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Disabilities in Divergent Deportation Contexts: Revisiting the Hispanic Epidemiological Paradox

Abstract: The Hispanic Epidemiological Paradox refers to an advantage in life expectancy among Hispanic immigrants (relative to U.S.-born groups) despite lower socioeconomic attainment. Although the paradox has been well-documented, the institutional context of today differs from earlier eras when evidence of the paradox first emerged. Today, Hispanic immigrants—including two-thirds of unauthorized immigrants—are now a long-term, settled population. Among Hispanic noncitizens, the possibility of deportation has grown rapidly as they become concentrated in dangerous jobs with limited health access. We explore the paradox among Hispanic immigrants to determine whether and where the previously observed advantages may be losing ground. We examine rates of disability among Hispanic immigrants and describe disability rates across divergent contexts. By examining disability in divergent contexts, we call attention to the indirect determinants of health in an era of mass deportations. We find reports of multiple disabilities are more common among Hispanic noncitizens who arrived in the US since the start of the Great Recession (2007 and onwards), but disabilities are less common among other Hispanic noncitizens as well as broader Hispanic and non-Hispanic populations.

Introduction

In an era of mass deportations, do the health effects of immigration enforcement and restrictive policymaking extend to disabilities? If so, which groups are most likely to report multiple disabilities in metro areas hit hardest by the mass deportation movement? Past work confirms restrictive policymaking can reshape health outcomes in select states and local communities (Cruz Nichols, Lebrón, & Pedraza, 2018; Torche & Sirois, 2018; Vargas & Benitez, 2019; Wang & Kaushal, 2018). We contribute to this research by examining the conditions under which we might expect enforcement to predict specific difficulties (e.g., cognitive, ambulatory, independent living, self-care, vision, or hearing). Our analyses allow us to determine whether deportations and disabilities rose in tandem – and whether the relationship applies to those most likely to be affected by enforcement (Hispanic noncitizens who arrived in the US recently) as well as other immigrant, Hispanic, and metro residents of high deportation areas.

In order to analyze the relationship between deportations and disabilities, we rely on U.S. Census data merged with administrative data from the Department of Homeland Security (DHS). Specifically, we leverage variation in individuals reporting multiple disabilities – as recorded in the American Community Survey (ACS) – and cumulative deportation rates under the Secure Communities immigration enforcement program, which operated across the country by 2013. Secure Communities is a nationwide enforcement program active across all county jails. It links noncitizen arrestees' biometric data to federal databases capable of identifying noncitizen arrestees (Cox & Miles, 2013; Rosenblum & Kandel, 2012). Given the ample discretion county officials could exercise in implementing the program (Pedroza, 2013, 2018a), the program resulted in wide variation in cumulative deportation rates. The program helped DHS deport hundreds of thousands of noncitizens and targeted Hispanic noncitizens. Under the Obama

Administration, deportation relief stemming from prosecutorial discretion usually extended to noncitizens with roots in the US, which tended to exclude recently arrived noncitizens.

We find recently arrived Hispanic noncitizens were, in fact, more likely to report multiple disabilities if they lived in metro areas with especially high cumulative deportation rates. By contrast, Hispanic noncitizens with comparatively longer U.S. tenure (i.e., arrived before 2007) were actually less likely to report disabilities. Similarly, U.S. citizen Hispanics and the broader non-Hispanic population were also less likely to report disabilities in high deportation metros. The results suggest that although the broader effects of enforcement can extend beyond the intended targets of enforcement, certain health outcomes – such as disabilities but also physical and mental health (Wang & Kaushal, 2018) and low birth-weight (Torche & Sirois, 2018) – so far remain limited to especially vulnerable segments of the immigrant population. We discuss the implications of these results in the context of research on the erosion of the Hispanic Epidemiologic Paradox (HEP), or the so-called immigrant health advantage, which can likewise wane as immigrants spend more time in the US and their sources of social support decline.

Literature

In this section, we review extant research on the Hispanic Epidemiologic Paradox (HEP). We first describe the HEP and summarize reasons why immigrant groups might report health advantages relative to other populations. Given our focus on the potential erosion of the HEP across certain kinds of metro areas, we discuss recent evidence in two areas: (a) the conditions under which we observe a diminished immigrant health advantage and (b) whether contextual effects matter for immigrant health outcomes. We contribute to existing research by drawing on a social determinants of health framework to examine whether Hispanic immigrant groups –

whose health advantages routinely appear in research on the HEP – are more likely to report negative health outcomes if they live in high deportation areas.

