E, Rangel-Gonzalez E. Explaining the Mexican-American health paradox using selectivity effects. Int Migr Rev 2015;49(4):878–906.
68. Morey BN, Gee GC, von Ehrenstein OS, et al. Higher breast cancer risk among immigrant Asian American Women than Among US-Born Asian American Women. Prev Chronic Dis 2019;16:E20. [PubMed: 30767860]
69. Cole HV, Reed HE, Tannis C, Trinh-Shevrin C, Ravenell JE. Awareness of high blood pressure by nativity among black men: implications for interpreting the immigrant health paradox. Prev Chronic Dis 2018;15:e121. [PubMed: 30289105]
70. Griffith DM, Johnson J, Zhang R, Neighbors HW, Jackson JS. Ethnicity, nativity and the health of American blacks. J Health Care Poor Underserved 2011;22(1):142. [PubMed: 21317512]

71. Viruell-Fuentes EA, Miranda PY, Abdulrahim S. More than culture: Structural racism, intersectionality theory, and immigrant health. Soc Sci Med 2012;75(12):2099–106. [PubMed: 22386617]
72. Abraído-Lanza AF, Chao MT, Flórez KR. Do healthy behaviors decline with greater acculturation? Implications for the Latino mortality paradox. Soc Sci Med 2005;61(6):1243–55. [PubMed: 15970234]
73. Castañeda H, Holmes SM, Madrigal DS, Young M-ED, Beyeler N, Quesada J. Immigration as a social determinant of health. Annu Rev Public Health 2015;36(1):375–92. [PubMed: 25494053]
74. Unger JB, Reynolds K, Shakib S, Spruijt-Metz D, Sun P, Johnson CA. Acculturation, physical activity, and fast-food consumption among Asian-American and Hispanic adolescents. J Community Health 2004;29(6):467–81. [PubMed: 15587346]
75. Okafor M-TC, Carter-Pokras OD, Zhan M. Greater dietary acculturation (Dietary Change) is associated with poorer current self-rated health among african immigrant adults. J Nutr Educ Behav 2014;46(4):226–35. [PubMed: 24581812]
76. Novotny R, Williams AE, Vinoya AC, Oshiro CE, Vogt TM. US acculturation, food intake, and obesity among Asian-Pacific hotel workers. J Am Diet Assoc 2009;109(10):1712–8. [PubMed: 19782170]
77. Gee GC, de Castro AB, Crespi C, et al. Pre-acculturation as a risk factor for obesity: findings from the Health of Philippine Emigrants Study (HoPES). SSM Popul Health 2019;9:100482. [PubMed: 31709297]
78. Kennedy S, Kidd MP, McDonald JT, Biddle N. The healthy immigrant effect: patterns and evidence from four countries. J Int Migr Integr 2015;16(2):317–32.
79. Morey BN, Bacong AM, Hing AK, de Castro AB, Gee GC. Heterogeneity in migrant health selection: the role of immigrant visas. J Health Soc Behav 2020;61:359–76. [PubMed: 32723093]
80. Abraido-Lanza AF, Dohrenwend BP, Ng-Mak DS, Turner JB. The Latino mortality paradox: a test of the" salmon bias" and healthy migrant hypotheses. Am J Public Health 1999;89(10):1543–8. [PubMed: 10511837]
81. Diaz CJ, Koning SM, Martinez-Donate AP. Moving beyond salmon bias: Mexican return migration and health selection. Demography 2016;53(6):2005–30. [PubMed: 27848222]
82. Cheong AR, Massey DS. Undocumented and unwell: legal status and health among Mexican migrants. Int Migr Rev 2018;56:571–601.
83. Surveying Ethnic Minorities and Immigrant Populations
84. Methodological Challenges and Research Strategies Amsterdam University Press; 2013.
85. Young M-EDT, Pebley AR. Legal status, time in the USA, and the well-being of Latinos in Los Angeles. J Urban Health 2017;94:764–5. [PubMed: 28875414]
86. Commodore-Mensah Y, Selvin E, Aboagye J, et al. Hypertension, overweight/obesity, and diabetes among immigrants in the United States: an analysis of the 2010–2016 National Health Interview Survey. BMC Public Health 2018;18(1):773. [PubMed: 29925352]
87. Menjívar C Liminal legality: Salvadoran and Guatemalan immigrants' lives in the United States. Am J Sociol 2006;111(4):999–1037.
88. Massey DS. Categorically unequal: the American stratification system New York: Russell Sage Foundation; 2007.
89. Ramírez AS, Golash-Boza T, Unger JB, Baezconde-Garbanati L. Questioning the dietary acculturation paradox: a mixed-methods study of the relationship between food and ethnic identity in a group of Mexican-American women. J Acad Nutr Diet 2018;118(3):431–9. [PubMed: 29289549]
90. Popovic-Lipovac A, Strasser B. A review on changes in food habits among immigrant women and implications for health. J Immigr Minor Health 2015;17(2):582–90. [PubMed: 23892613]
91. Gee GC, Hing A, Mohammed S, Tabor DC, Williams DR. Racism and the Life Course: Taking Time Seriously. Am J Public Health 2019;109(S1):S43–7. [PubMed: 30699016]
92. Gee GC, Walsemann KM, Brondolo E. A life course perspective on how racism may be related to health inequities. Am J Public Health 2012;102(5):967–74. [PubMed: 22420802]

