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Racialized legal status as a social determinant of health

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ABSTRACT

This article advances the concept of racialized legal status (RLS) as an overlooked dimension of social stratification with implications for racial/ethnic health disparities. We define RLS as a social position based on an ostensibly race-neutral legal classification that disproportionately impacts racial/ethnic minorities. To illustrate the implications of RLS for health and health disparities in the United States, we spotlight existing research on two cases: criminal status and immigration status. We offer a conceptual framework that outlines how RLS shapes disparities through (1) primary effects on those who hold a legal status and (2) spillover effects on racial/ethnic in-group members, regardless of these individuals' own legal status. Primary effects of RLS operate by marking an individual for material and symbolic exclusion. Spillover effects result from the vicarious experiences of those with social proximity to marked individuals, as well as the discredited meanings that RLS constructs around racial/ethnic group members. We conclude by suggesting multiple avenues for future research that considers RLS as a mechanism of social inequality with fundamental effects on health.

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1. Introduction

This article introduces the concept of *racialized legal status* (RLS) to foreground how the law serves as a fundamental mechanism of social stratification that produces racial/ethnic health disparities. Legal status—or, one's social position in relation to a society's rights and obligations as codified by the prevailing system of laws and techniques that govern different groups and social contexts (Stuart et al., 2015: 236; Uggen et al., 2006: 301–2)—has been understood to undergird processes of social exclusion (Krieger, 2012: 106–7) but seldom has it been conceptualized as a fundamental determinant of health disparities. This oversight is unfortunate, as many legal statuses are not randomly distributed in the general population. Rather, certain legal statuses in the U.S.—such as one's criminal (e.g., ex-felon) or immigration (e.g., undocumented) status—are racialized over time (Massey, 2007; Omi and Winant, 1994). We take *racialized* legal statuses to mean those social positions based on ostensibly race-neutral legal classifications that disproportionately impact racial/ethnic minorities. RLS constitutes a contemporary dimension of social stratification (Waters and Kasnitz, 2015), reproducing racial hierarchies to the detriment of

the most marginalized members of particular racial/ethnic groups.

Our argument is that RLS may operate as a social determinant of health and health disparities. Like Link and Phelan (1995: 81), we view social conditions—factors that implicate an individual's relationships with others—as fundamental causes of health and health inequality. Social conditions are “fundamental” because they structure multiple proximate causes of disease; removing any one proximate cause, such as stress, would not eliminate the relationship between social conditions and disease given the existence of other proximate causes, such as risky behaviors or limited access to health care. Link, Phelan, and their collaborators have posited class, racism, and stigma as fundamental causes of health because they structure access to the resources necessary for preventing and treating disease (Hatzenbuehler et al., 2013; Link and Phelan, 1995; Phelan and Link, 2015). In addition to class, racism, and stigma, we suggest that legal status may serve as a fundamental cause of health and racial/ethnic health disparities.

In order to illustrate the implications of RLS as a fundamental cause of health and health disparities in the U.S., we spotlight extant research on two cases: criminal and immigration statuses. Our goal is not to review the myriad ways these statuses relate to health; several excellent summaries of criminal (Dumont et al., 2012; Massoglia and Pridemore, 2015; Wildeman and Muller, 2012) and immigration status (Castañeda et al., 2015; Martinez et al., 2015) are already available. We take these findings as a starting point and ask how studying RLS may inform the literature

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on health disparities.

Our central contribution is to reveal two broad pathways through which RLS likely contributes to health inequality: (1) primary effects on those who hold a legal status and (2) spillover effects on racial/ethnic in-group members, regardless of these individuals' own legal status. Primary effects of RLS operate by marking an individual for material and symbolic exclusion. Spillover effects result from the vicarious experiences of those with social proximity to marked individuals, as well as the discredited meanings that RLS constructs around all racial/ethnic group members. We conclude by suggesting avenues for future research on RLS as a mechanism of inequality with fundamental effects on health disparities.

2. Racialized legal status

We define RLS as a discredited social position based on an ostensibly race-neutral legal classification that disproportionately impacts racial/ethnic minority groups. In the contemporary United States, legal classifications by race/ethnicity are held to a standard of strict scrutiny under the equal protection clause of the U.S. Constitution; yet, some forms of differential treatment are permissible. For example, affirmative action constructs racial legal categories in order to meet a compelling state interest in promoting racial justice and, most recently, achieving racial diversity (see [Waters et al., 2014](#): 382–384). Legal classifications—like other classificatory processes—can have heterogeneous effects on social inequality ([Lamont et al., 2014](#)). However, our definition of RLS centers on those classifications that exert a disproportionate burden on racial/ethnic minorities not only through the withholding of social and political rights from those marked by the status but also through stigmatization processes that enable statistical discrimination against in-group members who are not. Criminal and immigration statuses are two such examples in the U.S. ([Waters and Kasinitz, 2015](#)).