Past research on the paradox

The HEP refers to an unexpected relationship between health outcomes and the Hispanic population, especially Hispanic immigrants (Hummer & Chinn, 2011; Markides & Eschbach, 2005; Teruya & Bazargan-Hejazi, 2013). Researchers have found evidence of the HEP when examining various outcomes, ranging from longevity and mortality (Goldman, Glei, & Weinstein, 2017; Markides & Eschbach, 2005) to specific health risks (Bacon, Riosmena, & Rogers, 2017; Markides, Eschbach, Ray, & Peek, 2007).[1] Explanations for the HEP emphasize resilience and health-enhancing factors (Acevedo-Garcia & Bates, 2008; Ruiz, Hamann, Mehl, & O'Connor, 2016). Examining whether selection bias may explain the HEP, studies have found emigrant selection helps account for advantages attributed to immigrant status (Riosmena, Kuhn, & Jochem, 2017; Riosmena, Wong, & Palloni, 2013), while health-promoting factors may play a role in explaining certain positive outcomes (Riosmena et al., 2017). Relatedly, differences in who migrates back to their country of origin (a "salmon bias") may also help explain why Hispanic immigrants population appear relatively healthy (Arenas, Goldman, Pebley, & Teruel, 2015; Riosmena et al., 2013).[2] Finally, since the HEP did not always exist, the health advantages we observe may dissipate to pre-1960s levels (Palloni & Morenoff, 2001).

The HEP is not immutable and can erode

Researchers have begun identifying the conditions – such as generation status (Giuntella, 2016) – under which living in the US becomes more detrimental (Castro, 2007). Among these,

[1] Evidence of a HEP is not unequivocal (Camacho-Rivera, Kawachi, Bennett, & Subramanian, 2015; Lum & Vanderaa, 2010; Markides & Gerst, 2011).

[2] Such bias appears particularly applicable to Mexican immigrants (Palloni & Arias, 2004) but may not apply to other Hispanic groups (Abraido-Lanza, Dohrenwend, Ng-Mak, & Turner, 1999) or play only a limited role in accounting for the HEP in outcomes such as mortality (Turra & Elo, 2008).

duration of stay strongly predicts the trend toward increasing risk of mortality and chronic illness (Riosmena, Everett, Rogers, & Dennis, 2015). Similarly, the transition to old age appears to reduce the disability advantage among Hispanic immigrants (Markides et al., 2007; Sheftel & Heiland, 2018), which can erode further in the absence of extended social networks (Cantu & Angel, 2017; Eschbach, Ostir, Patel, Markides, & Goodwin, 2004; Montes-de-Oca, Ramírez, Santillanes, García, & Sáenz, 2015). Additionally, barriers to health access and utilization (Bacon et al., 2017; Cervantes et al., 2018) as well as high rates of obesity, diabetes, old age disability rates, and a rise in sources of stress associated with living in the US can also erode the HEP (Goldman, 2016). Given the research summarized above, immigrant health research needs to account for heterogeneity among immigrants, especially in the amount of time immigrants have lived in the US and in other factors that can affect immigrants' access to social support.

Whether state and local contexts can shape the HEP and immigrant health

Research on the role of community-level effects on immigrant health suggests state and local contexts can affect immigrant health. Recent work suggests mortality rates, smoking, and birthweight outcomes in an established immigrant destination can be worse than in 'new immigrant destinations' (Brazil, 2017; Fenelon, 2017). Although prior work found a weak relationship between anti-immigrant prejudice and mortality (Morey, Gee, Muennig, & Hatzenbuehler, 2018), mounting evidence suggests that the social determinants of health among immigrants (Castañeda et al., 2015) now include federal, state, and local policy environments, especially with regard to immigration enforcement (Perreira & Pedroza, 2019). For instance, restrictive policies can accelerate stressors in the immigrant community and erode support networks (Hagan, Leal, & Rodríguez, 2015; Hagan, Rodríguez, & Castro, 2011; Morey et al., 2018; Philbin, Flake, Hatzenbuehler, & Hirsch, 2018; N. Rodríguez, Paredes, & Hagan, 2017, 2019). The link between restrictive initiatives and declining health might stem from an erosion of

trust in mainstream health institutions (Cruz Nichols et al., 2018) and noncitizen workers becoming "stuck" in low-paying and hazardous jobs (Fernández-Esquer, Gallardo, & Diamond, 2018; Hall & Greenman, 2015; Orrenius & Zavodny, 2009) in contexts where finding a new job is made increasingly difficult by a rise in restrictionism (East, Luck, Mansour, & Velasquez, 2018; Lofstrom, Bohn, & Raphael, 2011). We contribute to this work by examining whether the rise in deportations across U.S. metros affected immigrant health, especially among immigrants with a higher likelihood of both health advantages and risk of deportation: recently arrived noncitizens.

Contribution to research on contextual determinants of immigrant health

In this paper, we examine whether local policy context shapes individual health outcomes. Specifically, we focus on disability rates (Markides et al., 2007; Sheftel & Heiland, 2018) among immigrants, and examine whether variation in U.S. metro deportation rates is related to higher rates of multiple disabilities. Analyzing the potential effects of immigration policymaking on health outcomes, empirical studies come to heterogenous conclusions. On the one hand, immigration policymaking does not necessarily lead to a tandem change in health access or outcomes in the immigrant population (Allen & McNeely, 2017; Koralek, Pedroza, & Capps, 2010). Such non-relationship could reflect resilient immigrant groups that largely decide to weather tough times by not changing their behavior and/or real changes in immigrant behavior that evade data collection efforts. On the other hand, among studies that do find a relationship between policy changes and health outcomes, three possible scenarios are discussed.

