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Cautious Citizenship: The Deterring Effect of Immigration Issue Salience on Health Care Use and Bureaucratic Interactions Among Latino U.S. Citizens

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Abstract

Research shows that health care use among Latino immigrants is adversely affected by restrictive immigration policy. A core concern is that immigrants shy from sharing personal information in response to policies that expand bureaucratic monitoring of citizenship status across service-providing organizations. This investigation addresses the concern that immigration politics also negatively influences health care utilization among Latino U.S. citizens. One implication is that health insurance expansions may not reduce health care inequities among Latinos due to concern about exposure to immigration law enforcement authorities. Using data from the 2015 Latino National Health and Immigration Survey, we examine the extent to which the politics of immigration deters individuals from health care providers and service-providing institutions. Results indicate that Latino U.S. citizens are less likely to make an appointment to see a health care provider when the issue of immigration is mentioned. Additionally, Latino U.S. citizens who know someone who has been deported are more inclined to perceive that information shared with health care providers is not secure. We discuss how cautious citizenship, or risk-avoidance behaviors towards public institutions in order to avoid scrutiny of citizenship status, informs debates about reducing health care inequities.

Introduction

A major challenge to reducing health care inequities is that the costs of health insurance and health care deter people from using health care services for which they are eligible. Policy designed to subsidize coverage and expand eligibility, like the 2010 Patient Protection and Affordable Care Act (ACA), helps address this challenge. For example, by September 2015, two years since key provisions of ACA coverage were implemented, Karpman and Long (2015) report a 41 percent decrease in uninsurance among non-elderly adults. However, they also report that inequities in uninsurance rates remain disproportionately high for Latinos (23 percent) relative to non-Latinos (7 percent), even in Medicaid expansion states (Karpman and Long, 2015). Expansions and subsidies may fall short if implemented without adequately accounting for various social, economic, and political forces (Chin, Walters, Cook and Huang, 2007; Kilbourne, Switzer, Hyman, Crowley-Matoka and Fine, 2008; Minkler, 2010). One line of research that attends to such complexity focuses on the relationship between immigration policy and health (Hacker, Chu, Leung, Marra, Pirie, Brahimi, English, Beckmann, Acevedo-Garcia and Marlin, 2011; Rhodes, Mann, Siman, Song, Alonzo, Downs, Lawlor, Martinez, Sun, O'Brien, Reboussin and Hall, 2015).

Disparate paths of research addressing inequities in health care coverage (DeRose, Escarce and Lurie, 2007; Joseph, 2016; Castañeda and Melo, 2014), health care access and utilization (Beniflah, Little, Simon and Sturm, 2013; DeRose, Escarce and Lurie, 2007; Donelson, 2015; Toomey, Umana-Taylor, Williams, Harvey-Mendoza, Jahromi and Updegraff, 2014), and health outcomes (Cavazos-Rehg, Zayas and Spitznagel, 2007; Miranda et al., 2011; Rhodes, Mann, Simn, Eunyoung Song, Alonzo, Downs, Lawlor, Martinez, Sun, OBrien, Reboussin and Hall, 2015) conclude that immigration policy is health care policy. Studies pointing to this conclusion begin by noting that immigration politics structures health-related outcomes because nativity and citizenship criteria determine program eligibility (Gee and Ford, 2011; Zimmermann and Fix, 1998). A related claim is that policy exclusions lead immigrants to worry that using welfare programs, including public programs related to health, will risk

that they or those they are close to are detected or classified as an unauthorized immigrant, which may spoil efforts to adjust citizenship status, or result in deportation (Fix and Passel, 1999; Park, 2011). Scholars also contend that immigration and immigrant policies reinforce definitions of national belonging that conflate citizenship status and ethnicity, which then transfers stigma associated with unauthorized immigration to entire groups of people, regardless of their citizenship status (Chavez, 2008; Viruell-Fuentes, Miranda and Abdulrahim, 2012; Fox, 2016). These studies highlight the salience of immigration issues and suggest why some people might be cautious about sharing personal identifying information, even with health care providers.

These strands of research corroborate a narrative that immigrant advocates use in describing withdrawal from full engagement in public life among immigrants and their U.S.-born co-ethnics in response to anti-immigrant policies (Vallejo, 2010; Kalet, 2009; National Council of La Raza, 2014). However, evidence is sparse on the extent to which restrictive immigrant policy spills over to U.S. citizens and their propensity to access health care services. The presumption has been that U.S. citizens are not personally at risk by an environment of more exclusionary immigrant policies; therefore, their behavior surrounding health care services that they are eligible for should not be shaped by such policies. We also know very little about whether the concerns outlined above extend broadly to other service-providing bureaucracies, or deeply to the perceptions that citizens have about the integrity of health care professionals to guard their personal information. Reducing health care inequities may require the trust of patients at various steps in the provision of health care services, including the collection of basic demographic information that helps determine appropriate diagnosis, treatment, and access to needed social and health care resources.

To what extent does the salience of immigration issues deter U.S. citizens from using health care services? Who expresses skepticism about sharing personal identifying information in health care settings? In the sections that follow we answer these questions theoretically and empirically. We argue that one consequence of contemporary restrictive immigrant policies is that it psychologically conditions Latinos to navigate daily life around considera-

tions of immigration policy, for themselves, for those they are close to, and members of their social networks. The growth in immigration enforcement bureaucracies charged with identifying and detaining people in the interior of the U.S. (Koulish, 2010; Meissner et al., 2013), as well as efforts to police citizenship by officials outside of law enforcement (Sampaio, 2015), facilitates a psychological aversion to immigration-related issues. We contend that the rise of a restrictive immigrant climate has taught even Latino U.S. citizens to adopt strategies that minimize risk of exposing or experiencing harassment associated with questions about their citizenship status.

Using a population-based survey experiment, we test the claim that immigration issue concerns structure one's willingness to seek medical attention. By priming concerns over "immigration issues," as opposed to "health insurance" policy concerns, we expect respondents to be less willing to engage with health care providers. When we refer to priming, we are referring to raising the relevance and recency with which certain considerations become activated in one's working memory (Taylor and Fiske, 1978; Fiske and Taylor, 1991). As a broader analysis, we also compare the effects of priming immigration to other facets of quotidian life. Despite their U.S. citizenship, we find Latinos exposed to the immigration cue shy away from engaging with doctors, police, and to a lesser extent, educators. We also find that a personal connection to someone who has been deported is associated with the belief that personal information shared with health care providers is not secure. In the final section we discuss implications of our study for addressing health care inequities.

Issue Publics, Policy Feedback, and the Immigration-to-Health Care Link

Our core theoretical argument is that the issue of immigration guides the way that many Latinos think about and engage health care resources. We contend that Latino health care inequities and evaluating efforts aimed at addressing such inequities requires an understanding of how immigration and health care policy overlap. Connections between restrictive

immigration and health care policy in the U.S. relay messages to Latinos that they are unwelcome in America, and this connection is sustained by a decades-long protracted salience of immigration politics for Latinos. In this section we draw on the concept of issue publics, priming, and the framework of policy feedback to motivate hypotheses about the relationship between immigration and engagement with health care providers.

Immigration Issue Salience and Latinos

Rather than one public that is highly informed about politics in general, societies consist of smaller issue publics (Converse, 1964; Key, 1966). Demands on our time from other aspects of life are too onerous to afford attention to a wide range of politics (Rosenstone and Hansen, 1993; Verba, Schlozman and Brady, 1995). But most people pay attention to one or two issues. Groups of individuals who pay close attention to an issue, like health care or immigration, are attentive to these political issues because of their salience in day-to-day life. Compared to non-members, members of issue publics form strong attitudes about their issue and use that issue to orient their political behavior (Krosnick, 1990). Moreover, information in the political environment that raises the salience and accessibility of particular considerations – what social psychologists call priming (Taylor and Fiske, 1978; Fiske and Taylor, 1991) – can stimulate information collection for those with intense interest in that issue (Hutchings, 2003). Priming effects can also influence political judgments broadly. For example, Nicholson (2005) found that issues primed by statewide ballot initiatives frame the way people think about and choose candidates for federal offices, even when those issues are not featured in those contests or extend beyond the scope of responsibilities associated with those offices. These studies uncover the power of priming effects to transcend institutional boundaries, and suggest that members of issue publics may use their issue priorities to guide how they think about other issue areas.