93. Paradies Y A systematic review of empirical research on self-reported racism and health. Int J Epidemiol 2006;35(4):888–901. [PubMed: 16585055]

94. Acevedo-Garcia D, Sanchez-Vaznaugh EV, Viruell-Fuentes EA, Almeida J. Integrating social epidemiology into immigrant health research: a cross-national framework. Soc Sci Med 2012;75(12):2060–8. [PubMed: 22721965]

95. Commission on Filipinos Overseas. Stock estimate of overseas Filipinos Manila: Department of Foreign Affairs POEA; 2011. p. 1–5.

96. San Juan E Overseas Filipino workers: the making of an Asian-Pacific diaspora. Glob South 2009;3(2):99–129.

97. Romina GA . Managing 'vulner abilities' and 'empowering'migrant Filipina workers: the Philippines' Overseas Employment Program. Soc Identities 2006;12(5):523–41.

98. Semyonov M, Gorodzeisky A. Occupational destinations and economic mobility of Filipino overseas workers. Int Migr Rev 2004;38(1):5–25.

99. Hilsdon A-M. What the papers say: representing violence against overseas contract workers. Violence Against Women 2003;9(6):698–722.

100. Holmes S Fresh fruit, broken bodies: Migrant farmworkers in the United States California: University of California Press; 2013.

101. Ferguson GM, Tran SP, Mendez SN, Van De Vijver FJ. Remote acculturation: conceptualization, measurement, and implications for health outcomes. Oxford: Oxford University Press; 2017. p. 157–73.

102. Ferguson GM, Bornstein MH. Remote acculturation of early adolescents in Jamaica towards European American culture: a replication and extension. Int J Intercult Relat 2015;45:24–35. [PubMed: 25709142]

103. Ferguson GM, Bornstein MH. Remote acculturation: The "Americanization" of Jamaican Islanders. Int J Behav Dev 2012;36(3):167–77.

104. Gee GC, de Castro A, Crespi CM, et al. Health of Philippine Emigrants Study (HoPES): study design and rationale. BMC Public Health 2018;18(1):771. [PubMed: 29925337]

105. HernÁndez-LeÓn R Restructuring at the source: high-skilled industrial migration from Mexico to the United States. Work Occup 2004;31(4):424–52.

106. Menjívar C, Abrego L. Legal violence: immigration law and the lives of Central American immigrants. Am J Sociol 2012;117(5):000.

107. Aptekar S Doctors as migration brokers in the mandatory medical screenings of immigrants to the United States. J Ethnic Migr Stud 2020;46(9):1865–85.

108. Waters MC, Gerstein PM. The integration of Americans into American society Washington, DC: National Academies of Sciences, Engineering, and Medicine; 2015.