First, rising deportations may foretell worse health outcomes for the general public, U.S.-born and foreign-born alike. In this scenario, metros with high deportation rates may represent a select group of areas where health generally lags behind other places. After all, increasingly stringent enforcement tends to coincide with spikes in unemployment, even playing harbinger to

the Great Recession (Joyner, 2018; O'Neil, 2011; Parrado, 2012), and tends to differentially affect states and localities (Moinester, 2018; Pedroza, 2013, 2018a). Indeed, Secure Communities negatively affected employment options among immigrants and the general U.S. population (East et al., 2018), possibly because select metros with a ramp up in deportations were already vulnerable to negative consequences. In sum, higher deportation rates may hasten declining health in locations predisposed to negative health outcomes for everyone.

Second, a growing body of research suggests restrictive immigration policymaking can affect health among immigrant-origin groups, including Hispanic noncitizens and Hispanic U.S. citizens alike. For example, in response to a rise in enforcement, Hispanic immigrant households may report increasing mistrust of mainstream institutions, declining health, and other negative outcomes (Alsan & Yang, 2018; Cruz Nichols et al., 2018; Vargas & Benitez, 2019; Watson, 2014), including among children in mixed-status families and households likely disrupted by enforcement (Amuedo-Dorantes & Arenas-Arroyo, 2018; Amuedo-Dorantes & Lopez, 2015). Indeed, when asked about the current immigration policy climate, nearly half of Hispanic adults – and two-thirds of Hispanic immigrants – report worrying "some" or "a lot" that someone they know may be deported (Lopez & Rohal, 2017), especially during a time when the salience of deportations has become widespread (Sanchez, Vargas, Walker, & Ybarra, 2015). Given that the state's investment in mass deportations came at a time when net migration from the largest source of working-age immigrants, Mexico, was approaching zero (Passel & Cohn, 2017), it seems entirely possible that the brunt of the health consequences of mass deportation was borne by U.S. citizens of Hispanic descent. Under these conditions, U.S. citizen and noncitizen Hispanics may have both become wary of seeking health-promoting services. In sum, it is possible that the general Hispanic population – not just Hispanic noncitizens – became exposed to health-detrimental conditions in metros with high deportation rates.

Finally, this paper examines whether deportations predict disabilities only among those most likely to be directly affected by intensifying enforcement. According to research on the effects of enforcement (Pedroza, 2018b), it is possible that certain enforcement consequences have, so far, only reached the immigrant population. For instance, the health and mental health consequences of Secure Communities on Hispanic immigrants has been found to be limited to immigrants living with noncitizen household members (Wang & Kaushal, 2018). Likewise, the effects of Arizona Senate Bill 1070 on low birthweight were limited to Hispanic immigrant women and not their U.S.-born counterparts (whether Hispanic or non-Hispanic) (Torche & Sirois, 2018). In this vein, even if U.S. citizen Hispanics report enforcement-related stressors, these may not ultimately amount to a higher incidence of reported disabilities. In other words, disabilities should be more common among Hispanic noncitizens than other Hispanics, and especially among Hispanic noncitizens living in high deportation metro areas. In addition, recently arrived Hispanic noncitizens should be both (a) healthier than those who arrived in earlier eras and thus more likely to have survived to older ages (Taylor, Lopez, Passel, & Motel, 2011) and (b) most likely to live under the risk of deportation because these recent arrivals are the least likely to qualify for naturalization and protections from deportation (Rosenblum & Kandel, 2012).

Data and Methods

In this section, we describe two data sources used to examine disabilities across deportation contexts: the U.S. Census data on our outcome of interest (multiple reported disabilities observed at the individual level), and administrative data from the Department of Homeland Security (metro-level deportation rates under Secure Communities). We also describe our analytic approach to examine whether deportation and disability rates rose in tandem, net of

other individual- and household-level determinants of health as well as metro and year fixed effects. We analyze individual outcomes nested within metro areas during the time period to analyze possible associations between deportations and disabilities that differ depending on which metro area that a resident calls home, as detailed in Pedroza (2018b).

Disability and health data

Following recent work (Sheftel & Heiland, 2018), we analyze ACS data on self-reported disability (Ruggles et al., 2018). The data provide prevalence estimates for six measures of disability (i.e., cognitive, ambulatory, independent living, self-care, vision, or hearing difficulty). We predict whether or not an individual reported two or more of these disabilities. Although we do not know when each person first experienced any of these difficulties, we interpret the presence of two or more disabilities as a proxy for cumulative health disadvantage.[3]

Deportation data

As a hypothesized determinant of health, we measure cumulative deportation rates [Figure 1] to capture the variation across metro areas in immigration enforcement under the Secure Communities program. Notably, we propose that *cumulative* deportations might be a more powerful predictor of negative health outcomes because multiple disabilities are likely to represent individuals' *long-term* exposure to health challenges. As such, we expect the cumulative intensity of enforcement to be a more stable social determinant of health than recent deportation activity (i.e., annual, metro-year deportation rates). For the purposes of our study, we define the cumulative deportation rate (D) to equal the number of deportations reported in each county since its local jail activated the Secure Communities program, adjusting for (a) the