For Latinos, the link between matters of immigration and matters of health care begins with the importance of immigration as an issue. Gallup's famed question that asks what is the "most important problem" facing the country, indicates that from 1994 to 2016, a mul-

tiracial nationally representative sample of Americans infrequently mention "immigration" as the most challenging issue, with most years registering less than 10 percent.[1] Unlike the perennial worry over jobs and the economy, only at key moments like the 2006 immigration rallies (19 percent), the 2007 congressional debates over national immigration reform (15 percent), and the 2014 surge in refugees from Central America seeking asylum in the U.S. (17 percent), did more than 1 in 10 Americans point to immigration as most important. In contrast, at six different points from 2004 to 2012, the Pew Hispanic Center observed no fewer than 27 percent of U.S. Latinos citing immigration as the top issue, with peaks of 37 percent in 2007 and 34 percent in 2012.[2] For about 1 in 3 Latinos, or three times as many compared to the general public, immigration is a chronically salient policy issue.

Latinos are a key constituency of the immigration issue public for a more basic reason. Fifty-two percent of Latino adults are foreign born, and 85 percent of all Latinos have at least one immigrant grandparent (Fraga et al., 2011). Migration into Latino communities in the U.S. has been sustained over a century, replenishing Latino ethnic identity and reviving anti-Latino nativist impulses (Gratton and Merchant, 2015; Jiménez, 2008). Unlike immigrants from various European countries, Latino incorporation traces through conquest in the 1800s, through migration preceding the Great Depression, to newcomers sponsored through the Bracero guest-worker program that operated from 1942 to 1964, and to present-day workers from Mexico and other Latin American countries responding to demand for cheap labor in the U.S. since the 1970s (Gutiérrez, 2004; Douglas S. Massey, 2002).

The salience of immigration for Latino U.S. citizens today also stems from their personal proximity to undocumented immigrants, who are the focus of the most intense debates in immigration politics. In a 2014 survey of Latinos, Lopez, Gonzalez-Barrera and Krogstad (2014) of Pew Hispanic Center found that 23 percent of U.S.-born Latinos, and 31 percent of U.S.-born children of at least one immigrant parent, reported personally knowing someone who had been detained for immigration-related reasons or deported in the past year. Responses collected one year later in the 2015 Latino National Health and Immigration Survey

[1] http://www.gallup.com/opinion/polling-matters/196733/gallup-review-americans-immigration-election.aspx
[2] http://www.pewresearch.org/fact-tank/2014/06/02/top-issue-for-hispanics-hint-its-not-immigration/

(LNHIS), a survey that the authors of this study helped to design and field, suggest a similar figure: 39 percent of Latino U.S. citizens, inclusive of immigrants who are naturalized citizens, personally know someone who has been deported. A major implication of deep and widespread personal connections to the immigration experience is that Latino U.S. citizens are chronically primed by immigration matters in everyday life, including matters related to health care.

The concepts of issue priming and issue publics help clarify the salience of immigration issues to Latinos and the potential connection to other issues. The key to understanding why immigration politics is an obstacle to reducing health care inequities is the historical overlap between immigration and welfare-state policies. The overlap between immigration and welfare policies reveals crucial lessons to Latinos about their place in America, both as suspect clients of the welfare-state, as well as default targets of immigration enforcement. Next, we draw on the concept of policy feedback to explain why immigration provokes a psychological aversion to engagement with health care-providing resources among Latinos.

Policy Feedback and Deterred Engagement with Health Care Providers

The policy feedback framework posits that policy creates new politics by influencing mass publics through "resource" and "interpretive" effects (Pierson, 1993). Policy investments in senior citizens (Campbell, 2002) and veterans (Mettler, 2005), for example, redistribute resources like money and time, which facilitate political participation. Policy also has interpretive effects that can reshape later rounds of policy processes by empowering some voices and discouraging others. Interpretive policy effects begin simply with policy that classifies people and codifies criteria, like nativity and citizenship, that determines who receives benefits and who receives burdens (Schneider and Ingram, 1993). Policy also imparts lessons through participation in public programs that signal who is a deserving member of the polity (Soss, 2002). Programs like GI Bill (Mettler, 2005), Social Security (Campbell, 2007), and Head Start (Soss, 2002), teach people that government is responsive and empower participants to engage in civic life. By contrast, "stop-and-frisk" policies and "show-me-your-papers"

laws that disproportionately target Blacks and Latinos communicate to members in those groups that government is not responsive to their needs and they are second-class members of society. Studies show that such laws nudge Latinos and African Americans to distrust and avoid government (Burch, 2013; Rocha, Knoll and Wrinkle, 2015; Walker, 2014; Weaver and Lerman, 2010). Here, we are interested in the interpretative lessons Latinos might glean from immigration policies and policies related to the provision of health care.

The social construction of immigrants and Latinos as less deserving stems from nineteenth century public charge laws used to regulate entry into the United States. The U.S. is a nation that welcomes immigrants, the reasoning goes, but the U.S. must secure its own welfare before aiding the less fortunate of other nations. Public charge laws also exclude persons alleged or convicted of a crime, a provision lawmakers connected to Mexican immigrants in debates producing the 1924 *Johnson-Reed Act* (Ngai, 2004). Importantly, *Johnson-Reed* introduced the concept of *illegal alien* (Ngai, 2004: 58), which "Europeans and Canadians tended to be disassociated from," but "became constitutive of a racialized Mexican identity and of Mexicans' exclusion from the national community and polity."[3] From the perspective of policy feedback, overlap between immigration and welfare-state policies reifies nativity and citizenship as markers that distinguish more from less "deserving" groups (Myers, 2007). Policy feedback theory anticipates that products of past policy, like the designation of *illegal immigrant* and public charge rules, can have long-lasting influence on future policy outcomes and how subsets of the population view government.

The policy roots of health care inequities that grow from policing citizenship and nativity remain with us today. For example, the ACA continues to invoke citizenship and nativity as boundaries of our social obligations (Joseph, 2016). Specifically, the health care exchanges created through the ACA call for local bureaucrats and computer systems to flag the citi-

[3] Consuls applied such laws in 1900s to exclude Mexicans (Daniels, 2005). As evidence that stereotypes of Latinos as lazy and criminal spread via bureaucratic practice, Fox (2012) cites public charge data from the U.S. Bureau of Immigration showing that between 1906-1932, Mexicans were deported at a rate that was higher than any other *single* nationality group.

zenship status of applicants. The ACA systems are extensions of exclusions codified in the 1996 Personal Responsibility, Work Opportunity and Reconciliation Act (PRWORA), which reinforced citizenship and nativity-based privilege by barring immigrants with authorized U.S. presence who arrived after the law passed from accessing public benefits for five years or until attaining proper status. Although numerous states countered the five-year residency ban by legislating immigrants back into the fold within their jurisdiction, the 1996 federal bar initially excluded authorized immigrants from Medicaid, Food Stamps and Supplemental Security Income. States have implemented similar exemptions to cover excluded populations under the ACA. Still, contemporaneous to PRWORA are policies like the 1996 Illegal Immigration Reform and Immigration Responsibility Act (IIRIRA) and the Anti-Terrorism and Effective Death Penalty Act (ATEDPA), which expanded U.S. immigration enforcement powers by removing key components of due process for non-citizens, increasing the set of deportable crimes, and allowing retro-active application of deportation proceedings for crimes previously adjudicated (Welch, 2002). Like PRWORA, IIRIRA and ATEDPA widen the gap in rights between noncitizen and citizen, setting the stage for the federal immigration enforcement of the 1990s that Watson (2014) and Vargas (2015) identify as deterring eligible people from using various welfare programs, including Medicaid.