Reasons for the disproportionate presence of racial/ethnic minorities among discredited criminal and immigration statuses are many. They include not only a history of legal and extralegal discrimination against these groups ([Clair and Denis, 2015](#); [FitzGerald and Cook-Martin, 2014](#); [Fox and Bloemraad, 2015](#)) but also the differential enforcement and disparate impact of purportedly race-neutral laws on racial/ethnic minorities ([Pager and Shepherd, 2008](#)). Numerous studies have found that blacks and Latinos are treated more punitively than similarly-situated whites at various stages of criminal justice processing ([Spohn, 2013](#)). In the case of immigration status, removal or deportation—the primary arm of the immigration enforcement system to which all immigrants are vulnerable under certain conditions (see [Eagly, 2013](#))—primarily targets Latin American immigrants ([Rosenblum and McCabe, 2014](#)). Scholars debate whether minorities' overrepresentation among certain legal statuses results from race-linked differential treatment or race-neutral disparate impact ([Clair and Winter 2016](#): 333–334). Yet, others have suggested that even if discrimination is not a proximate, it is likely a distal, cause of racial inequality ([Ray and Seamster, 2016](#)). Seemingly race-neutral causes in one domain can be attributed to race-linked causes in another ([Reskin, 2012](#)). Differences in criminal offending rates (race-neutral cause), for instance, are linked to residential segregation and employment discrimination (race-linked cause) ([Massey, 1995](#)). Acquiring immigration papers (race-neutral cause) can likewise be traced to ethno-racial structures (race-linked cause) in both the sending and receiving countries (see [Acevedo-Garcia et al., 2012](#) for a review on the importance of a cross-border perspective on health). For example, [Asad and Hwang](#)

(2016) reveal how U.S.-bound Mexicans from indigenous communities are more likely than their peers in non-indigenous communities to migrate undocumented, and [Fox and Bloemraad \(2015\)](#) show how Mexican immigrants' naturalization rates in the early twentieth-century U.S. varied by their regional proximity to white European immigrants in their receiving contexts.

That seemingly race-neutral social classifications may bear on social stratification processes is not new, at least not theoretically. Feminist and critical race scholars have theorized the concept of “intersectionality,” encouraging scholars to consider the cross-cutting and interactive “relationships among multiple dimensions of social life” ([McCall, 2005](#): 1771; see also [Crenshaw, 1991](#)). Medical sociologists also have relied on intersectionality theory to explain health outcomes. For example, [Williams et al. \(1994](#): 31) refer to studies that document “multiple vulnerability,” or the additive and/or multiplicative risk factors faced by individuals who occupy multiple devalued social categories. [Virell-Fuentes et al. \(2012](#): 2099) similarly propose that an intersectional approach that “considers the simultaneous and mutually constitutive effects of the multiple social categories of identity, difference, and disadvantage that individuals inhabit” yields a more complete understanding of immigrant health.

We draw inspiration from the literature on fundamental causes and the literature on intersectionality to argue that RLS reproduces social inequality, with fundamental consequences for racial/ethnic health disparities. The concept of RLS not only focuses on the intersection of traditional markers of stratification such as race or class but also advances legal status as an under-theorized and increasingly-important dimension of inequality (see also [Waters and Kasinitz, 2015](#)). In addition, our concept foregrounds the spillover effects of discredited legal classification among members of racial/ethnic groups who do not hold the legal status. When legal categories—such as being an ex-felon or being undocumented—are racialized, so too are the social statuses constructed around them ([Alexander, 2012](#); [Brown, 2013](#)). RLS thus results in individuals' dual and recursive exclusion from society, entailing both material and symbolic harms for legally-marked individuals and legally-unmarked in-group members. For example, employers discriminate more harshly against blacks with criminal records than similarly-situated whites, revealing the compounded disadvantage of a criminal record for blacks ([Pager, 2008](#)). Ban-the-Box initiatives—policies meant to remove hiring discrimination on the basis of one's criminal record—nevertheless may increase racial disparities in employment, likely because employers statistically discriminate by using black and Latino race/ethnicity as a proxy for criminal status in the absence of this information on jobseekers' applications ([Doleac and Hansen, 2016](#)). Regarding immigration status, policies aimed at curbing undocumented immigration depress Medicaid uptake for long-term Mexican legal permanent residents in the U.S. more than they do for those from other countries ([Watson, 2014](#): 329). This negative impact on healthcare acquisition may stem from Mexican legal permanent residents' worries that they will be misrecognized as, and punished for being, undocumented ([Derose et al., 2007](#)).

Having outlined RLS theoretically, we now turn to highlighting the known consequences of racialized criminal and immigration legal statuses for health disparities. Throughout, we signal important limitations of the burgeoning literature on this topic. We then develop a conceptual model linking RLS to racial/ethnic health disparities and suggest avenues for future research. Although research on criminal and immigration statuses has rarely been considered in tandem (but see [King et al., 2012](#); [Waters and Kasinitz, 2015](#)), our analytic exercise reveals how RLS serves as a form of social stratification in the study of health and health

disparities.

3. Racialized legal status and health: two illustrations

3.1. Criminal status

In the U.S., an individual's criminal status is based on legal classifications of illicit behaviors and their resultant legal processing by state and federal authorities. Criminal justice processing can result in a range of legal statuses, the most discredited of which incur the loss of certain social and political rights. Arrest is the least severe and most common form of criminal status. Additional criminal statuses may accrue as an individual makes his or her way through the criminal justice process such as being a pre-trial detainee, a convicted misdemeanor, a convicted felon, a probationer, an incarcerated person, a death row inmate, and a formerly-incarcerated person. At nearly every stage of criminal justice processing, blacks and Latinos disproportionately accrue criminal statuses relative to whites (Spohn, 2013). For example, it is estimated that nearly half of all black men born in the 1980s experienced at least one arrest by the age of 23 as compared to about 40 percent of white men (Table 1). More severe criminal statuses tend to reflect even starker racial/ethnic disparities. For example, among one cohort of American men, an estimated 26.8 percent of black males have ever been incarcerated in comparison to 12.2 percent of Latino males and 5.4 percent of white males (Table 2).