[3] As a check to ensure we are measuring cumulative disadvantage in a sensible way, we also predict whether individuals report three or more disabilities.

number of days each of the 260 metro areas had participated in the program in subsequent years and (b) the size of the noncitizen population:

$$D = \log\left(\left\{\frac{cumulative\ removals\ and\ returns}{noncitizens\ per\ thousand}\ x\ \frac{days\ since\ initial\ activation}{365}\right\} + 1\right)$$

Lagged deportation rates (t - 2 years) are merged with ACS responses for all metro residents. To further account for variation due to the non-uniform rollout of the Secure Communities program, we restrict our analyses to the five years (2013-2016) when the vast majority (over 90 percent) of counties were subject to the program's deportation policies.

In our data, ACS metro residents living in an identifiable county are assigned deportation rates corresponding to their county of residence as long as they stayed in the same county when surveyed by the ACS. This group includes metro residents with an ACS county identifier as well as those whose metro location corresponds to a single county. Second, ACS metro residents without any county identifier and whose broader metro area straddles multiple counties are assigned a synthetic deportation rate, which is the sum of the county-specific deportation rates weighted by the resident noncitizen population. For example, if one metro area stretches across two counties, and one county's noncitizen population is four times as large as the other, then the deportation rate is adjusted accordingly (e.g., D1 x 0.8 + D2 x 0.2).[4]

Individual and household determinants of health

The HEP research literature has identified the key determinants of health that partially account for an observed immigrant health advantage. Based on these prior works, we account for duration of stay (Riosmena et al., 2015) in the US by measuring years since arrival among the foreign-born. We also acknowledge difference in disabilities across the life course (Markides et

[4] We conduct separate analyses to determine whether the results differ when we include a small share (8%) of residents that moved to a different county in the same state (see results).

al., 2007; Sáenz, 2015) –e.g. among younger versus older Hispanic immigrants (N. Rodríguez et al., 2019; Sheftel & Heiland, 2018) – and adjust for individual's age and its squared term (age^2). Since recent immigrant arrivals are more likely to be male (Riosmena et al., 2017), and since health outcomes often differ by sex(Acevedo-Garcia & Bates, 2008; Ruiz et al., 2016), we also indicate each person's sex (Female: 1; Male: 0). Living below the official poverty line and low educational attainment are both associated with worse health outcomes, and so we account for poverty status (1: below poverty line; 0: above poverty line) and educational attainment (categorical variable: <12 years completed as the reference; 12 years completed; 1-2 years of post-secondary; 4+ years of post-secondary; and other, including individuals in school). Individuals with disabilities can select into health insurance coverage (either publicly-funded or not) and Supplemental Security Income (SSI), and we include indicators for both. We also account for differences in marital status (1: married and living with spouse; 0: other marital status) because those who live with a spouse tend to also exhibit other health-promoting behaviors. Similarly, differences in occupation and employment status predict health outcomes, and so we create a categorical variable that accounts for three sectors (reference: professional; compared to farm or production) as well as employment status (unemployed; not in the labor force). Finally, since the Hispanic population is the focus of this study, we include fixed effects for each of the 59 Hispanic origin groups measured in the ACS.

Analytic approach

We first describe time trends in disability rates across metro areas with a focus on disability across divergent deportation contexts. We then present multivariate regression results to test our hypotheses. We employ linear regression models that account for the large number of metro areas in the CPS sample. Instead of treating the relationship between disabilities and independent variables identically across all metro areas, each metro resident's likelihood of

reporting multiple disabilities is compared to residents in the same metro area and then compared to the distribution of housing-related factors in the national sample of metro areas. In sum, the regression models account for variation across individuals (*i*) in each metro area (*m*) in a given year of CPS data (*t*):

$$Y_{i,m,t} = \alpha + \beta_1 \left(deportation_{m,t-2}\right) + \sum \beta X_{i,m,t} ,$$

where *deportation* equals the rate of deportation in year *t – 2* (preceding the year leading up to each administration of the ACS survey) and *X* is a set of individual and household variables.

Results

Consistent with research on the HEP, disability rates are unevenly reported across subsets of Hispanic and non-Hispanic groups. Table 1 displays the share of metro residents reporting multiple disabilities, by racial/ethnic group, citizenship status, and deportation context. Among all metro residents, 7.39% reported multiple disability rates during the study period (2013-2016). Not surprisingly, given what we know about health selection among Hispanic immigrants, Hispanic noncitizens had the lowest overall rates of multiple disabilities (3.42%). In addition, U.S. citizen, non-Hispanic, white residents had similar rates of multiple disabilities as Hispanic U.S. citizens (7.64% and 7.34%, respectively). U.S. citizen, non-Hispanic, black metro residents had multiple disability rates higher than each of the groups in Table 1 (9.85%). Since we are mainly interested in whether these disability patterns differ by the intensity of immigration enforcement, we also report disability rates by deportation context.[5]

[5] Multivariate models focus on these racial/ethnic groups. For reference, during this time period and in metros with Secure Communities, multiple disability rates were inversely related for other groups as well. They were 12.93% among Native Americans (and lower in high deportation metros, 12.06%, than low deportation contexts, 15.47%). Among Asian U.S. citizens, multiple disabilities were less common (5.23% compared to 5.30% and 5.16% in low versus high deportation areas). Asian noncitizens reported multiple disability rates (3.29%) similar to Hispanic noncitizens, but Asian noncitizens also reported nearly identical rates in low versus high deportation contexts (3.17-3.18%).