More explicit ties between law enforcement officials and public health bureaucrats stretch back over a century. According to Molina (2006), rather than unsanitary living conditions of labor camps provided by railroad companies, public health workers advanced racist claims of Mexicans' aversion to bathing to explain the spread of typhus in Los Angeles in 1916. After blaming Mexican immigrant railroad workers for typhus outbreaks, public health workers enacted policy that required railroad companies to quarantine new workers from Mexico and report the names of all new hires to the Los Angeles Board of Health. As Molina (2006: 66) explains, "[q]uarantine guards, invested with the same legal power as deputy sheriffs, policed the quarantine observation facilities to prevent anyone from leaving," and "the expanding information exchange between public agencies and private companies placed Mexicans under an unprecedented level of surveillance." Through their authority to implement health policy,

public health officials associated themselves with immigration authorities. Ironically, by redirecting public health politics into immigration policy debates, health officials sowed the seeds of aversion towards their services, and potentially generated future Latino health care inequities.

Working with immigration authorities, relief bureaucrats divulged client information that guided mass deportation operations during the Great Depression. According to Fox (2012), Depression-era social workers ensured that poor European migrants settled into a world of relief and *inclusion*, while Blacks in the South and Latinos in the Southwest, by contrast, faced *exclusion* from relief. For Mexicans and U.S.-born Mexican Americans, stakes mounted when charity workers passed applicant information to immigration officials that led to *expulsion* from the U.S. As a strategy to thin welfare rolls, some relief agents like "the head of the Arizona Board of Public Welfare had no objections to letting immigration officers have access to the personal histories of all aliens applying for relief," while others like "the county board's lawyer advised against it, "on the ground that many deserving aliens would be afraid to ask for help"" (Fox, 2012: 151). As policy implementers, relief bureaucrats were aware of the "interpretive" effects – that is, the impact on public clients – of their choice to coordinate or not with immigration authorities. As targets of overlapping welfare and immigration policies, Latinos are very likely to have understood the stakes of turning to relief programs in this context, and gleaned a lesson to avoid public program participation.

Nativity and citizenship-based exclusions from public program benefits are not limited to the Depression-era past; nor is cooperation between local welfare bureaucrats and federal immigration authorities. In 1994 California voters enacted Proposition 187, an initiative restricting undocumented immigrants from using public schools and public hospitals. The measure mandated public workers report to officials any person who they *suspected* of being undocumented. By interpreting "a discrete act of violating immigration law" as "a criminal tendency in Mexicans" (Jacobson, 2008: 47), supporters of Proposition 187 reinforced the conflation of ethnicity with citizenship status, and revived the Depression-era practice of using local welfare bureaucrats as extensions of federal immigration enforcement authorities.

The courts deemed California's Proposition 187 unconstitutional. But, proponents left a legacy of arguments to justify policy prescriptions for public program exclusion and expulsion from the country, as well as reasoning to condone racial profiling as the means to achieve such ends. For instance, policy logic that conflates citizenship status with Latino identity motivated a health insurance fraud detection program targeting Latina women of child-bearing age at airports (Park, 2011: 2). The California Department of Health Services initiated this fraud detection program, but it was discontinued in early 2000s, according to Park (2011: 2), after investigators found program implementers "legally liable for overstepping the scope of their authority by attempting to influence federal [Immigration and Naturalization Services] decisions on whether to admit or deport immigrants as well as sharing confidential medical information in the process." Similarly, Proposition 187 replica legislation like Arizona's SB 1070 (2010), Alabama's HB 56 (2011), and Georgia's HB 87 (2011), invoke the term "illegal alien," as justification for service-providing bureaucrats to identify suspected undocumented immigrants, sustaining the spectre of racial profiling. Historically, policing citizenship happens at airports, welfare offices, on the streets when encountering police, all contexts where personal information must be divulged.

Sensitivity to racial profiling and policing citizenship is particularly acute for Latinos following post-9/11 public investments in operations that focus on deporting people from the interior. According to the U.S. Department of Homeland Security, the number of deportations from 2000 to 2015 exceeded the total number of deportations in the 20th century.[4] Record-level deportations are possible, in part, because programs like Secure Communities expand the geographic reach of immigration enforcement across and within each U.S. state by coordinating federal and local law enforcement resources (Cox and Miles, 2013; Pedroza, 2013; Meissner et al., 2013). As evidence that Latinos have internalized policy lessons from Secure Communities operations as predicted by policy feedback theory, Rocha, Knoll and Wrinkle (2015) find that deportations increase distrust in federal and local government among both immigrant and U.S.-born Latinos. Fueling criticism of interior-oriented immigration

[4] `https://www.dhs.gov/immigration-statistics/yearbook`

enforcement programs is evidence of racial profiling by local police who identify and detain Latino U.S. citizens, as well as persons without criminal records (Kohli and Chavez, 2013; PBS, 2011). In addition to bringing immigration authorities closer to their day-to-day life, interior operations are salient to Latinos because immigrants from Latin American countries represent 96 percent of deportations from the U.S. since 2010 (TRAC (Transactional Records Access Clearinghouse), 2014). In fact, after Arizona lawmakers passed a law mandating local police officers to inquire about immigration status during routine traffic stops (SB 1070), a 2010 survey of Latino voters in Arizona found that 72 percent said they believe that police primarily target Latinos (Barreto and Segura, 2010). A later 2011 survey of Latinos found that a majority of Latinos believe their group absorbs the brunt of restrictive immigration policies (Manzano, 2011). For Latinos, mass deportation is not an abstraction, it is a reality that fuels worry for relatives, friends, co-workers, and students across Latino communities.

Literature links mistrust of health care providers and health care systems to health care inequities. These inequities are shaped by histories of institutional and interpersonal racism from medical institutions towards racial minorities, as well as racialized power imbalances between predominantly white health care providers and racial minority patients (Smedley, Stith and Nelson, 2003; Sewell, 2015). In addition to the racializing role of public health institutions described above, studies indicate medical abuse of Guatemalans in the 1940s who were intentionally infected with syphilis and other infectious conditions (Reverby, 2011), and the forced sterilization of Californians in the early- to mid-twentieth century (Stern, Novak, Lira, O'Connor, Harlow and Kardia, 2017). These medical and public health abuses serve to widen the structural space between Latinos and health care systems to shape patient mistrust of providers and public health institutions. Indeed, Sewell (2015) reports that Latino adults are more likely than non-Latino White adults to express mistrust in their health care providers' medical decision-making and interpersonal competence. Similarly, qualitative research suggests that some undocumented immigrant youth perceive physicians to prioritize health care finances over just medical decision-making, contributing to mistrust in providers (Raymond-Flesch, Siemons, Pourat, Jacobs and Brindis, 2014). This evidence

base suggests that racial inequities in mistrust of health care providers may contribute to health care inequities.

The arc from historical to contemporary accounts shows that immigration and public health policy streams compound one another to "position [Latinos] as a stigmatized out-group in American social cognition (Massey, 2013: 267)." Past policy patterns that connect welfare stigma and social program deterrence give historical context to the 22 percent of Latinos in 2007 who indicated that they were less likely to use government services because of increased public attention to immigration issues (Pew Hispanic Center, 2007: 18). Importantly, this figure is the same for immigrant and U.S.-born Latinos, and was collected prior to the major expansions in interior-oriented immigration enforcement operations noted above (Golash-Boza, 2012; Koulish, 2010; Meissner et al., 2013). From the perspective of persons who are likely to be profiled, or personally know someone who is likely to be profiled or has been deported, the interpretive lessons from contemporary immigration and welfare policy is that local law enforcement is not worthy of their trust, nor are the people and organizations who keep personal information that might be turned over to law enforcement officials. As Zayas (2015: 81) notes, in response to restrictive immigration policy, Latino communities, "devise new ways of coping and techniques to evade the new restrictions and harsher penalties for immigration violations." Yet, as a source of factors that deter people from using health care services, we know very little about the extent to which the politics of immigration spills over to influence U.S. citizens.

