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Anti-Immigrant Rhetoric and Policy as Manifestations of Structural Racism—Implications for Advancing Health Equity

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Recent work by researchers and policy makers has argued that solutions to racial inequities in health must target manifestations of structural racism, such as barriers to economic mobility, high-quality education, health care, and high-paying jobs, and the context and policies that allow racial inequities to persist.¹ Despite this long-overdue reckoning with the pervasiveness and consequences of structural racism in the United States, there are significant challenges to conducting research on discriminatory rhetoric and policies that target particular groups and are associated with health outcomes. Both the 2016 presidential election and subsequent Trump administration were characterized by anti-Muslim and anti-immigrant rhetoric as well as corresponding policy actions targeting individuals from Muslim-majority and Latin American countries, most notably Executive Order (EO) 13669, commonly referred to as the “Muslim Ban.” In an innovative analysis, Samuels and colleagues² evaluated the association of the “Muslim Ban” with health care utilization among adults from Muslim-majority countries residing in Minneapolis and St. Paul, Minnesota, examining changes in primary care and emergency department (ED) visits before and after the ban was enacted. The Minneapolis-St. Paul metropolitan area is home to the largest Somali Muslim population in the United States, one of the Muslim-majority countries included in the ban. Leveraging data from 252,594 patient records from HealthPartners, a major health care and insurance organization, the analysis examined health care utilization among individuals born in EO-targeted nations, those born in Muslim-majority nations not targeted by the EO, and non-Latinx patients born in the United States. The study found that primary care visits increased sharply after the 2016 election for individuals born in Muslim-majority countries not targeted by the EO. After the ban, there was an immediate increase in ED visits among individuals born in EO-targeted nations, with the largest differences observed in the first 30 to 60 days after issuance of the EO. There was also an increase in the number of missed primary care visits among individuals from Muslim-majority countries not included in the ban after the EO was enacted. These findings represent significant changes in health care utilization. Samuels et al² estimated that individuals from Muslim-majority nations not targeted by the ban missed approximately 101 additional primary care appointments beyond what they were expected to miss in the absence of the EO. Similarly, approximately 232 additional ED visits were made by individuals born in countries targeted by the EO in the 360-day period following the ban, above what would have been expected in the absence of the EO. Samuels et al² argue that the study findings of health care utilization outcomes among individuals from both Muslim-majority countries included and not included in the EO likely reflect elevated cumulative stress across Muslim populations due to the overall sociopolitical context rather than 1 particular policy.

The study by Samuels et al² offers critical insights into the health implications and structural foundations of anti-Muslim discrimination, which is an understudied topic despite decades of increasing government surveillance and profiling of Muslims in the United States.³ Another recently published study on the impact of the “Muslim Ban” found higher odds of preterm birth among women from banned countries after the EO was issued.⁴ Research with Latinx populations confirms the adverse associations of discriminatory immigration policies with health, ranging from psychological to birth outcomes.⁵ The study by Samuels and colleagues² contributes to gaps in the literature on the impacts associated with anti-Muslim and anti-immigrant discrimination, which, to date, has largely focused on adverse psychological outcomes,³ and is the first to examine the

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association of anti-Muslim policy initiatives with health care utilization, to our knowledge. An important implication of the analysis by Samuels and colleagues\(^2\) is the potentially cumulative associations of both negative rhetoric and specific policy actions with health outcomes for Muslim communities and other marginalized populations, such as Latino, African American, American Indian, and Asian populations. Negative national rhetoric regarding Muslims may also have an impact across religious groups; for example, Sikh communities and South Asians more broadly faced discrimination and hate crimes after the events of September 11, 2001. One study found that Middle Eastern, North African, and South Asian Sikh mothers were more likely to have low birthweight babies in the 37 weeks after September 11, 2001, relative to the same period 1 year prior.\(^6\) Given the increase in anti-Asian American hate crimes unfolding during the COVID-19 pandemic, associated with increased anti-Asian rhetoric and perceived linkages between the COVID-19 virus and individuals of Asian descent,\(^7\) it will be similarly important to situate structural racism and its associated health outcomes for this community in future research efforts.

A notable innovation of the study by Samuels and colleagues\(^2\), given limited data on religious affiliation in most publicly available data sets and surveillance systems, is the use of patient data from an electronic health record system that included patients’ country of birth. The analysis leveraged big data to analyze the association of the ban with both patients from Muslim countries specified in the ban and patients from other Muslim-majority countries. Most of the study’s sample was of Somali origin, and as Samuels et al\(^2\) note, future research should examine and account for the diverse racial and ethnic compositions of Muslim communities, their varying migration trajectories, generational status, and differences in racialized identities. Systematic efforts to collect data on discrimination, religious identity, and disaggregated categories of race and ethnic subgroup affiliation are needed to advance research on Muslims and other stigmatized populations, such as Sikhs, South Asian Americans, and Arab Americans. Improvements in the measurement of discrimination across communities, such as a 2021 study by Ahmed\(^8\) validating a scale assessing anti-Muslim discrimination, are complementary to these efforts, and will enhance our understanding of the effects of structural racism on health.

It is encouraging that leadership at the National Institutes of Health and the Centers for Disease Control and Prevention have publicly identified racism as a fundamental driver of health disparities and advanced initiatives to support research on the impact of structural racism and discrimination on minority health and health disparities. The study by Samuels and colleagues\(^2\) serves as a model for understanding how structurally embedded discriminatory sociopolitical contexts may impact health, and point toward the need for further research understanding the effects of structural racism in Muslim, Arab, Asian American, and other understudied communities.
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