Depending on legal severity and social stigma, criminal statuses can result in a range of legal and extralegal burdens with potential structural and psychosocial implications for health. Each of these individual-level consequences can have collateral consequences for the material well-being of families and neighborhoods (Roberts, 2000), as well as the broader symbolic meanings associated with racial/ethnic minority groups (Alexander, 2012). Police stops and arrest experiences can have immediate implications for perceptions of injustice (Shedd, 2015), especially among black and Latino youth (Hagan et al., 2005). Having an arrest record can result in employment and housing discrimination (Ispa-Landa and Loeffler, 2016). Court involvement, even absent legal punishment, can result in legal fees (Harris, 2016). Pre-trial detainment can result in job loss and strained social ties (Comfort, 2007). A misdemeanor conviction alone, absent time served in jail or prison, can result in employment and housing discrimination (Pager, 2008), and myriad additional consequences for immigrants (Eagly, 2013). Depending on the state, felony conviction may result in restrictions on voting, jury service, housing, financial aid, and parental rights (Uggen et al., 2006). Certain crimes, such as sex crimes, can carry additional social costs related to stigma (Wacquant, 2009). If a convicted person is sentenced to jail or prison, incarceration can result in exposure to

Table 2
Estimates of cumulative risk of imprisonment for men, by race/ethnicity.

	Percent Ever Incarcerated by Age 30–34 (born 1975–79) ^a	Percent Ever Incarcerated by Age 30–34 (born 1975–79) ^b
White males	3.3	5.4
Latino males	–	12.2
Black males	20.7	26.8

^a Source: Estimates are based on data from the 2004 Survey on Inmates of States and Federal Correctional Facilities, as calculated by Western and Wildeman (2009). Note that imprisonment is measured as incarceration for a felony conviction of 12 months or longer and thus does not count those who have only served a jail time sentence of less than 12 months (Western and Wildeman, 2009: 230). Differences were found to be statistically significant.

^b Source: Estimates are based on data from NLSY79 from Western and Pettit (2010), Table 1.

infectious diseases and stress (Massoglia, 2008a), as well as family hardship or dissolution (Apel, 2016; Comfort, 2007). After release, parole or probation status may increase the likelihood of re-incarceration (Phelps, 2013; Tonry and Lynch, 1996). Even when convicted and formerly-incarcerated persons are not legally barred from participating in American political and social life, they still may withdraw from these domains (Brayne, 2014; Uggen et al., 2004; White, 2015)—and, all else equal, minorities may withdraw more than whites (White, 2015).

Much research on criminal status and health focuses on incarceration, arguably the most severe form of criminal status. Earlier research on incarceration and health compared the health profiles of incarcerated persons to those of the general population, observing poorer health among those incarcerated in both jails and prisons (Binswanger et al., 2009). Given that individuals who experience incarceration are likely different from the general population in various ways, recent research has attempted to account for selection bias in order to estimate the causal effect of incarceration on health (Schnittker et al., 2011: 135–136). This literature has considered health during detainment and after release. Studies that seek to isolate incarceration's causal effect during detainment exhibit mixed findings, whereas studies on incarceration's effect post-release have mostly found prior incarceration experience to have a negative effect on health (Wildeman and Muller, 2012: 18–19). For instance, one study found that mortality rates are lower for black men incarcerated in state prisons than for black men in the general population (Patterson, 2010), but others have found that morbidity rates and exposure to infectious diseases are higher among those incarcerated in prisons (Massoglia, 2008a; Schnittker et al., 2011: 135–136). Leaving prison exacerbates health concerns among the formerly incarcerated, with ex-prisoners across racial/ethnic groups more at risk for a drug overdose than

Table 1
Estimates of cumulative risk of arrest for men, by race/ethnicity.

	Percent Ever Arrested by Age 23 (born 1980–84) ^a	Percent Ever Arrested by Age 24–34 (born 1974–84) ^b
American Indian males	–	56
Black males	48.9	52
Hispanic males	43.8	–
Other males	–	45
White males	37.9	41
Asian/Pacific Islander males	–	24

^a Source: Estimates are based on data from the 1997 National Longitudinal Survey of Youth (NLSY), as presented in Table 3 of Brame et al., (2014). Brame et al. found that differences between white males and black males were statistically significant, whereas differences between Hispanic males and white and black males were not.

^b Source: Estimates are based on data from the National Longitudinal Study of Adolescent Health, as calculated by Barnes et al., (2015). Barnes et al. found that differences between Asian males and all other racial groups were statistically significant. White-black differences and American Indian-white differences were found to be statistically significant.

the general population as they return to toxic eco-social environments (Binswanger et al., 2007; Dumont et al., 2012).