Bivariate patterns reveal support for a relationship between enforcement (mean cumulative deportation rate: 2.1; or $(e^{2.1}-1) = 7$ deportations annually per thousand noncitizens) and disabilities across multiple groups. In general, metro residents in low deportation contexts (i.e., cumulative deportation rates one standard deviation below the mean) did report multiple disabilities less often than their counterparts (7.30% compared to 7.40%) living in metro areas with high rates of deportation, or one standard deviation above the mean deportation rate. The bivariate pattern is driven by two groups: Hispanic noncitizen residents (3.42% had multiple disabilities, compared to 3.98% in high deportation areas) as well as non-Hispanic, U.S. citizen white residents (7.64% compared to 7.91% with multiple disabilities in high deportation contexts). The remaining sub-groups report no comparable, proportional relationship between enforcement and disabilities. Next, we examine whether the bivariate relationships hold when we account for other social determinants of health.

[Table 1 about here]

We first analyze the relationship between cumulative deportation rates and disabilities among the general population. Again, the analysis sample focuses on residents living in metro areas where county and federal officials had already activated a Secure Communities program. If deportations represent a proxy for declining conditions for the general population, then multiple disabilities should be more common in high deportation areas for everyone – not just those likely affected by deportations. In Table 2, models 1 and 2 display results for all metro residents in the analysis sample. We find a *negative* relationship between deportations and disabilities, either without covariates (model 1) or with a full set of individual and household determinants of health (model 2). Among all non-Hispanic metro residents (models 3 and 4), deportation rates are also inversely related to disabilities, and the relationship holds among U.S. citizen whites (models 5 and 6) as well as U.S. citizen black residents when accounting for individual- and household-

level covariates (model 8).

We also examine whether enforcement foretells adverse reports of disabilities among Hispanics. We find no such evidence for most Hispanic groups. When analyzing reported disabilities among all Hispanics versus Hispanic U.S. citizens, we find deportations inversely predict disabilities once we account for all covariates of health (models 10 and 12). Similarly, among Hispanic noncitizens arriving before 2007, deportation rates are weak predictors of disabilities, and the association is only significant – and also negative, as above – when we account for other covariates of health. The latter result contradicts a bivariate pattern (see Table 1) that initially suggested disabilities were more common among long-term, Hispanic, noncitizen residents living in high deportation areas (4.18% with multiple disabilities) than those in low deportation contexts (3.33%). In sum, if enforcement hastens negative health outcomes among the general population or the broader Hispanic population, we find no evidence of such generalized, diffuse effects when examining disabilities.

[Table 2 about here]

Only among Hispanic noncitizens who are also recent arrivals do we find a relationship between cumulative deportation rates and reporting more than one disability. The results suggest that, at least when it comes to disabilities (sight, hearing, mobility, and other difficulties), the health consequences of immigration enforcement appear to be concentrated among those most likely to be affected by the rise of mass deportations. Hispanic noncitizens who arrived in the US during or after the Great Recession generally report the *lowest* rates of multiple disabilities (2.30% across metros and 2.68% in high deportation contexts, Table 1). And yet their reported disabilities are higher when they report having settled in metros with an especially restrictive deportation context. Net of other determinants of health – including Hispanic-origin fixed effects (introduced in models 4-6) – no other group reports more disabilities in high deportation

contexts, including non-Hispanics, Hispanic U.S. citizens, and long-term Hispanic residents. Among recently arrived Hispanic noncitizens, rising cumulative deportations are associated with a 3.4% rise in the likelihood of two or more reported disabilities after we account for determinants of health and focus on metros with 100 or more Hispanics (model 6).[6]

In addition to deportation rates, and consistent with the literature on the HEP, reporting multiple disabilities is more common among Hispanic noncitizens who (a) have been in the US longer (models 3-6), (b) are older (models 2-6), and (c) are not in the labor force or receiving SSI benefits (models 5-6). Results are substantially the same when we conduct a series of robustness checks to determine whether the results are sensitive to decisions regarding the sample or the analytic approach described above.[7]

[Table 3 about here]

Discussion and Conclusion

In this paper, we examined whether individuals were more likely to report disabilities in metro areas with high deportation rates compared to their counterparts in metros with relatively low deportation rates. Multivariate results confirm a positive relationship between rising cumulative deportations and a higher likelihood of reporting multiple disabilities. The

[6] Since the average annual increase in cumulative deportations (for this sample) was 0.215 and the mean disability rate for the same sample was 0.023 (2.3%), then the relationship between deportations and multiple disabilities (Beta: 0.0036; caution: p-value = 0.066) equals: (0.215*0.0036) / 0.023 = 0.034, or 3.4%. This estimate is lower than the predicted 4.1-6.9% rise in likelihood of multiple disabilities predicted in models 1 through 5, or about half when comparing model 1 (with no covariates) and the final model (3.4% compared to 6.9%).