Hypotheses

Our central claim is that overlap between welfare policy and immigration policy condition Latinos to avoid service-providing bureaucracies, including health care related services. We believe that inter-organization cooperation that directs contact with welfare-state officials to immigration enforcement authorities creates uncertainty about the intentions of social service bureaucrats. One plausible consequence of policy that creates uncertainty about interacting with social welfare organizations motivates our first and second hypotheses:

H1: Priming "immigration issues" deters Latino U.S. citizens from using health care services.

H2: More generally, priming "immigration issues" provokes Latino U.S. citizens' aversion to public service-providing officials.

We also argue that past experiences or anticipated experience with deportation undermines the credibility of social service organizations to keep the personal information of clients secure. The historical and contemporary policy confluences produced by immigration politics and welfare politics teach Latinos, even those who are U.S. citizens, to exercise caution in revealing, or at least to be sensitive to inquiries about, one's citizenship status or that of those with whom they are close. In the language of policy feedback, a potential interpretive effect of policing citizenship is that any bureaucrat who asks for personal identifying information may not be viewed as worthy of trust. We expect Latino U.S. citizen attitudes about the security of personal information in the hands of health care providers to be conditional on proximity to undocumented immigrants. We hypothesize the following:

H3: Latino U.S. citizens with personal connections to undocumented immigrants are more skeptical about the security of personal information shared with health care providers.

In the next section we introduce a set of original survey questions that help us take a closer look at how immigration politics spills over to health care for Latino U.S. citizens. Specifically, we use an experimental approach to evaluate the causal link between immigration and using health care services, as well as other service-providing organizations. We complement this analysis with a probe of why some people might be cautious about sharing personal identifying information.

Data and Methods

We take advantage of the 2015 Latino National Health and Immigration Survey (LNHIS), a survey sponsored in part by the Robert Wood Johnson Foundation (RWJF) Center for

Health Policy at the University of New Mexico, as well as collaborating scholars from the University of Michigan at the time of the study implementation. Latino Decisions, a firm specializing in developing and fielding surveys of Latinos, implemented the survey and worked in conjunction with contributing scholars from multiple universities to design the survey instrument. The survey is uniquely designed to assess many of the most pressing health and health care concerns of the Latino community, as well as a wide range of matters related to the issue of immigration. The ability to evaluate attitudes about health, health care, and immigration issues with the same sample makes this an ideal dataset for our investigation.

The Latino National Health and Immigration Survey (Total N=1,493) relies on a sample provided by a mix of cell phone and landline households along with web surveys. This mixed-mode approach improves our ability to capture a wide segment of the Latino population in the sample by providing a mechanism to poll the growing segment of the Latino population that lacks a land-line telephone as well as those who prefer to engage surveys on-line. This approach is sensitive to some of the major shifts in survey methodology driven by changes in the communication behavior of the population. More specifically, the increasing number of Americans who have decided to use a cell-phone for telephone communication while doing away with their land-line telephone motivates our expansion of sample beyond land-line households. A total of 989 Latinos were interviewed over the phone and an additional 504 Latinos were sampled through the Internet to create a dataset of 1,493 respondents. The web-based respondents were randomly drawn from the Latino Decision's national panel of Latino adults. The web mode allows respondents to complete the survey in either English or Spanish, and contained the exact same questions as the telephone mode. Respondents from the web are from a double-opt-in national Internet panel, and then randomly selected to participate in the study, and weighted to be representative of the Latino population.

All phone calls were administered by Pacific Market Research in Renton, Washington. The survey has an overall margin of error of +/- 2.5 percent with an AAPOR response rate of 18% for the telephone sample. Latino Decisions selected Puerto Rico and the 44 states with the highest number of Latino residents for the sampling design, which collectively account

for 91 percent of the overall Latino adult population. Respondents across all modes of data collection could choose to be interviewed in either English or Spanish. All interviewers were fully bilingual. Among those interviewed by phone, a mix of cell phone only (35 percent) and landline households (65 percent) were included in the sample, and the full dataset including both phone and web interviews were weighted to match the 2013 Current Population Survey universe estimate of Latino adults with respect to age, place of birth, gender, and state. We use these weights in the statistical regression analysis below. The survey was approximately 28 minutes long and was fielded from January 29, 2015 to March 12, 2015.

Our analysis is divided into three parts (one for each hypothesis), all of which focus on the 1,001 out 1,493 respondents who are Latino U.S. citizens, either naturalized or by birth. We evaluate the first and second hypotheses using a subset of 732 out of the 1,001 participants who are U.S. citizens and were included in a population-based survey experiment that we describe below in greater detail. The outcome variables of interest are self-reported health care use and engagement with other public service-providing organizations. We use all 1,001 participants who are U.S. citizens to examine the third hypothesis about attitudes regarding the nature of personal information in health care settings. Specifically, we explore the correlates of the belief that information that patients disclose to health care professionals is shared with others rather than kept private and secure.

Results

Population-Based Survey Experiment: The Effect of Cueing Immigration Issues

We begin our analysis with a priming effect experiment administered to a representative sample of Latinos. This powerful design combines internal validity that rules out plausible alternative explanations with external validity that assures the observed effects exist in the population of interest as a whole (Mutz, 2011). In a priming experiment the aim is to compare whether exposure to a particular stimulus, in this case a phrase, influences responses to a later query. By randomly assigning respondents to either "health insurance"

or "immigration issues" cues, we can compare which cue promotes or deters use of health care services, independent of other factors. We asked the following question: "When you are thinking about making an appointment to see a doctor or a nurse, or going to a clinic for health care, with all of the public attention to [**issue prime**], are you more likely to use health care services, less likely to use health care services, or it has not made a difference?"

Importantly, our selection of cues is designed to be subtle in two respects. First, because the items that are asked at the beginning of the 2015 LNHIS focus primarily on questions of health and health insurance (i.e. the ACA), the "health insurance" cue should provide continuity in the priming of considerations that prior survey items had already activated. For this reason, we anticipate that exposure to the phrase "health insurance" will activate considerations in a respondent's mind related to whether they have health insurance coverage, the costs of coverage, and perhaps the last visit to a health care provider or any wellness issue they are currently experiencing. Second, the "immigration issues" cue makes no explicit mention of immigration raids, detention, deportation, family separation, or any other outcomes associated with restrictive immigration policy. Instead, "immigration issues" also leaves open the possibility that expansive, welcoming, or otherwise positive considerations associated with immigration policy will be activated, including those related to "sanctuary cities," Deferred Action for Childhood Arrivals (DACA), Deferred Action for Parents of childhood Arrivals (DAPA), and the DREAM Act. For this reason, we anticipate that priming "immigration issues" will activate whatever balance of considerations a respondent holds in their memory about the issue of immigration.

If our claim that immigration provokes aversive responses is misguided, then we should see no difference in the reported anticipated use of health care services. In fact, our design does not preclude the possibility of observing the opposite, that "immigration issues" cues a greater expectation of using health care services. However, if simply mentioning the phrase "immigration issues" nudges U.S. citizens to shy away from health care providers, then we will have identified evidence consistent with the "interpretive effects" that policy feedback scholars would theorize in this case.