Research on incarceration and health has been criticized for affording little consideration to mental health (Wildeman and Muller, 2012: 20, 26). Whereas some studies have considered the mental health profiles of incarcerated populations (Fazel and Baillargeon, 2011), fewer have considered incarceration's causal effect on mental health, though this area of inquiry is growing (see Turney et al., 2012; Turney et al., 2013). In addition, data limitations with respect to length and type of incarceration (e.g., jail vs. prison) complicate comparisons of incarceration's health effects, as well as the potential mechanisms (e.g., acute vs. chronic stress) linking observed associations (see Massoglia and Pridemore, 2015: 302). While a couple studies consider how distinct forms and periods of incarceration may differentially shape health (Binswanger et al., 2009; Schnittker and John, 2007), more systematic comparisons are warranted.

Incarceration's effect on racial/ethnic health disparities has been theorized (Binswanger et al., 2012), but empirical examinations are limited (Massoglia, 2008b). For example, of the 26 studies Wildeman and Muller (2012) reviewed, only five directly assessed this question. Using various methods to examine incarceration's effect on disparities—such as controlling for income and education (Schnittker and John, 2007), propensity score matching (Massoglia, 2008b), or comparing macro-level variations in incarceration to macro-level variations in racial/ethnic disparities (Wildeman, 2012)—this nascent line of inquiry generally supports the hypothesis that incarceration explains some of the variation in racial/ethnic groups' health, specifically in AIDS infection rates among women (Johnson and Raphael, 2009), functional limitations (Massoglia, 2008b; Schnittker and John, 2007), and infant mortality (Wildeman, 2012). Many of these studies also reveal the spillover effects of an individual's incarceration on the health of family members.

Understanding the spillover consequences of incarceration—as well as other criminal statuses such as police contact—is a growing area of research (Wildeman and Muller, 2012). The above research on incarceration and spillover effects focuses on how direct contact with (formerly-) incarcerated persons affects the health of family members through the spread of disease or stress. In addition to this research, some research has considered how living in proximity to those subject to legal enforcement shapes one's health. For example, Sewell et al. (2016) examine the collateral consequences of policing for neighborhood residents. They find that neighborhood-level aggressive policing tactics are associated with individual-level psychological distress among men, but not women, who live in over-policed neighborhoods. They show how vicarious experiences of policing can spill over to negatively impact the mental health of residents who may not have direct experiences with aggressive policing.

In comparison to the incarceration literature, the research on police contact and health is limited in volume and tends to focus on mental health. Aside from Sewell et al. (2016), described earlier, Geller et al. (2014) examine self-reported anxiety levels and post-traumatic stress among a different sample of young men in New York City. They find that men who had experienced police contact reported higher levels of general anxiety than men who had not. More aggressive encounters predicted higher levels of post-traumatic stress. Sewell and Jefferson (2016) undertake one of the few studies to consider physical health effects of police contact. They find that more invasive neighborhood-level policing increases individuals' odds of having an asthma episode and worse self-rated health but decreases their odds of a diabetes diagnosis and obesity. But they find that invasive policing has heterogeneous effects on many physical health measures by race/ethnicity—often to the

detriment of blacks, Latinos, and Asians as compared with whites. While Sewell and Jefferson (2016) provide clues, existing studies on policing have rarely directly assessed policing's causal effect on population health disparities. Beyond policing and incarceration, research on other statuses—such as probation status and/or death row status—remains underexplored. The limited measures available in existing datasets may account for researchers' difficulties in reliably estimating the relationship between these other criminal statuses and health (Massoglia and Pridemore, 2015: 301).

With respect to assessing explanatory mechanisms, research linking various criminal statuses to health tends to privilege direct structural pathways (e.g., limited access to healthcare) (Dumont et al., 2012; Patterson, 2010) or stress-related pathways related to physical or eco-social deprivation (e.g., acute stress of detention or chronic stress of neighborhood policing) (Schnittker and John, 2007: 125–126). Less work evaluates the relationship between individuals' perceived stigma associated with holding a discredited criminal status and health. Research outside the health literature suggests that the perceived stigma of various criminal statuses contributes to stress, unhealthy coping behaviors, and avoidance of health-promoting institutions (Brayne, 2014; Shedd, 2015). We are aware of only one study in the health literature that identifies the relationship between perceived stigma on the basis of criminal status and stress mechanisms (Turney et al., 2013), which finds a positive association between such perceived discrimination and psychological distress.

In sum, and with an eye toward understanding RLS as a social determinant of health disparities, research should continue to examine: (1) criminal statuses beyond incarceration; (2) the impact of perceived stigma attributed to criminal status on psychosocial stress mechanisms; and (3) the collateral consequences of criminal statuses not only for the families and neighbors of those who hold them but also for racial/ethnic group members who do not.

3.2. Immigration status

The U.S. federal government classifies its immigrant population of 42 million into four general legal categories, including undocumented, discretionary, temporary, and permanent groupings (see Waters and Pineau, 2015: 94 for a full review). Each category confers differential degrees of legal protection to those immigrants who hold them and determines these individuals' access to important political, labor market, and social opportunities in the U.S. (Bosniak, 2007). Perhaps the most obvious implication of an immigrant's legal classification is his or her degree of vulnerability to immigration enforcement actions such as detention or deportation. Even absent direct experience with immigration enforcement, just the threat of it shapes how immigrants navigate daily life (De Genova, 2002). The immigration enforcement system has disproportionately impacted U.S. immigrants from Latin America since at least 2005 (Table 3; see also Rosenblum and McCabe, 2014). Moreover, estimates suggest that Hispanic and Asian immigrants are more likely to be undocumented than are white or black immigrants (Fig. 1).