109. Derose KP, Bahney BW, Lurie N, Escarce JJ. Immigrants and health care access, quality, and cost. Med Care Res Rev 2009;66(4):355–408. [PubMed: 19179539]

110. Hacker K, Chu J, Arsenault L, Marlin RP. Provider's perspectives on the impact of Immigration and Customs Enforcement (ICE) activity on immigrant health. J Health Care Poor Underserved 2012;23(2):651–65. [PubMed: 22643614]

111. Gonzales RG, Burciaga EM. Segmented pathways of illegality: reconciling the coexistence of master and auxiliary statuses in the experiences of 1.5-generation undocumented young adults. Ethnicities 2018;18(2):178–91.

112. Gonzales RG, Suárez-Orozco C, Dedios-Sanguineti MC. No place to belong: contextualizing concepts of mental health among undocumented immigrant youth in the United States. Am Behav Sci 2013;57(8):1174–99.

113. Rhodes SD, Mann L, Simán FM, et al. The impact of local immigration enforcement policies on the health of immigrant Hispanics/Latinos in the United States. Am J Public Health 2015;105(2):329–37. [PubMed: 25521886]

114. Garcini LM, Renzaho AMN, Molina M, Ayala GX. Health-related quality of life among Mexican-origin Latinos: the role of immigration legal status. Ethnicity Health 2018;23(5):566–81. [PubMed: 28158950]

115. Patler C, Pirtle WL. From undocumented to lawfully present: do changes to legal status impact psychological wellbeing among latino immigrant young adults? Soc Sci Med 2018;199:39–48. [PubMed: 28318760]
116. Van Natta M, Burkeb NJ, Yen IH, et al. Stratified citizenship, stratified health: examining Latinx legal status in the US healthcare safety net. Soc Sci Med 2018;220:49–55. [PubMed: 30391641]
117. Cabral J, Cuevas AG. Health inequities among Latinos/Hispanics: documentation status as a determinant of health. J Racial Ethnic Health Dispar 2020;7:874–96.
118. Pourat N, Wallace SP, Hadler MW, Ponce N. Assessing Health care services used by California's undocumented immigrant population In 2010. Health Aff 2014;33(5):840–7.
119. Wallace SP, Young MEDT. Immigration versus immigrant: the cycle of anti-immigrant policies. Am J Public Health 2018;108(4):436–7. [PubMed: 29513594]
120. Ryo E, Peacock I. The landscape of immigration detention in the United States Washington, DC: American Immigration Council; 2018.
121. Pew Research Center. Chapter 4: U.S. Public Has Mixed Views of Immigrants and Immigration. Modern Immigratoin Wave Brings 59 Million to U.S., Driving Population Growth and Change through 2065 [Web]. 2015; https://www.pewresearch.org/hispanic/2015/09/28/chapter-4-u-s-public-has-mixed-views-of-immigrants-and-immigration/. (2020). Accessed 20 Nov 2020.
122. Sudhinaraset M, Ling I, To TM, Melo J, Quach T. Dreams deferred: contextualizing the health and psychosocial needs of undocumented Asian and Pacific Islander young adults in Northern California. Soc Sci Med 2017;184:144–52. [PubMed: 28527372]
123. Sudhinaraset M, To TM, Ling I, Melo J, Chavarin J. The Influence of deferred action for childhood arrivals on undocumented Asian and Pacific Islander young adults: through a social determinants of health lens. J Adolesc Health 2017;60(6):741–6. [PubMed: 28359735]
124. Martinez O, Wu E, Sandfort T, et al. Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review. J Immigr Minor Health 2015;17(3):947–70. [PubMed: 24375382]
125. Ortega AN, McKenna RM, Kemmick Pintor J, et al. Health care access and physical and behavioral health among undocumented Latinos in California. Med Care 2018;56:919. [PubMed: 30216201]
126. Akresh IR, Frank R. Health selection among new immigrants. Am J Public Health 2008;98(11):2058–64. [PubMed: 18309141]
127. Obinna DN. The challenges of American legal permanent residency for family-and employment-based petitioners. Migr Dev 2014;3(2):272–84.
128. Jasso G Migration and stratification. Soc Sci Res 2011;40(5):1292–336. [PubMed: 26321771]
129. Kelly CS, Anaman G. Heath status of US immigrants and the process of becoming a legal permanent resident alien. J Appl Bus Econ 2019;21(1):49–57.
130. Coon M, Chi M. Visa Wait times and future earnings: evidence from the national survey of college graduates. J Econ Race Policy 2019;2(1–2):43–61.
131. Cheong AR, Massey DS. Undocumented and unwell: legal status and health among Mexican migrants. Int Migr Rev 2019;53(2):571–601. [PubMed: 31896890]
132. Filion N, Fenelon A, Boudreaux M. Immigration, citizenship, and the mental health of adolescents. PLoS ONE 2018;13(5):e0196859. [PubMed: 29723297]
133. United States Department of State Bureau of Consular Affairs Visa Bulletin—October 2019. Washington, DC: United States Department of State Bureau of Consular Affairs; 2019. p. 1–10.
134. Phelan JC, Link BG. Is racism a fundamental cause of inequalities in health? Ann Rev Sociol 2015;41(1):311–30.
135. Gómez Cervantes A "Looking Mexican": indigenous and non-indigenous Latina/o immigrants and the racialization of illegality in the Midwest. Soc Probl 2021;68:100–17.
136. Berger M, Sarnyai Z. "More than skin deep": stress neurobiology and mental health consequences of racial discrimination. Stress (Amsterdam, Netherlands) 2015;18(1):1–10. [PubMed: 25407297]
137. Morey BN. Mechanisms by which anti-immigrant stigma exacerbates racial/ethnic health disparities. Am J Public Health 2018;108(4):460–3. [PubMed: 29470116]