[7] We conducted a number of robustness checks. The above results exclude those who moved and crossed county lines, but excluding them may bias our estimates toward zero if noncitizens vulnerable to health hazards leave high deportation areas. Among intra-state movers, we assign these residents their state-level deportation rate because the ACS does not report the county they left. The association between deportations and disabilities remains about the same when we include these residents (3.6%). Furthermore, we also analyzed the relationship between deportations and disabilities by employing Bayesian multi-level models with random effects for year and metro area. Based on those results, rising cumulative deportation rates appear to be a marginally positive predictor of multiple disabilities. Similar in magnitude to the above results, the expected mean increase in odds of multiple disabilities is about 5% per 1 unit increase in the cumulative deportation rate.

association holds only among recently arrived Hispanic noncitizens. All other groups – including non-Hispanics, Hispanic U.S. citizens, and noncitizens who are long-term residents – were less likely to report disabilities in metros with high deportation rates. Next, we discuss possible explanations for the results as well as limitations and implications.

Research on the health effects of immigration policymaking have so far focused on the intended and unintended consequences of laws and enforcement. Research calls attention to how restrictive policies can affect not only noncitizens (especially unauthorized immigrants) but also entire households and immigrant communities (Amuedo-Dorantes & Lopez, 2015; Cruz Nichols et al., 2018). In light of such evidence, perhaps enforcement negatively affects a wide range of groups, whether intentionally or not. We contribute to this literature by reexamining the epidemiological paradox among Hispanics. Specifically, we examine whether the apparent health advantage Hispanics – especially immigrants – enjoy compared to non-Hispanic groups has thus far eroded under the weight of cumulative deportation rates. Although enforcement can (and sometimes does) reach beyond its intended targets, our results recommend caution regarding how much enforcement programs have reshaped health outcomes in immigrant communities.

We confirm what others have found when examining specific, serious, and negative health outcomes during the rise of restrictive policymaking. Low birthweight as well as health and mental health distress are concentrated among certain segments of the Hispanic immigrant community; either those living with noncitizens or immigrant mothers who were pregnant during a particularly hostile – and relatively short-lived – policy climate (Torche & Sirois, 2018; Wang & Kaushal, 2018). We view multiple disabilities as another example of a specific, serious, and negative health outcome that seems related to immigration enforcement. As such, research on the health consequences of enforcement should specify conditions under which we might observe

certain groups exhibit different kinds of negative health outcomes we suspect stem from changes in enforcement and related policies.

Although the potential mechanisms underlying the positive relationship between enforcement and disabilities remain out of view in this study, we anticipate the policy and employment context since the start of the Great Recession may help account for our results. First of all, these noncitizens arrived in the US during the Great Recession and its prolonged recovery. At the same time, deportations soared to record levels and national debates regarding access to health insurance explicitly targeted this group as undeserving of coverage. In other words, these noncitizens were especially vulnerable to exclusion from health institutions and may have been further relegated to marginal segments of the labor market. In such a context, recent Hispanic noncitizen arrivals may have felt stuck in their current job (East et al., 2018; Lofstrom et al., 2011) and worried about the prospect of finding a new job if they quit. In addition to such worries, exploitative employers (Valenzuela, 2006) may also have felt increasingly emboldened to expose all low-wage Hispanic workers (not just unauthorized immigrants) to dangerous working conditions that could lead to serious injury. Under those circumstances, our results suggest an uptick in disabilities among a vulnerable segment of the population: Hispanic noncitizens most likely exposed to the implementation of Secure Communities during a time of rising uncertainty. Given that recently arrived Hispanic noncitizens generally had low disability rates (2.3% reported multiple disabilities), our results suggest the context in which they arrived in the US helped erode part of their relative advantage.

Although we find a relationship between disabilities and deportations, the association is relatively modest. To be clear, enforcement did not catalyze a surge in noncitizen disabilities. In the context of the literature on enforcement, the results do fall within the range detected in comparable studies. For example, heightened enforcement predicts a 20% rise in the likelihood

that a Hispanic, US-born child lives in a household headed by a single, female, and likely undocumented mother (Amuedo-Dorantes & Arenas-Arroyo, 2018) and a 10 percentage point rise in food insecurity among Mexican, non-citizen households (Potochnick, Chen, & Perreira, 2017). The results presented in this paper are closer to the relationship between enforcement and poverty: heightened enforcement predicts a 4% rise in the likelihood of living in poverty among U.S.-born children with likely unauthorized parents (Amuedo-Dorantes, Arenas-Arroyo, & Sevilla, 2018).