An immigrant's legal classification can entail a range of legal and extralegal burdens that implicate health through structural and psychosocial pathways. Existing research on the burdens of immigration status tends to focus on the experiences of Latinos, given this racial/ethnic group's overrepresentation in the U.S. immigrant population (Passel et al., 2014). Whereas immigrants with an undocumented status enjoy few civil and labor protections, immigrants with a discretionary, temporary, or permanent status enjoy progressively more protections, access to public benefits, and labor mobility (Jones-Correa and de Graauw, 2013). Lacking documents can result not only in employment (Donato and Sisk, 2012)

and housing discrimination (Hall and Greenman, 2013; McConnell, 2015) but also in the sorting of immigrants into racially-segregated neighborhoods (Hall and Stringfield, 2014). For those caught twice while attempting to enter the U.S. clandestinely, jail time and up to a twenty-year bar on future admission to the country is possible (Stumpf, 2011). A nascent literature suggests that even legalized categories of immigrants can face consequences similar to their undocumented peers should they become swept up in the immigration enforcement system (Asad, 2017; Baum, 2010; Eagly, 2013; Golash-Boza, 2015; Menjívar and Abrego, 2012). Short- and long-term stays in immigrant detention facilities expose immigrants to unsafe and unsanitary conditions and contribute to these individuals' risk of experiencing post-traumatic stress, depression, and mental health-related disability (see Steel et al., 2006). Following detention, removal from the country may result in family separation (Dreby, 2015), stress and depression (Dreby, 2012), and perhaps death as deportees attempt to re-enter the U.S. (Cornelius, 2001). The threat of immigration enforcement may also have collateral consequences for immigrants who have never had contact with the system, leading immigrants and their U.S.-citizen children to avoid health-promoting institutions in order to minimize their personal risk of detection, detention, and deportation (Bean et al., 2015).

Only recently have researchers begun to consider how various immigration statuses affect health. Public health scholars interested in nativity long have agreed that immigrants fare better than native-born Americans on multiple dimensions of mental and physical health, including when comparing immigrants with their same-race, native-born counterparts (see Cunningham et al., 2008;

Singh et al., 2013). Attributable to migrant selectivity (Jasso et al., 2004; Palloni and Morenoff, 2001), this immigrant health advantage holds even for the undocumented (see, e.g., Dang et al., 2011; Korinek and Smith, 2011). Over time, however, limited access to health care and stress associated with living undocumented in the U.S. may deteriorate these immigrants' mental health, with likely consequences for physical health outcomes as well (Yoshikawa, 2011). Documented immigrants, too, appear to lose some of their health advantage over native-born Americans due to well-founded perceptions that changes to immigration policies since 1996 have not only made their physical presence in the U.S. more precarious (Asad, 2017) but also that these changes have restricted their access to public benefits (Derose et al., 2007). Arbona et al. (2010: 364) suggest that this declining health advantage may be due to acculturative stress, or the "psychosocial strain experienced...as [immigrants] adapt to life in a new country." Ethnographic studies lend further credence to the acculturative stress hypothesis (Menjívar and Abrego, 2012).

As research accumulates on the relationship between distinct immigration statuses and health, so too does the mixed evidence on this question. Although policy changes since 1996 (see Waters and Pineau, 2015: 377–402) have restricted all immigrants' access to affordable health care—with the undocumented especially affected—Marrow (2012) finds that undocumented immigrants in San Francisco overcome some of the barriers to care that undocumented immigrants in other U.S. locales confront (see also Joseph, 2016 in Massachusetts). Moreover, Amuedo-Dorantes et al. (2013) use a sample of undocumented Mexicans who have experienced enforcement actions to show that punitive immigration policies do

Table 3
Percentage of U.S. removals by immigrants' region of origin, 2005–2014.

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Latin America	92.5	94.0	94.2	95.0	95.3	95.6	96.1	97.0	97.8	98.0
Caribbean	1.7	1.2	1.2	1.2	0.8	0.7	0.8	0.6	0.5	0.4
Sub-Saharan Africa	1.0	0.7	0.7	0.6	0.5	0.5	0.4	0.3	0.3	0.3
Asia	1.7	1.6	1.8	1.2	1.1	1.2	1.1	0.8	0.6	0.5
All Other Countries	3.1	2.5	2.1	2.1	2.2	2.0	1.6	1.2	0.9	0.8

Note: Cells may not sum to 100 due to rounding.

Source: Authors' tabulation of Table 41, 2014 Yearbook of Immigration Statistics, Department of Homeland Security.