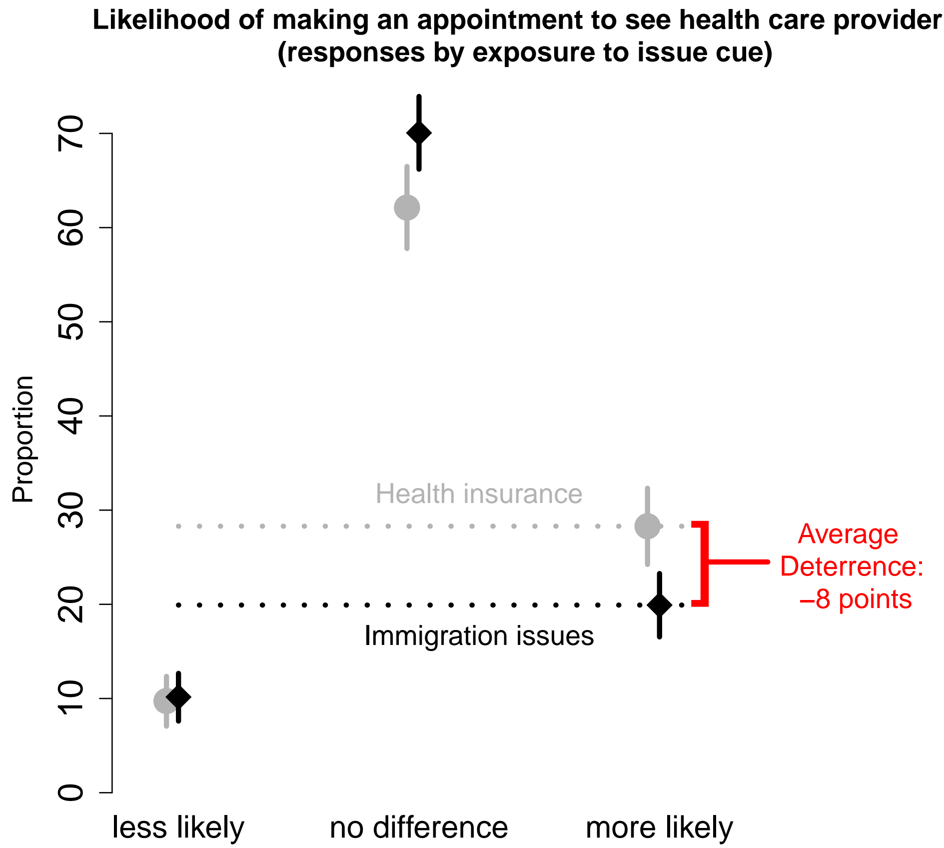

Figure 1: *Survey Experiment Results. Points represent the proportion of respondents who indicated how likely they are to make an appointment to see a health care provider. Dark diamonds represent responses from those who were randomly assigned to receive the "immigration issues" cue; gray circles represent the responses from those who were randomly assigned to receive the "health insurance" cue. Source: 2015 Latino National Health Immigration Survey*

The evidence presented in Figure 1 shows that 29 percent of the respondents who were randomly assigned to receive the "health insurance" cue say that they are "more likely" to make an appointment to see a health care provider. At 19 percent, the proportion expressing "more likely" is marginally fewer among respondents who were cued with "immigration issues" than for participants primed with the "health insurance," about 8.4 percentage points lower (according to a chi-square test: $\chi^2 = 6.95$, $p = 0.03$; and according to a chi-square goodness of fit test: χ^2=12.99, $p = 0.0015$). The difference in the effects of the cues is complicated by one point. About 70 percent of respondents cued with "immigration issues"

say "no difference" in the likelihood of making appointments with health care providers compared to 62 percent who hear "health insurance," a difference of 7.9 points. Still, the 90 percent confidence intervals for each proportion estimate overlap considerably in the "less likely" responses and overlap a bit in the "no difference" responses. The lack of confidence interval overlap in the "more likely" responses indicates a statistically discernable effect. Although we observe stronger evidence for the aversion hypothesis, there does appear to be suggestive evidence of either a resilience or pushback response to the "immigration issues" cue among Latino U.S. citizens.

Survey Experiment: Cautious Citizenship Towards Public Service-Providing Institutions

The 2015 LNHIS data also allows us to extend our analysis of this experiment by comparing responses to questions that immediately followed the experiment. Here, we probe how far immigration politics is pushing Latinos to practice cautious citizenship, or exercise reticence to engage in the public sphere and with public service-providing institutions in order to avoid scrutiny of their citizenship status or that of their family members or social networks. Immediately following the priming experiment, we administered a battery of questions that is designed to measure the extent to which people are practicing cautious citizenship more broadly. The activities and behaviors include contact with police, educators, and to facilitate comparison, health care providers, as well as a set of daily life activities like taking public transportation, picking up someone from the airport, driving a car, and renewing or applying for a driver's license. We find that 1 in 6 Latino U.S. citizens avoid contact with service-providing bureaucracies, including police, educators and health care providers. But does priming immigration induce aversion more broadly?

The magnitude of these effects is not trivial. On average, across the seven activities that we inquired about, ten percent of Latino U.S. citizens indicate avoidance when cued on "health insurance," as illustrated by the dashed gray line in Figure 2. For those exposed to the "immigration issues" cue, the average proportion expressing avoidance of daily-life

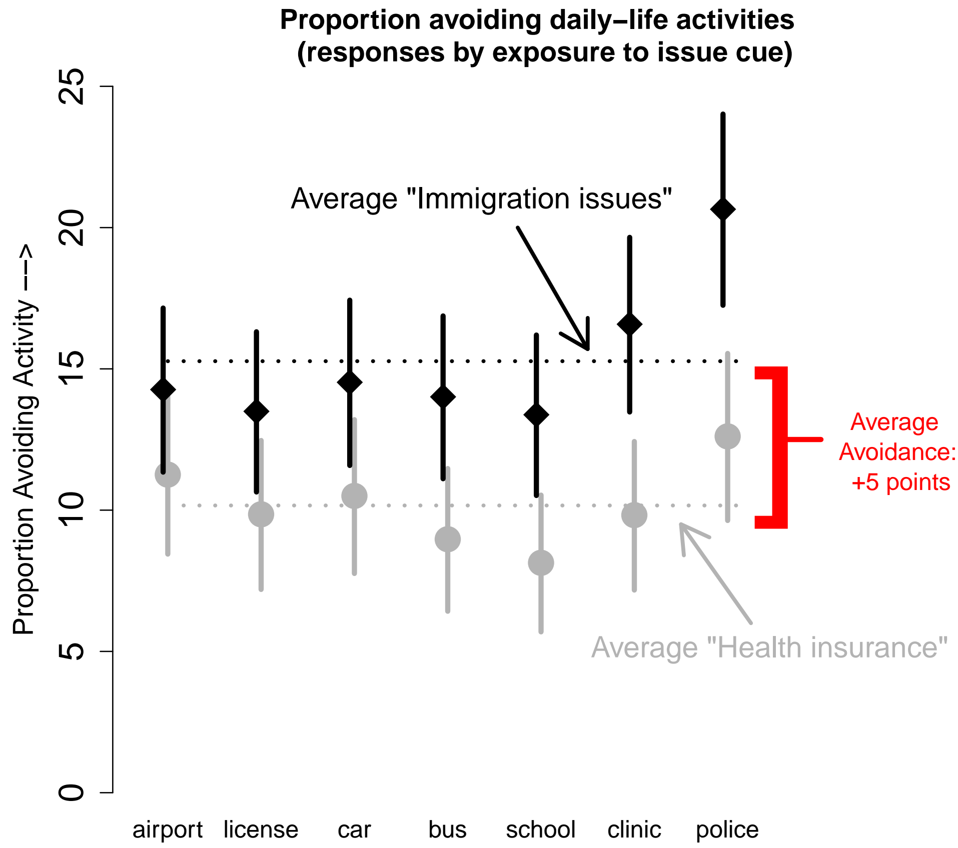

Figure 2: *Survey Experiment Results. Points represent the proportion of respondents who indicated that they avoid a daily-life activity in order to avoid scrutiny of their citizenship status. Dark diamonds represent the responses from those who were randomly assigned to receive the "immigration issues" cue; gray circles represent the responses from those who were randomly assigned to receive the "health insurance" cue. Source: 2015 Latino National Health Immigration Survey*

activities in order to avoid questions about their citizenship status is fifty percent higher, or five percentage points higher, as marked by the dashed black line at 15 percent. Priming "immigration issues" is particularly consequential for engaging various service providers. People appear to be deterred from educators, health care providers, and police. The mere mention of immigration issues prompts about 20 percent of Latino U.S. citizens to say that they avoid the police compared to 12 percent who are primed with health insurance, approximately an 8 point difference. Corroborating what the main survey experiment indicated, we find that 10 percent of those exposed to the "health insurance" cue avoid health care

providers, represented in Figure 2 with the x-axis label "clinic," versus 16 percent for those who were primed with "immigration issues."