Our results feature data limitations. We analyze pooled cross-sections and know when immigrants arrived in the US and where they settled, but we have no data on when they first experienced any (or multiple) disabilities. In addition, our analyses focus mostly on residents who stay in the same county and metro area, and we also follow a small share of intra-state movers using information on their state-level deportation context; but we cannot do the same for interstate movers and residents who leave metro areas. Yet our merged data do leverage variation among metro residents and compare disability reports across a range of deportation contexts.

The HEP refers to an immigrant advantage, a source of resilience that can erode under certain conditions such as duration of stay and lack of social support. Our results suggest that the HEP may have eroded at a slightly faster pace in metro areas with high cumulative deportation rates than in metros with low deportation rates. Just as others have suggested that deportations can diminish immigrants' accumulated social capital (Hagan et al., 2015; Rugh & Hall, 2016), we likewise call attention to the implications of investing in mass deportations at the expense of an immigrant health advantage. In the long term, the social effects of enforcement can further erode the HEP in ways we have only begun to understand and reliably measure.

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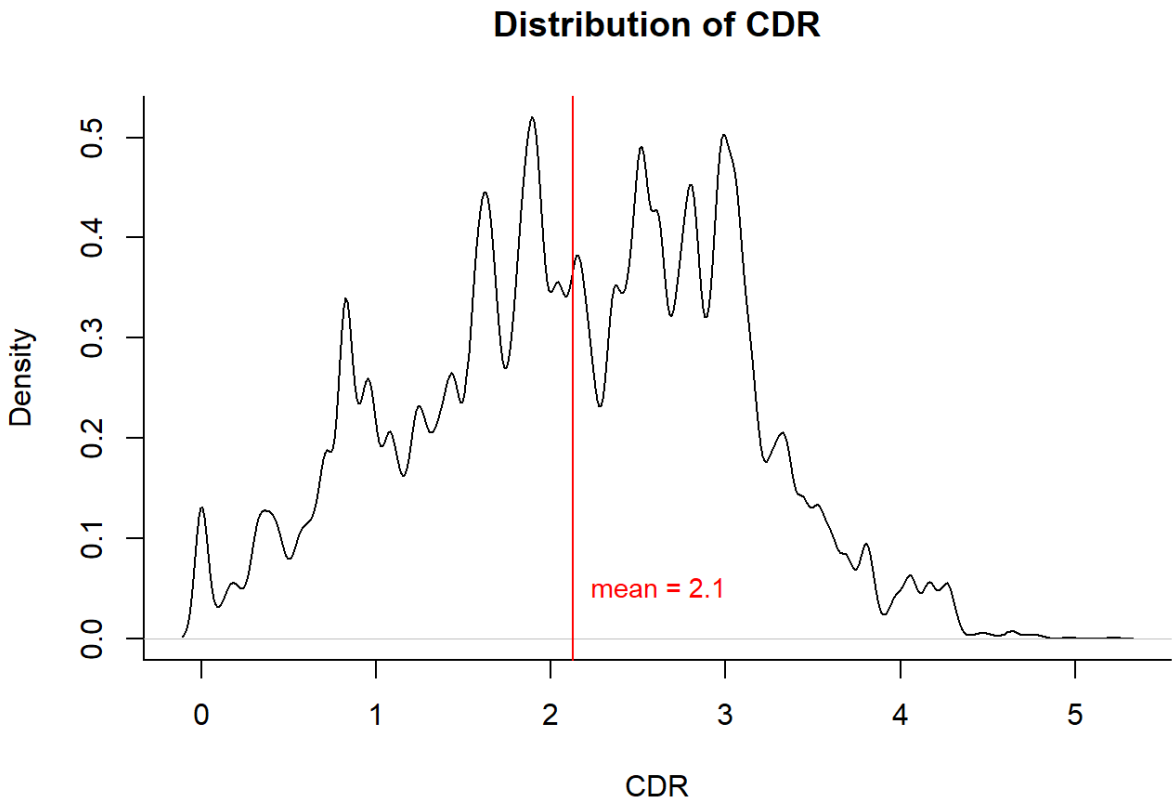
Figure 1: Cumulative Deportation Rates across U.S. Metro Areas in American Community Survey (2013-2016)



Source: Cumulative deportation rates using Secure Communities data across residents in metro areas (2013-2016). Since Secure Communities data was reported at the county level, a synthetic deportation rates (i.e., the sum of the county-specific deportation rates weighted by the resident noncitizen population) is assigned to metros straddling multiple counties.