138. Paradies Y, Ben J, Denson N, et al. Racism as a determinant of health: a systematic review and meta-analysis. PLoS ONE 2015;10(9):e0138511. [PubMed: 26398658]
139. Guzman CEV, Sanchez GR. The impact of acculturation and racialization on self-rated health status among US Latinos. J Immigr Minor Health 2018;21:129–35.
140. Garcia SJ. Bridging critical race theory and migration: moving beyond assimilation theories. Sociol Compass 2017;11(6):e12484.
141. García SJ. Racializing "illegality": an intersectional approach to understanding how mexican-origin women navigate an anti-immigrant climate. Sociol Race Ethnicity 2017;3(4):474–90.
142. Herrera J Racialized illegality: the regulation of informal labor and space. Latino Stud 2016;14(3):320–43.
143. Boen CE, Hummer RA. Longer—but Harder—Lives?: the Hispanic health paradox and the social determinants of racial, ethnic, and immigrant-native health disparities from midlife through late life. J Health Soc Behav 2019;60:434–52. [PubMed: 31771347]
144. Bonilla-Silva E Rethinking Racism: Toward a Structural Interpretation. Am Sociol Rev 1997;62(3):465–80.
145. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. The Lancet 2017;389(10077):1453–63.
146. Del Real D "They see us like Trash": how Mexican illegality stigma affects the psychological well-being of undocumented and US-born young adults of Mexican Descent. In: Immigration and health, vol. 19. Bingley: Emerald Publishing Limited; 2019. p. 205–28.
147. López N, Vargas E, Juarez M, Cacari-Stone L, Bettez S. What's your "street race"? Leveraging multidimensional measures of race and intersectionality for examining physical and mental health status among Latinxs. Sociol Race Ethnicity 2017;41:49–66.
148. LeBrón AMW, Schulz AJ, Gamboa C, Reyes A, Viruell-Fuentes EA, Israel BA. "They are clipping our wings": health implications of restrictive immigrant policies for Mexican-origin women in a northern border community. Race Soc Probl 2018;10(3):174–92.
149. Pedraza FI, Nichols VC, LeBrón AM. Cautious citizenship: the deterring effect of immigration issue salience on health care use and bureaucratic interactions among Latino US citizens. J Health Polit Policy Law 2017;42(5):925–60. [PubMed: 28663179]
150. Kim SM, Yellow Horse AJ. Undocumented Asians, left in the shadows. Contexts 2018;17(4):70–1.
151. Hersch J The persistence of skin color discrimination for immigrants. Soc Sci Res 2011;40(5):1337–49.
152. Telzer EH, Vazquez Garcia HA. Skin color and self-perceptions of immigrant and U.S.-born Latinas: the moderating role of racial socialization and ethnic identity. Hisp J Behav Sci 2009;31(3):357–74.
153. Landale NS, Oropesa RS, Noah AJ. Experiencing discrimination in Los Angeles: Latinos at the intersection of legal status and socioeconomic status. Soc Sci Res 2017;67:34–48. [PubMed: 28888290]
154. Cuevas AG, Dawson BA, Williams DR. Race and skin color in Latino health: an analytic review. Am J Public Health 2016;106(12):2131–6. [PubMed: 27736206]
155. Morey BN, Gee GC, Muennig P, Hatzenbuehler ML. Community-level prejudice and mortality among immigrant groups. Soc Sci Med 2018;199:56–66. [PubMed: 28438421]
156. Rosenblum A, Darity W, Harris AL, Hamilton TG. Looking through the shades: the effect of skin color on earnings by region of birth and race for immigrants to the United States. Sociol Race Ethnicity 2016;2(1):87–105.
157. Perreira KM, Wassink J, Harris KM. Beyond Race/Ethnicity: skin color, gender, and the health of young adults in the United States. Popul Res Policy Rev 2019;38(2):271–99. [PubMed: 31595099]
158. Young M-EDT, Leon-Perez G, Wells CR, Wallace SP. Inclusive state immigrant policies and health insurance among Latino, Asian/Pacific Islander, Black, and White noncitizens in the United States. Ethnicity Health 2017;24:960–72. [PubMed: 29052425]