The strength of this part of our analysis is that we can make a direct comparison of priming effects to other areas of life. Table 1 shows that the "immigration issues" cue generates an aversive response across seven different areas of day-to-day life, and the differences in proportion for various public services are robust to several statistical tests. That avoidance effects are greatest for local law enforcement agencies is not surprising because local police are increasingly implicated in the deployment of immigration enforcement operations that focus on identifying and detaining unauthorized immigrants in the interior of the country. However, when primed with the "immigration issues" cue, the extent of Latino U.S. citizens' deterrence from health care providers 6 percent is surprisingly similar to the avoidance reported with respect to police 8 percent, shown in Figure 2.

Table 1: Tests of difference in proportion of sample who report avoiding daily-life activities between those randomly assigned to the welcoming (Health insurance) and averse (Immigration issues) condition. Data analyzed is subset of U.S. Latino citizens from the Latino National Health and Immigration Survey.

	Chi-square	Kruskal-Wallis	Wilcox-Mann-Whitney	N
airport	0.221	0.221	0.221	729
license	0.125	0.125	0.125	727
car	0.101	0.101	0.101	725
bus	0.033	0.033	0.033	727
school	0.023	0.023	0.023	721
clinic	0.007	0.007	0.007	728
police	0.004	0.004	0.004	720

Figures represent p-values.

Privacy of Health Information

Building on answers to our first and second research questions, which suggest that after simply drawing their attention to the issue of immigration, Latino U.S. citizens indicate that they will steer clear of health care providers and other public service bureaucrats, we turn next to assessing how deep this disinclination goes in the context of health care. For our purpose here, we crafted an original survey question that simply asks: "Which of the following statements do you agree with most: Personal information I provide to my doctor

and health care providers is secure and kept private; or, Personal information I provide to my doctor and health care providers is sometimes shared and not always secure." In the statistical analysis below we assign a value of 0 to those who believe personal information is private and secure, and assign a value of 1 to respondents who believe that information is shared and not always secure. We model the more skeptical view – that information is not always secure – using logistic regression.

Our main explanatory variables are nativity and proximity to persons vulnerable to immigration-related detentions or deportation. We use the following question to measure nativity, "Were you born in the United States, on the island of Puerto Rico, or in another country?" Although all of the respondents in our analysis are U.S. citizens, this indicator, which we coded (0=U.S. born, 1=foreign-born), allows us to separate the foreign-born who are likely to be more directly sensitive to immigration enforcement. We include persons born on the island of Puerto Rico as U.S.-born, but conducted a robustness check and find no differences when categorizing Latinos born in Puerto Rico as born outside of the continental U.S., in all models. Expulsion is one of the most coercive responses from the state, and we expect that experience with deportation, even if it is experienced indirectly through social connections, casts doubt on the assurances that any organization may claim about keeping personal information secure. To explore the "interpretive effects" of the historical overlap between immigration policies and health care bureaucracy practices, we include an indicator of whether someone personally knows an undocumented immigrant (coded 1 if yes, 0 otherwise). With these data we can also probe further with an indicator that distinguishes those who personally know someone who has been deported (coded 1 if yes, 0 otherwise).

Our question on the security of personal information was asked prior to the experiment that we reported above, so we are not concerned about the effect of priming "immigration issues" versus "health insurance." However, we do want control of factors that are likely to correlate with skepticism of personal information security. For example, given that the majority of people who are deported from the U.S. are from Mexico — according to TRAC (Transactional Records Access Clearinghouse) (2014) that figure is 69 percent in 2012 and 65

percent in 2013 — we include an indicator for Mexico national origin, which we anticipate will be positively associated with a skeptical view. Because there is a stereotype that Americans do not have a non-English mother-tongue accent, we also include an indicator for whether the respondent completed the interview in Spanish language, with the expectation that this indicator is a proxy for who is most sensitive that their identity as an immigrant will be exposed, or sensitive that others will assume they are an immigrant. We use an item that asks respondents how many times they visited their primary care doctors or clinic in the past year. The specific survey question asks "Thinking about all of the members of your household, including adults and dependent children, approximately how many visits to primary care doctors or clinics have been made in the past year?" Given the question wording and variability of household composition, we standardize this variable with the total number of individuals in the household with the following survey item, "What is the total number of persons living in your household?" We anticipate that frequency of contact with health care professionals, on average, is negatively associated with a skeptical view, suggesting either a continuation of safe encounters, or a "selection out" of people who have been adversely affected or want to preempt adverse consequences. Studies of distinct, but related matters about social trust and trust in government, suggest a generally positive relationship between age and trust, even considering period and cohort (Jennings and Stoker, 2004; Robinson and Jackson, 2001; Sutter and Kocher, 2007). Our cross-sectional data limit our ability to disentangle age from period and cohort effects, however, we can include a measure of age in years. We also partial out a general sense of political sophistication and awareness about public policies using a 8-point ordinal scale of education level (1=no formal schooling, 2=Grades 1-8, 3=Some High School, 4=High School or GED, 5=Some College, 6=Bachelor's Degree, 7=Master's Degree, 8=Doctoral level), and a four-point ordinal measure of whether a person pays attention to politics (0 = "hardly at all," 1 = "only now and then," 2 = "some of the time," 3 = "most of the time"). Finally, we also include an indicator for gender (1 if respondent identifies as a woman, 0 for man), to proxy for gender differences in health care experiences and caregiving responsibilities related to taking family members to see health

care providers. Summary statistics for variables used in this analysis are in Table 2.

Table 2: Unweighted summary statistics of covariates in model of attitude that personal information shared with healthcare providers is not secure. Data: 2015 Latino National Health and Immigration Survey

Variable	N	Mean	St. Dev.	Min	Max
Believes information is not secure	1,001	0.283	0.451	0	1
Knows someone who is undocumented	1,001	0.571	0.495	0	1
Knows someone who has been deported	1,001	0.411	0.492	0	1
Immigrant	1,001	0.248	0.432	0	1
Spanish language interview	1,001	0.245	0.430	0	1
Mexico national origin	1,001	0.497	0.500	0	1
Doctor/clinic visits last year per family size	1,001	3.394	6.133	0	87
Highest education level completed	1,001	4.907	1.453	1	8
Income between $20,000 and $40,000	1,001	0.201	0.401	0	1
Income between $40,000 and $60,000	1,001	0.147	0.354	0	1
Income between $60,000 and $80,000	1,001	0.116	0.320	0	1
Income between $80,000 and $100,000	1,001	0.077	0.267	0	1
Income between $100,000 and $150,000	1,001	0.093	0.290	0	1
Income greater than $150,000	1,001	0.055	0.228	0	1
Income refused to report or missing	1,001	0.143	0.350	0	1
Woman	1,001	0.622	0.485	0	1
Attention to Politics	1,001	2.898	1.037	1	4
Age in years	1,001	45	17.237	18	98

Our analytical approach here is to delve deeper into the link between immigration and health care. Latino U.S. citizens are not the intended targets of restrictive immigration enforcement. However, we intend to evaluate the relationship between personal connections to those who are directly vulnerable to restrictive immigration enforcement and attitudes about the security of personal information that is shared in the context of a health clinic, health care providers office, or hospital. The results of our regression analysis are reported in Table 3. Statistical tests ($\beta = 0.407$; s.e. $= 0.156$) indicate that knowing someone who is undocumented is positively associated with the belief that personal information shared with health care providers is not secure (Model 1). Similarly, knowing someone who has been deported ($\beta = 0.456$; s.e. $= 0.152$) is also associated with the skeptical view (Model 2). These results are robust to alternative model specifications, including the inclusion and exclusion of alternative operationalizations of socio-economic status indicators, the inclusion of state-fixed effects, and additional indicators for national origin.