Table 1: Percent of Metro Residents Reporting Multiple Disabilities (by Citizen Status, Race/Ethnicity, and Deportation Context)

		Non-Hispanic			**Hispanic**				
Disabilities	**All metro residents**	*Total*	*U.S. Citizen, White*	*U.S. Citizen, Black*	*Total*	*Hispanic, U.S. citizen*	*Hispanic, not U.S. citizens*	*Hispanic, not U.S. citizens, arrived <2007*	*Hispanic, not U.S. citizens, arrived >2006*
Multiple disabilities	7.39	7.69	7.64	9.85	6.00	7.34	3.42	3.62	2.30
Low deportation context	7.30	7.43	7.41	9.69	6.33	7.85	3.01	3.33	1.58
High deportation context	7.40	7.86	7.91	9.5	6.01	7.18	3.98	4.18	2.68

Source: Disability rates figures reflect sample of residents living in metro areas with a Secure Communities program (2013-2016). Deportation contexts reflect whether residents live in a metro area whose cumulative deportation rates are one standard deviation below or above the mean (2.13 ± 0.94).

Table 2: Log odds of reporting multiple disabilities among metro residents (2013-2016) by race/ethnicity and citizenship status

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
VARIABLES	**All metro residents**		**Non-Hispanics**		**Non-Hispanic, white, U.S. citizens**		**Non-Hispanic, black, U.S. citizens**	
CDR	-0.0007**	-0.0020***	-0.0005*	-0.0017***	-0.0011***	-0.0016***	0.0024**	-0.0020**
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.001)	(0.001)
Observations	5,807,672	5,807,672	4,953,610	4,953,610	3,768,679	3,768,679	583,745	583,745
R-squared	0.0031	0.1844	0.0031	0.1824	0.0032	0.1769	0.0052	0.1919
Full controls	NO	YES	NO	YES	NO	YES	NO	YES
Hispanic-origin fixed effects	NO	YES	N/A	N/A	N/A	N/A	N/A	N/A

	(9)	(10)	(11)	(12)	(13)	(14)
VARIABLES	**All Hispanics**		**Hispanic U.S. Citizens**		**Hispanic noncitizens (arrived before 2007)**	
CDR	-0.0000	-0.0026***	0.0004	-0.0022**	-0.0007	-0.0034***
	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)
Observations	854,062	854,062	594,909	594,909	222,071	222,071
R-squared	0.0069	0.2038	0.0057	0.2090	0.0105	0.1833
Full controls	NO	YES	NO	YES	NO	YES
Hispanic-origin fixed effects	NO	YES	NO	YES	NO	YES

Standard errors in parentheses *** p<0.001, ** p<0.01, * p<0.05, + p<0.10. Full controls include sex, age, age^2, poverty and insurance status, SSI benefit receipt, marital status, educational attainment, occupation and employment status. In order to include both U.S.-born and foreign-born residents in the analysis sample above (models 1-4 and 9-10), only model 14 accounts for years in the US.

Table 3: Log odds of reporting multiple disabilities (*Hispanic Noncitizens arriving after 2006*)

	(1)	(2)	(3)	(4)	(5)	(6)
Deportation rate	0.0074***	0.0063***	0.0059***	0.0052**	0.0044**	0.0036*
	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)	(0.002)
Age		-0.0126***	-0.0126***	-0.0127***	-0.0116***	-0.0117***
		(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Age^2		0.0002***	0.0002***	0.0002***	0.0002***	0.0002***
		(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Female		0.0027+	0.0027+	0.0027+	-0.0029+	-0.0030+
		(0.001)	(0.001)	(0.001)	(0.002)	(0.002)
Years in USA			0.0007*	0.0007*	0.0008**	0.0008**
			(0.000)	(0.000)	(0.000)	(0.000)
Below poverty line					0.0024	0.0025
					(0.002)	(0.002)
Any health insurance					0.0063***	0.0067***
					(0.002)	(0.002)
Any SSI income					0.1274***	0.1291***
					(0.008)	(0.008)
Married (spouse present)					-0.0065***	-0.0060***
					(0.002)	(0.002)
Education (0: < 12 yrs.)						
12 years					-0.0027	-0.0020
					(0.002)	(0.002)
1-2 yrs. college					-0.0067*	-0.0065*
					(0.003)	(0.003)
4+ yrs. college					-0.0065*	-0.0061*
					(0.003)	(0.003)
n/a, no schooling					0.0164***	0.0167***
					(0.003)	(0.003)
Employment (0: not in labor force)						
unemployed					-0.0150*	-0.0141*
					(0.007)	(0.007)
professional					-0.0168***	-0.0160***
					(0.003)	(0.003)
service					-0.0180***	-0.0173***
					(0.002)	(0.002)
farm					-0.0266***	-0.0262***
					(0.005)	(0.005)
production					-0.0193***	-0.0188***
					(0.003)	(0.003)
Constant	0.0060	0.2186***	0.2164***	0.2169***	0.2180***	0.2202***
	(0.004)	(0.008)	(0.008)	(0.008)	(0.008)	(0.008)
Observations	37,082	37,082	37,082	37,082	37,082	36,231
R-squared	0.0147	0.1593	0.1594	0.1608	0.1704	0.1665

*** p<0.001, ** p<0.01, * p<0.05, + p<0.10. Standard errors in parentheses. Metro residents with Secure Communities program (2013-2016). Model 6 limited to metros with 100+ Hispanics (N = 36,231). Models 4-6 include detailed Hispanic-origin fixed effects.