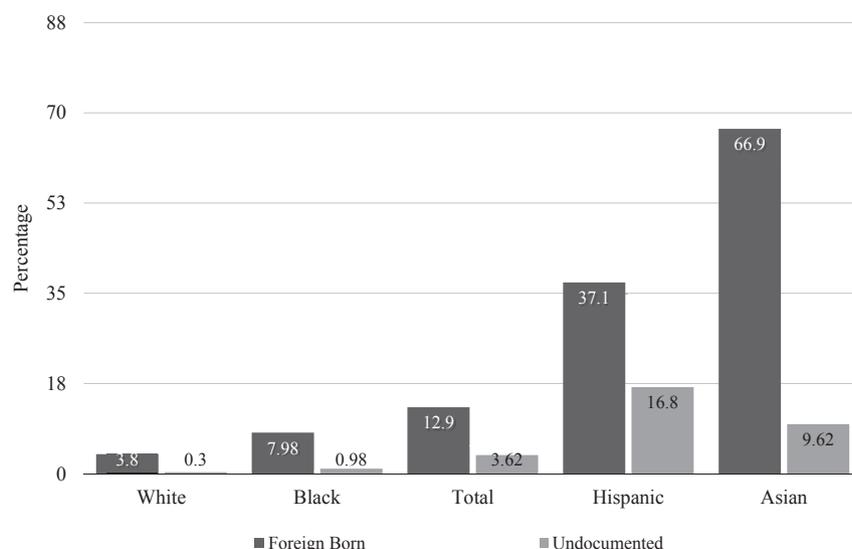


Fig. 1. Percentage of major racial/ethnic groups in U.S. by nativity and immigration status, 2010.

Source: Foreign-born estimates are based on authors' calculation of 2010 U.S. Census data provided by IPUMS, augmented with undocumented estimates from Passel et al. (2011).

not deter respondents' self-reported access to health care in the U.S. By contrast, [Watson \(2014\)](#) relies on nationally-representative data from the Current Population Survey and finds that long-term permanent residents respond to the enactment of punitive policies by not enrolling in Medicaid. These divergent findings may be, in part, a function of existing study designs, which often rely on convenience samples of these hard-to-find and legally-vulnerable immigrant populations in order to assess how legal categorization shapes health care access and utilization (but see [Venkataramani et al., in press](#)). How immigrants across legal categories understand the structural constraints to health care, and how they respond to them when seeking healthcare, requires greater systematization.

Research on the effect of immigration status on population health disparities—or whether immigrants' legal categorization contributes to racial/ethnic health disparities—is more limited. Studies foreground how nativity, rather than legal classification, impacts racial/ethnic health disparities ([Cunningham et al., 2008](#)). Given that racial/ethnic groups contain unequal proportions of members holding discredited immigration statuses ([Fig. 1](#)), the focus on nativity rather than legal classification may obscure the health problems the most vulnerable group members face (see [Waters et al., 2014: 384](#)). For instance, [Orrenius and Zavodny \(2009\)](#) use nationally-representative data to show that U.S. immigrants tend to work in occupations with higher risk of injury compared with their U.S.-born peers. In supplementary analyses, the authors find that naturalized citizens relative to noncitizens tend to work in industries with lower fatality rates. This result lends preliminary support to the idea that legal categorization implicates health disparities within the immigrant population. Although more work is needed that considers how legal categorization shapes racial/ethnic health disparities, some research suggests that more precarious immigration statuses—more likely to be held by marginalized minorities—shape health outcomes by depressing healthcare access and utilization ([Castañeda et al., 2015; Martínez et al., 2015](#)). Researchers could further interrogate disparities through a comparison of macro-level changes in racial/ethnic health disparities with macro-level changes in immigration policy or through research designs that estimate independent effects of immigration status, net of other traditional determinants of health disparities such as class (see [Wildeman and Muller, 2012: 15](#)).

Studies investigating the link between immigration status and health foreground the structural impediments to healthcare. Fewer studies have examined the psychosocial pathways linking immigration status and health, though some research has examined how immigrants' perceptions of race- ([Gee et al., 2006a](#)) or language-based ([Yoo et al., 2009](#)) discrimination shape immigrant health. For example, [Gee et al. \(2006b\)](#) study the association between perceived racial discrimination and mental health among a snowball sample of black and Latino immigrants in New Hampshire. They find that perceptions of discrimination are predictive of poor mental health among black and Latino immigrants relative to native whites. Disentangling the extent to which these perceptions of discrimination are attributable to immigrants' race, nativity, or immigration status (see [Waters and Kasinitz, 2015](#)) is complicated by a lack of data on a reference group of white immigrants, as well as measures of English-language proficiency and legal categorization. When research does consider the potential psychosocial pathways linking immigration status and health, it often emphasizes indirect pathways, such as how detention, deportation, and/or family separation contribute to elevated levels of stress ([Hacker et al., 2012; McGuire and Martin, 2007; Suárez-Orozco et al., 2002](#)). How immigrants across and within racial/ethnic and legal categories perceive the daily risks of living in the U.S. remains underexplored despite its potential impact on mental and physical

health ([Castañeda et al., 2015](#)).

Holding a discredited immigration status bears not only on the health of individual immigrants but also spills over to affect the families and communities of which they are a part (see [Aranda and Vaquera, 2015; Enriquez, 2015; López, 2015](#)). The Migration Policy Institute ([2015](#)) estimates that households with at least one immigrant parent contain 17.5 million U.S.-citizen and noncitizen children. When the immigration enforcement system targets an immigrant parent, this individual's children are directly implicated. Parents' immigration status is associated with children's cognitive development ([Brabeck and Xu, 2010; Yoshikawa, 2011](#)), as well as anxiety and depressive symptoms during adolescence ([Potochnick and Pereira, 2010](#)). These outcomes may be the result of parents passing on their worries about the immigration enforcement system to their children, U.S. citizens or otherwise ([Yoshikawa, 2011](#)). Communities with large proportions of same-race U.S.- and foreign-born group members may also experience the deleterious consequences of a racialized legal status ([Viruell-Fuentes et al., 2012: 2102–2103](#); see also [Hacker et al., 2011](#)), particularly if they live in locales receiving new flows of same-race immigrants. [Jiménez \(2008\)](#) shows how intergroup boundaries between Mexicans and non-Mexicans sharpen in contexts of heavy Mexican immigration, with U.S.-born Mexicans racialized as “foreign” or “illegal.” [Getrich \(2013\)](#) describes how such dynamics produce stress in the immigration enforcement context, revealing how immigration officials at the Tijuana-San Diego border racialize and interrogate U.S.-citizen youth of Mexican descent as if they were undocumented immigrants (see also [Armenta, 2017](#)).