For the magnitude of the relationship we can translate these logit model coefficients into

predicted probabilities and relative risk figures. Visual evidence of the role of personal connections to undocumented and deported individuals is presented in Figure 3. The plots indicate that older age is positively correlated with skepticism about personal information ($\beta = 0.010$; s.e. $= 0.005$). For example, the upper-left panel traces the predicted probability of expressing skepticism about personal information being secure across the full range of age in years. The model predicts that people who know someone who is undocumented generally hold more skeptical views, no matter what their age. However, our ability to distinguish this difference or the actual relationship itself has considerable uncertainty as indicated by the overlapping 90 percent confidence bands across most ages. The exception is the estimate for individuals who are approximately 35 to 50 years of age, which includes the 45-year average age of respondents in our sample. The upper-right panel shows the model identifies distinctly greater skepticism among those who know someone who has been deported. Particularly for those people between the ages of 30 and 40, which coincides with the modal 30-39 years of age range of most deportees (TRAC (Transactional Records Access Clearinghouse), 2014), the probability of expressing skepticism is estimated to be between 19 percent and 22 percent for someone who knows someone who has been deported. By contrast, skepticism for this same age range is between 27 percent and 30 percent for people who do not know someone who has been deported. The bottom panels translate this relationship into relative risks. Our statistical model estimates that a forty-five year old, the average age from our sample, who knows someone who is undocumented, is about 12 percent at greater risk of expressing a skeptical view regarding personal information shared with health care providers. For that same forty-year old, knowing someone who has been deported, corresponds to a 21 percent greater likelihood of being "at risk" of skepticism.

Also noteworthy, the number of doctor visits per household size is negatively associated with the skeptical view of personal information security. One possible explanation is that doctor visits provide greater exposure to health care providers, and this familiarity may reduce uncertainty about the systems and actors in health care settings. Experience with completing forms, providing personal information, and critically importantly, coinciding with

the absence of encounters with immigration authorities, may boost confidence that personal information is, in fact, secure in the hands of health care providers.

Similarly, women were less likely to express skeptical views. To the extent that women are generally more likely to handle health care appointments and visits for themselves and family members, then this further corroborates the interpretation that repeat positive interactions facilitate familiarity and trust with health care related organizations and actors. Another possibility is that because 85 percent of deportees are men (TRAC (Transactional Records Access Clearinghouse), 2014), our model is picking up a broader skepticism that men hold in general about sharing personal information with any sources. Our data do not allow us to probe these explanations. However, the patterns in the relationships between skepticism of sharing personal information on the one hand, and personal connections as well these demographic factors on the other, do lend support to the idea that restrictive immigration policy can induce people to shy away from health care providing resources.

In a multivariate statistical model, we find no evidence of a relationship between either Spanish language interview or Mexican national heritage with the belief that personal information may be compromised in a health care setting. This non-finding may reflect the power of racial/ethnic profiling to influence the formation of attitudes for Latinos, in general.

Table 3: Logistic regression of the belief that personal information shared with health care providers is not secure, among Latino U.S. citizens.

	Information is Not Secure = 1	
	(1)	(2)
Knows someone who is undocumented	0.407*	
	(0.156)	
Knows someone who has been deported		0.456*
		(0.152)
Immigrant	−0.098	−0.080
	(0.184)	(0.184)
Spanish language interview	−0.144	−0.095
	(0.200)	(0.198)
Mexico national origin	0.136	0.149
	(0.151)	(0.151)
Doctor/clinic visits last year per family size	−0.037	−0.038
	(0.020)	(0.021)
Highest education level completed	−0.084	−0.096
	(0.064)	(0.064)
Income between $20,000 and $40,000	−0.058	−0.054
	(0.249)	(0.249)
Income between $40,000 and $60,000	−0.263	−0.256
	(0.274)	(0.275)
Income between $60,000 and $80,000	0.245	0.274
	(0.290)	(0.290)
Income between $80,000 and $100,000	−0.567	−0.482
	(0.356)	(0.355)
Income between $100,000 and $150,000	0.131	0.210
	(0.322)	(0.323)
Income greater than $150,000	−0.439	−0.386
	(0.452)	(0.451)
Income refused to report or missing	0.009	0.017
	(0.261)	(0.261)
Woman	−0.451*	−0.427*
	(0.149)	(0.149)
Attention to Politics	0.056	0.060
	(0.080)	(0.080)
Age in years	0.010*	0.011*
	(0.005)	(0.005)
Constant	−1.028*	−1.013*
	(0.426)	(0.423)
Observations	1,001	1,001
Log Likelihood	−536.980	−535.151
Akaike Inf. Crit.	1,107.960	1,104.301

*p<0.05
Note: Baseline for comparison of national origin indicators is “Mexico”
Baseline for comparison of income indicators is “less than $20,000”
Source: 2015 Latino National Health and Immigration Survey

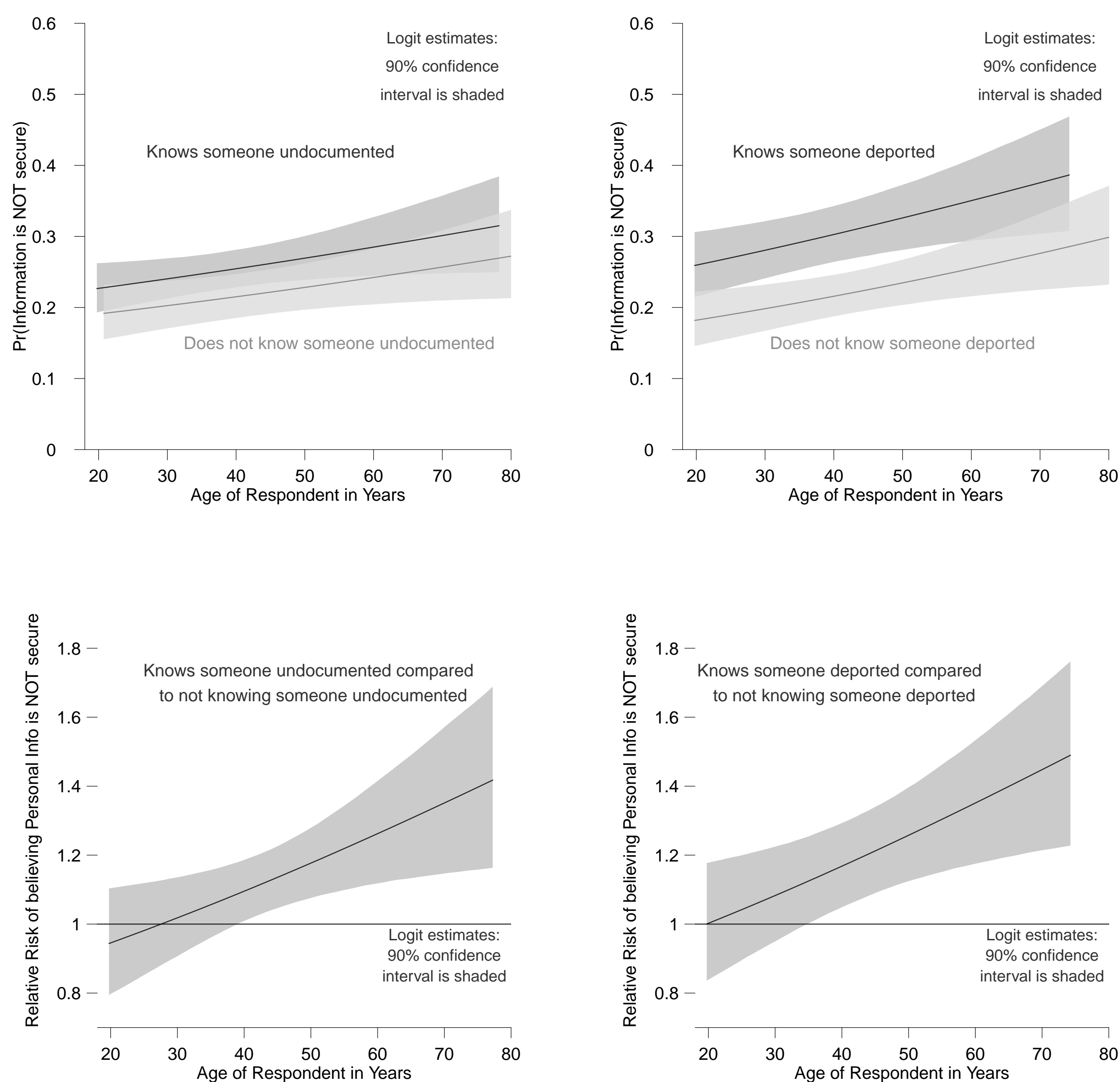

Figure 3: Plots in left column show the relationship between knowing someone who is undocumented and the belief that personal information shared with health care providers is not secure. Plots in right column show the relationship between knowing someone who has been deported and the belief that personal information shared with health care providers is not secure. The top row depicts the results of 10,000 simulations to calculate predicted probabilities, and the bottom row traces the relative risk of knowing or not knowing someone who is undocumented/deported. Data: 2015 Latino National Health and Immigration Survey