159. Venkataramani AS, Shah SJ, O'Brien R, Kawachi I, Tsai AC. Health consequences of the US Deferred Action for Childhood Arrivals (DACA) immigration programme: a quasi-experimental study. Lancet Public Health 2017;2(4):e175–81. [PubMed: 29253449]

160. Vargas ED, Sanchez GR, Juárez MD. The impact of punitive immigrant laws on the health of Latina/o populations. Polit Policy 2017;45(3):312–37. [PubMed: 29200985]

161. Aguilar C Undocumented critical theory. Cultural studies critical methodologies Thousand Oaks: Sage Publication; 2018.

162. Sáenz R, Manges DK. A call for the racialization of immigration studies: on the transition of ethnic immigrants to racialized immigrants. Sociol Race Ethnicity 2015;1(1):166–80.

163. Rumbaut RG. Pigments of our imagination: On the racialization and racial identities of "Hispanics" and "Latinos." In: How the United States Racializes Latinos. London: Routledge; 2015. p. 25–46.

164. Romero M Crossing the immigration and race border: a critical race theory approach to immigration studies. Contemp Justice Rev 2008;11(1):23–37.

165. Garcia RJ. Across the borders: immigrant status and identity in law and latcrit theory. Fla L Rev 2003;55:511.

166. Bauer GR. Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity. Soc Sci Med 2014;110:10–7. [PubMed: 24704889]

167. California Health Interview Survey. CHIS 2015–2016 methodology series: report 2—data collection methods Los Angeles: UCLA Center for Health Policy Research; 2017.

168. UCLA Center for Health Policy Research. California Health Interview Survey. CHIS Los Angeles: UCLA Center for Health Policy Research; 2019.

169. Capps R, Bachmeier JD, Van Hook J. Estimating the Characteristics Of Unauthorized Immigrants using U.S. Census Data: combined sample multiple imputation. Ann Am Acad Polit Soc Sci 2018;677(1):165–79.

170. Altman CE, Spence C, Hamilton C, Bachmeier JD. Health insurance coverage: logical versus survey identification of the foreignborn. J Immigr Minor Health 2020. 10.1007/s10903-020-01045-y.