Taken together, and with an eye toward understanding RLS as a determinant of health disparities, research is needed that examines: (1) the implications of distinct legal categories of immigrants—including and beyond the undocumented—for health, across and within racial/ethnic groups; (2) how perceived stigma on the basis of legal categorization operates as a psychosocial pathway to health; and (3) the spillover consequences of immigration statuses for the health not only of those who hold the status but also of those who do not.

4. Racialized legal status as a social determinant of health: implications for future research

Scholars studying the determinants of health and health disparities in the U.S. often examine traditional markers of stratification such as race, class, or sex. While important, this research nevertheless overlooks newer forms of stratification that bear on these same outcomes. In this article, we offered RLS—a social position based on an ostensibly race-neutral legal classification that disproportionately impacts racial/ethnic minorities—as one undertheorized axis of stratification with independent effects on health and health inequality. By spotlighting existing research on two racialized legal statuses—criminal and immigration statuses—we suggested several areas of research needed to better link these two discredited social positions to health disparities.

We advance our conceptual model linking RLS to racial/ethnic health disparities in [Fig. 2](#) as a shared reference point for future research. This model applies to both criminal and immigration statuses, given the parallel processes of apprehension, detainment, surveillance, and statistical discrimination that these legal classifications entail. Our model highlights three pathways through which RLS shapes racial/ethnic health inequalities. First, RLS entails mostly-negative consequences for the mental and physical health of the individuals who hold it. This primary effect operates in much the same way as other fundamental causes of health—that is, by limiting individuals' access to the economic, social, and cultural resources necessary for promoting health and well being ([Link and](#)

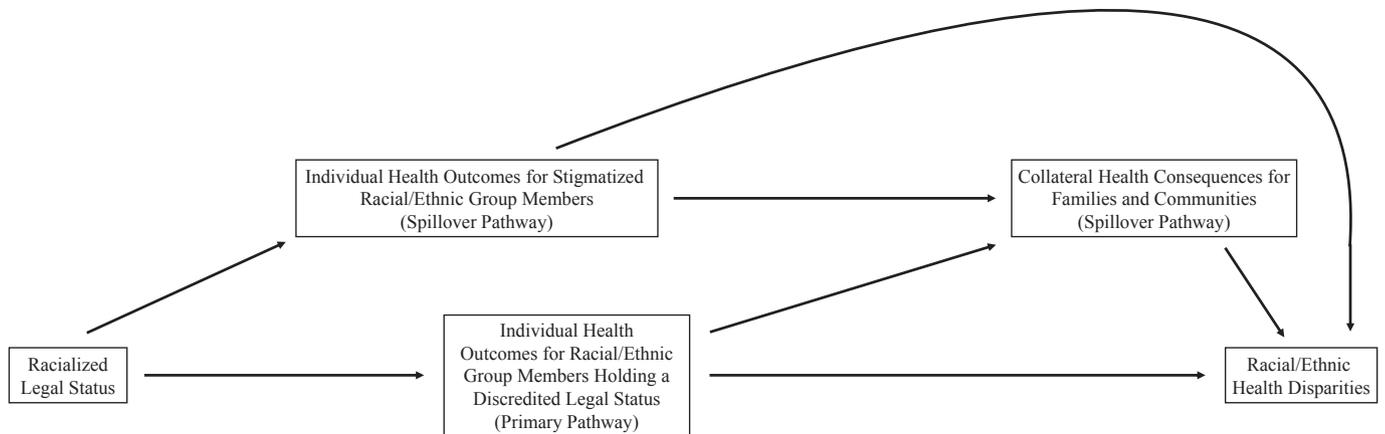


Fig. 2. Conceptual model linking racialized legal status to racial/ethnic health disparities.

Phelan, 1995); by exposing individuals to disease and stress; and likely (though rarely studied) through the psychosocial consequences of perceived stigma on the basis of legal status.

A second pathway is through spillover effects on legally-unmarked racial/ethnic in-group members with social proximity to an individual holding a discredited legal status. This pathway works by spreading disease (e.g., HIV/AIDS) or proximate risk factors (e.g., stress) to the family members and neighbors of those marked by the discredited status. If sufficient numbers of racial/ethnic group members come to hold a stigmatized status, this may shape a group's overall health profile and contribute to disparities.

The third pathway also operates through a spillover effect, but it impacts racial/ethnic group members who are misrecognized as holding a discredited legal status; these individuals are therefore subject to statistical discrimination. As we have seen, research has documented how the police and/or immigration officials stop and detain law-abiding African Americans and U.S.-citizen Latinos given the legal stigma surrounding their racial/ethnic groups. These moments of contact and the anticipatory and acute stress they trigger likely have negative and independent consequences for health outcomes.