Conclusion

On March 6, 2014, an interview of President Obama aired on Univision, a Spanish language cable network, where he encouraged Latinos to sign up for health insurance using the online marketplace.[5] The appearance was part of a broader effort to secure the success of his marquee domestic policy, the ACA, which depended on a substantial number of uninsured individuals to enroll in a health insurance plan. President Obama explained that, "part of the reason that it's so important for us to reach out to the Latino community is the Latino community is the most likely to be uninsured." For a brief moment the interview became tense when Univision anchors played a video showing an undocumented woman afraid to enroll her U.S. citizen children for health insurance. She was concerned that immigration officials would use personal information collected through the online marketplace to deport her. President Obama assured the anchors and the audience that "none of the information that is provided in order for you to obtain health insurance is in any way transferred to immigration services." However, one observer remarked: "[Latino families] hear [the President's] assurance, but because of the level of deportations that have happened, there's a lot of families that don't know whether they can trust that assurance" (Easley, 2013). For Latinos, the hyper-saliency of immigration trumps health and health care issues.

At the heart of President Obama's outreach campaign is a desire to reduce health care inequities. By expanding and subsidizing health insurance coverage, the ACA addresses costs as a major deterrent of access and use of health care services. However, the exchange above reveals another deterrent – widespread concern among Latinos about a general overlap between immigration policy and health care policy. While the concern may be concentrated among Latino immigrants, and especially undocumented immigrants, the woman's testimony indicates that Latino U.S. citizens, in this case her children, are also stakeholders. The exchange also locates uncertainty about the connection between immigration and health

[5]For the full transcript of the interview see: `http://communications-univisionnews.tumblr.com/post/79266471431/univision-news-transcript-interview-with`

care policies at points where personal information is shared in the course of applying for health care and social services. She did not use the language of policy feedback, but her worry suggests that she has internalized policy lessons that are similar to those learned by Latinos from past overlap between health, health care and immigration policies. The implications for health care inequities are that even if expansions and subsidies do their part to reduce costs, the politics of immigration may stymie engagement with health insurance marketplaces and the use of health care services in ways that are not presently addressed by health care reformers or health care management systems.

But to what extent do these dynamics spill over to Latino U.S. citizens? Our aim to assess the connection between the politics of immigration and use of health care resources began with an original, simple survey experiment. We extended our experimental analysis to compare the effects of immigration on engaging other public services, and followed that up with a deeper dive into attitudes about the security of personal information that is shared with health care providers.

As we might expect from most exercises of this sort, the evidence is qualified. First, our experiment indicates a causal connection between the issue of immigration and the use of health care resources. By randomly assigning people to receive an "immigration issues" cue, we learned that Latino U.S. citizens are nudged away from making appointments to see health care providers. Second, our subtle prime of immigration considerations continues to provoke an averse response, as indicated by a greater proportion of people who withhold from fully engaging in daily life activities in order to avoid scrutiny of their citizenship status. The psychological aversion primed by "immigration issues" appears to operate to greater extent for encounters with police, and to lesser extent for encounters with educators. We view this as evidence that Latino U.S. citizens practice cautious citizenship, and they do so broadly. Like previous studies, this one analysis suggests a broad effect of immigration policy, but it speaks less to whether these concerns about immigration are also related to what happens once people do make appointments to see a health care provider.

Police, educators, and health care providers are all examples of service-providing bureau-

crats that are difficult to interface with anonymously. This point motivated us to further interrogate the role of sharing personal information with health care providers. Our contribution on this front reveals the depth of the connection between immigration politics and health care. Skepticism about the security of personal information in the hands of doctors, nurses, and health care administrators is correlated with knowing someone who has been deported. Clearly, for some individuals the stakes may be revealing one's citizenship status to law enforcement officials, thus jeopardizing their unlawful residence in the United States. For others, it may be a move to protect family members who have authorized presence in the U.S., or avoid family separation. Whatever the case, these indirect experiences with immigration enforcement parallel the reticence to engage public programs and government that scholars in the policy feedback tradition anticipate and have found in other contexts. In this case, however, we see that public policy (immigration) appears to inform attitudes about professionals that are seemingly unrelated to that particular policy (health care providers), and it does so among people who are not supposed to be the direct targets of that policy. These results build on and extend considerably the literature regarding racial inequities in provider trust, one important factor that contributes to health and health care inequities. The findings from our investigation suggest that racializing policies shift propensity for Latino U.S. citizens to make an appointment to see a health care provider, and proximity to undocumented immigrants shape their concerns that information shared with health care providers is not secure.

Yet, the subtle cue in our experiment does not fully capture the range of existing immigration policy. Our strategy fulfilled our purpose to test the "balance" of considerations that would be cued by the phrase "immigration issues." Documenting the causal effects of explicitly expansive and explicitly restrictive immigration policy is an exercise for future experimental analysis. Although our experiment takes place over the course of a telephone or web-based interview, analogous field experiments may present themselves as national and sub-national immigrant policy shifts. Whatever the direction that immigration politics takes, it is very likely that immigration will remain a highly salient issue for Latinos. As

President Obama exited the White House his successor entered after a campaign of promises for more restrictive immigration policy, suggesting that the dynamics identified in this study will remain relevant to the provision of health care, and by extension, to the study of health and health care inequities.

The statistical results suggest that skepticism about the security of personal information shared with health care providers is about more than just a general distrust of health care providers. The correlation to knowing someone who has been deported fits the narrative that at least some Latinos live by a calculus to manage the risk of exposing one's citizenship status. Still, our analysis does not rule out the possibility that the mechanism through which distrust develops is the performance of health care providers. Nevertheless, for many health care providers, Latinos represent a growing share of their patient roster. And, from what we learned in this investigation, the salience of immigration follows people into their interactions with health care providers. If trust in health care providers corrodes in response to linkages with immigration policy, then where does that leave doctors, nurses, health care administrators, and hospital managers who are taking on the mission to reduce health care inequities?

One strategy that health care providers can adopt is to provide all patients with assurances at the point of intake that their personal information is kept private and secure and implement policies and practices that support this assurance. To the extent that this is a promise that they can keep, they should announce this commitment broadly and frequently. A second strategy is to coordinate this commitment with other organizations and services like local immigrant advocacy organizations and local police whose job may also be hampered by spillover from immigration politics. In some ways doctors are like police: both solve puzzles that involve humans in need of help, and their successes are shaped by the extent to which individuals and communities trust them and their institutions. Perhaps doctors can learn from local law enforcement agencies that have experience dealing with publics that are reluctant to call them for services or disclose information that helps them do their job. A third strategy is to "go public" with the issue. Health care providers are rep-

resented by various interest groups and associations like the American Medical Association and American Nurses Association, and elected officials are attentive to constituent concerns, especially those that are coordinated and persistent. If the politics of immigration is keeping Latinos from seeing their doctors and nurses, or discouraging Latinos from providing all the information that is needed to assign appropriate diagnoses and treatments, then doctors are stakeholders in immigration policy. By introducing such complications to the provision of health care, we suspect that the politics of immigration injects a new source of inefficiency and greater costs associated with delayed treatment. For these reasons the political arena may be a fruitful place for doctors and nurses to explain that immigration enforcement is interfering with their ability to deliver services, and makes the services they do deliver more expensive.

A central challenge of efforts to achieve health equity is that many of the organizations and policies that address health care-related issues operate in a broader institutional and policy context. This investigation joins a growing number of studies that are uncovering how immigration policy is health care policy. Any effort to address health care inequities is impeded without an understanding of how contemporary immigration politics conditions people to stay away from or distrust interactions with health care providers.

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