Study shows how U.S. immigration policy can have domestic health effects

July 30 2021

Credit: CC0 Public Domain

After a controversial federal order suspending travel to the U.S. from seven Muslim-majority countries was signed in 2017, the number of visits to emergency departments by Minneapolis-St. Paul area residents

from those nations increased significantly. And that development followed an already marked increase in primary care visits by members of the same population, which began in November 2016 following an election season characterized by significant anti-immigrant rhetoric.

That's according to a new *JAMA Network Open* study led by a Brown University health services researcher in collaboration with a group of public health and health services researchers from across the country. Those changes in health care utilization likely reflected elevated cumulative stress due to an increasingly hostile climate toward Muslims in the U.S., the authors say.

"It's clear that U.S. immigration policies can have significant effects on the health of people living here in the U.S.," said Dr. Elizabeth Samuels, corresponding author of the study and an assistant professor of emergency medicine at Brown University's Warren Alpert Medical School. "In this case, we saw a rise in emergency department visits among people from nations targeted in the ban as well as a rise in missed appointments from people from Muslim majority countries not named in the ban. I think that that's indicative of the kind of rippling health effects these types of policies can have."

On Jan. 27, 2017, one week after taking office, President Donald Trump issued Executive Order 13769, "Protecting the Nation from Foreign Terrorist Entry into the United States." Samuels said that when the order took effect, she and other medical colleagues wondered how the immigration policy might affect the health of people from Iran, Iraq, Libya, Somalia, Sudan, Syria and Yemen (the included countries) living in the U.S.

Similar policies have exacerbated levels of discrimination, hostility and "othering" that Muslims in the U.S. experience, she said, and research has shown that increases in hate crimes and hostility directed toward

Muslims negatively impacts their health. For example, Samuels notes, after the Sept. 11 attacks, rates of anxiety, depression and low birth weights increased among Arab Americans.

However, because of the way demographic and health data is collected in the U.S., Samuels wasn't sure if the changing health behaviors of Muslims in the U.S. was even something that could be measured, because health care administrative databases are not mandated to collect information on religious affiliation.

"One of the biggest challenges for those of us who work in Muslim communities is to try to figure out how to find Muslim Americans within U.S. health care databases, because unlike race, ethnicity or even sexual or gender identity, religious identity is not routinely captured or recorded," said Dr. Aasim I. Padela, a study author and professor of emergency medicine, bioethics, and the medical humanities at the Medical College of Wisconsin. "And in an emotionally-charged post-9-11 environment in which Muslims are often stigmatized, there's actually a disincentive to offer up this kind of information."

The result is that while there are smaller studies involving these communities, there is a lack of population-level data. But in researching potential study populations, Samuels discovered that health care provider and insurance company HealthPartners collected country of origin data on patients visiting clinics and hospitals in the Minneapolis-St. Paul area, home to the largest Somali Muslim community in the U.S.

In conducting the study, the researchers analyzed the HealthPartners database and grouped 252,594 patients receiving care between January 2016 and December 2017 into three groups: adults born in one of the nations included in the executive order; adults born in Muslim-majority nations not listed in the order; and U.S.-born non-Latinx adults. They compared changes in primary care and emergency department visits,

missed scheduled clinic appointments, and visits they categorized as "stress-responsive," among individuals from nations included in the executive order from one year before to one year after it was issued.

They found that after the order was issued, there was an immediate increase in emergency department visits among people from the included countries. The study estimates that 232 additional emergency department visits were made by people from Muslim ban-targeted nations in the 360 days after the Muslim ban was issued beyond what would have been estimated if emergency department utilization had followed a trend similar to that seen by U.S.-born non-Latinx adults. This was especially pronounced in the first 30 to 60 days after the ban was issued.

Study results suggested that adults born in Muslim-majority nations not listed in the order missed approximately 101 additional primary care appointments during the time period beyond what they would have expected to miss if following the trend of non-Latinx U.S.-born people.

Some forms of health care utilization were also noted to change even before adoption of the ban. Clinic visits and stress-related diagnoses increased before the executive order was issued, most notably after the 2016 presidential election.

Despite the statistically significant increase in emergency visits, Samuels says she was surprised not to see larger overall health effects, especially related to stress, in the wake of the order. In the study, the researchers discuss why this might be, and how potential changes in health care utilization after the order may have been attenuated by factors specific to Minneapolis-St. Paul. The very factor that made it possible to focus on this population in the study—a concentrated, civically engaged community of Somali-Americans and Muslims—may have also offered protection against political stressors, they note, as the ability to secure

benefits through social structures, like community associations or civic organizations, may attenuate the negative health impacts of discrimination.

Padela said that while discrimination is known to impact health care behaviors, measuring the health effects of discrimination in an aggregate fashion, especially for a population that isn't quantified by health care groups, is tricky.

"This study was able to not only identify a Muslim community within the health care system, but also to analyze their health care behaviors before and after a policy-level decision widely recognized as discriminatory," he said.

More information: Elizabeth A. Samuels et al, Health Care Utilization Before and After the "Muslim Ban" Executive Order Among People Born in Muslim-Majority Countries and Living in the US, *JAMA Network Open* (2021). DOI: 10.1001/jamanetworkopen.2021.18216

Provided by Brown University