Our model invites several avenues for future research. First, scholars should interrogate RLS as a broad social category. To do so entails more than accounting for individual-level race or legal status covariates. By studying legal classification as a social process that creates discredited legal categories—with both individual- and group-level effects—researchers could better understand how racial/ethnic health disparities remain, even after controlling for individual-level stratification markers. It may be, for example, that the effect of RLS on health for whites is stronger at the individual rather than group level, given the lack of criminal and immigration stigma among whites; in contrast, RLS may exert stronger group-level effects for racial/ethnic minority groups. Disentangling individual- and group-level effects of RLS is an important path for future research.

Second, future research should examine the health effects of legal statuses independently and in comparison. Criminal and immigration statuses each entail health consequences for the minorities who hold them, as well as in-group members who do not. But, considered together, parallel experiences with policing and detention are endemic to both statuses (Waters and Kasinitz, 2015). Evaluating whether, how, and why these separate racialized legal statuses operate similarly or differently in the context of health is likely to be generative, as some research intimates that holding a criminal or undocumented status has similar effects on social exclusion (Schachter, 2016: 1009).

Third, since legal classifications evolve over time, future research should compare racial/ethnic groups' health trajectories. Various criminal statuses, for example, historically have stigmatized certain Asian ethnic groups in the U.S. (see Hing, 1998). Today, many observers note that Asian immigrants face declining exclusion; yet, certain ethnic groups—such as South Asian Muslims—continue to confront racialized legal classifications that result in their social exclusion (Lee and Kye, 2016). Understanding how different racial/ethnic groups' respective racialized legal statuses implicate health and health disparities warrants sustained scrutiny.

Fourth, insight into the ecological effects of RLS—or whether its effect varies by social context—is necessary. For instance, the burdens of legal status may affect racial/ethnic minorities more than whites in areas with higher shares of white residents. As Gottschalk (2016) notes, although racial disparities in incarceration may be higher in whiter areas, the overall incarceration rate tends to be lower. Similarly, racial/ethnic health disparities may be starker in whiter areas, even as minorities' overall health may be better than that of their same-race peers in less-white areas. In addition, researchers could investigate whether and how macro-level stressors (Williams and Mohammed, 2009: 29) related to racialized legal statuses—such as the election of a president, law and order politics, or immigration raids—shape health outcomes. Finally, research that investigates whether and how RLS operates in different cultural (Asad and Kay, 2015) and national (Beckfield and Krieger, 2009) contexts may shed light on how legal regimes contribute to racial/ethnic health disparities.

Fifth, and as noted earlier, data limitations hamper many studies of the effects of criminal and immigration status. Suggestions for how to address some of these constraints are discussed elsewhere (see Binswanger et al., 2012: 102–104; Waters and Pineau, 2015: Chapter 10). We offer several additional suggestions. Researchers could modify existing stigma/discrimination scales—e.g., the Everyday Discrimination Scale (Williams et al., 1997)—to include attribution questions (see Shariff-Marco et al., 2009) related to perceptions of stigma on the basis of criminal or immigration status. These revised scales could be added to new or already-existing data collection efforts, such as the National Longitudinal Study of Adolescent to Adult Health and the National Longitudinal Survey of Youth. To assess variation of RLS by local context, researchers could consider conducting and comparing analyses across community health surveys. If such surveys do not capture individual-level RLS, researchers could consider the group-level effects of RLS by matching these data sets with community-level indicators of policing or detention/incarceration rates (e.g., Sewell et al., 2016).

Moreover, health researchers should advocate for the inclusion of legal status questions in health survey collection; as we have argued, legal status should be considered a stratification marker analogous to race, gender, or class. Incorporating legal status variables in individual-level health surveys would allow researchers to disentangle individual-level and group-level effects of RLS. Qualitative studies also could be helpful here, particularly since they can provide insight into the processes shaping health and health-seeking behaviors among the individuals, families, and communities that RLS impacts. Such qualitative work could provide evidence of the individual- and group-level mechanisms linking observed associations.

Finally, assessing the causes of RLS should also be considered an important component of future health research. Conceptualizing RLS as a social determinant of health redirects disparity-reduction efforts to the socio-legal regimes that sustain these inequalities. Understanding legal classification as a primary mechanism for maintaining systemic racism through the reproduction and valuation of racialized categories extends recent theoretical interpretations of racism as a fundamental cause (Phelan and Link, 2015), revealing racism to be not only a function of covert discrimination or implicit bias but also explicit legal classification systems that, despite their disparate impact, maintain legitimacy in the eyes of many through their apparent race-neutrality. The legal incorporation of racialized groups has functioned as one pathway to destigmatization, and, in turn, the likely reduction of health disparities (see Clair et al., 2016). Policy efforts to reduce health disparities should thus shift attention from modifying individuals' behaviors and toward altering the legal landscape.

5. Conclusion

This article conceptualized the importance of RLS as a social determinant of health. Through the cases of criminal and immigration statuses, we outlined how RLS shapes racial/ethnic health and health disparities through (1) primary effects on those who hold a discredited legal status; and (2) spillover effects on racial/ethnic in-group members, regardless of these individuals' own legal status. We offered a conceptual model that we hope will serve as a reference point for future research on how RLS exerts an independent effect on racial/ethnic health and health disparities.

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