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The Health Care System and Racial Disparities in Maternal Mortality

By Theresa Chalhoub and Kelly Rimar May 10, 2018

In a series of publications, the Center for American Progress has begun to examine the multifaceted issue of disparities in maternal and infant mortality for African American women and infants. African American women are three to four times more likely to die from childbirth than non-Hispanic white women, and socioeconomic status, education, and other factors do not protect against this disparity. Instead, sexism and racism are primary drivers.[1] While such disparities have a number of dimensions, a main area for reform is the current structure and function of the health care system. Although the Affordable Care Act (ACA) created historic advances in health insurance coverage, millions still go without health insurance each year, many of them people of color. In addition, those with insurance often still have trouble accessing high-quality, patient-centered care. The following brief begins to outline the complex and various factors within the health care system that likely contribute to such maternal mortality disparities for African American women.

Several recent stories show the practical effects of inequality and illuminates how the health care system fails to listen to African American women's health concerns. The story of Dr. Shalon Irving provides just one example.[2] In January 2017, just three weeks after giving birth, Dr. Irving died of complications related to high blood pressure. Irving—an epidemiologist at the Centers for Disease Control and Prevention and a lieutenant commander in the U.S. Public Health Service—had dedicated her career to investigating public health disparities. Pregnancy had been a challenge for Shalon, who suffered from a blood disorder that caused clotting and discomfort. However, Shalon remained vigilant in monitoring her health throughout her pregnancy, and delivered her daughter, Soleil, via cesarean section at 37-weeks. Though the delivery had been a success, healing from the operation proved to be a slow process and, among other things, her blood pressure fluctuated in the weeks after she gave birth. Certain that something was not right, Shalon continued to follow-up with her doctors, although her health continued to deteriorate. On January 28, 2017, hours after returning from an appointment with her doctor, Dr. Shalon Irving collapsed at home and died at age 36, leaving behind her infant daughter.

Racial disparities in risk factors related to pregnancy—such as hypertension, anemia, and gestational diabetes—exist and are exacerbated by stress related to racial inequality and often inadequate health care, which is not in tune with African American women's needs. However, many physical health factors do not explain the disparity for African American women in maternal mortality. Studies have shown that smoking and drug abuse, as well as obesity, do not explain why more African American mothers die from pregnancy.[3] While there are a number of areas for reform within the health care system, key steps in reducing such devastating disparities include increased access to health insurance, quality health care, and providers that practice patient-centered and culturally sensitive care.

Access to health insurance

Access to health insurance is often the first step in receiving quality, affordable health care. The ACA made incredible progress in increasing the number of people with affordable health insurance, with roughly 20 million more people obtaining insurance under this law.[4] This leap forward has helped millions access the health care they need, and recent studies have shown that, while access to health insurance does not eliminate disparities in maternal and infant mortality, it may play a role in healthier pregnancies and births.

One such study examined the effect of Medicaid expansion—a provision in the ACA where states could expand Medicaid coverage to individuals up to 138 percent of the federal poverty level (FPL)—on infant mortality.[5] It found that, between 2014 and 2016, infant mortality rates fell in states that had expanded Medicaid, while rates rose in states that did not. In addition, in states that did expand Medicaid, infant mortality for African American infants fell by more than twice the rate that it did in non-Medicaid expansion states. The authors of the study suggest that increased access to health care services and contraception may have been factors in the decrease in infant mortality in Medicaid expansion states, allowing women to both access services before and after their pregnancy as well as better plan their pregnancies. Another study found that the ACA provision allowing young adults to stay on their parents' health insurance plan until age 26 was associated with increased early prenatal care, more adequate prenatal care, and a lower rate of preterm birth.[6] As such coverage gains remain in place longer, more data will be available to evaluate the effects of increased access to health insurance on health outcomes.

Access to health care

Even with health insurance, accessing timely, culturally appropriate, quality care can often be difficult. Many women, especially those in rural or underserved areas, lack physical proximity to doctors or hospital maternity wards to receive pregnancy care or

deliver a baby. Access to additional services, such as specialists, reproductive health care, and mental health care, can also be of concern. Even when physical access to needed providers and facilities is available, cost can often stand in the way for many women to receive necessary care.

Access to providers, hospitals, and maternity wards

In many areas, access to hospital maternity wards, OB-GYNs, and other medical professionals is scarce, making it much harder for women to access timely prenatal care and find a quality facility to deliver their child. For example, Washington, D.C., just closed two maternity wards—Providence Hospital and United Medical Center—that primarily served lower-income women.[7] The closure of these maternity wards leaves many women without options as they try to navigate where to access care and deliver their babies. It also jeopardizes the continuity of care that is often critical to having a healthy pregnancy. Seeing the same provider throughout a pregnancy allows doctors to better manage any health conditions and creates a relationship between a doctor and patient that is critical to receiving the highest-quality care. Similar hospital closures across the country, or general lack of options and facilities, are leaving many women with few or no good options.

Mamatoto Village: Helping families of color have positive birth experiences

Mamatoto Village is a nonprofit organization in Washington, D.C., that is dedicated to supporting women of color during pregnancy and postpartum as well as empowering them to be providers in the maternal health space. Mamatoto Village offers a number of trainings to those interested in community health work, including courses in perinatal health work, perinatal family support, community birth work, and lactation support. Through its family-centered approach, Mamatoto Village works to improve the experiences of women, families, and babies. In 2017, 74 percent of women working with Mamatoto Village gave birth vaginally, and there were zero infant or maternal losses. Ninety-two percent of women with labor support attended their 6-week postpartum follow-up appointment, and 89 percent of women were able to initiate breastfeeding. Mamatoto Village works to honor and support women and communities of color and offers a valuable alternative to the traditional care model.[8]

Access to reproductive health care

Access to reproductive health care is also an important factor in addressing maternal health disparities. While the ACA and Medicaid expansion increased access to reproductive health services, too many women, especially low-income women and women of color, do not have access to necessary reproductive health care—including contraception, abortion, STI screenings, and reproductive cancer screenings—due to a variety of restrictions and funding shortfalls. This leaves them vulnerable to many risk factors around pregnancy. Recent improvements in maternal and infant health across the 20th century are due, in part, to expanded contraceptive access and use.[9] Contraceptives allow women to plan their pregnancies around their personal health and circumstances. Research shows that planned pregnancies are associated with better health outcomes than unplanned pregnancies, which are associated with low birth weight and a smaller likelihood of receiving early prenatal care.[10] Women with planned pregnancies are also less likely to smoke and drink alcohol while pregnant,[11] and for women with underlying health conditions, planning a pregnancy allows them to manage conditions before becoming pregnant, reducing the risk of complications.

Long-acting reversible contraception (LARC) is one option a trained medical provider can recommend during counseling to women seeking immediate postpartum contraception.[12] Unfortunately, financial barriers often stand in the way, including the fact that Medicaid reimbursement for immediate postpartum LARC is limited.[13] Contraceptive counseling and support services for women who choose to delay or avoid pregnancy should always be offered using a woman-centered approach, meaning medical care should be compassionate and take full account of the woman's lived experiences and circumstances.

Health care training and workforce issues

A variety of health care workforce and training issues underlie disparities in maternal mortality. Many of the instances where women have experienced complications or died during pregnancy or birth include aspects where medical professionals have not been fully attentive to African American women's experiences or medical needs. Two potential themes emerge from these stories as well as the programs that are already working to counteract these disparities: First, availability of OB-GYNs and other professionals who are demographically similar to the women served is of critical importance, and, second, all medical professionals must consistently provide care that listens to women and is culturally sensitive and patient-centered.

While diversity and training in the medical profession has increased, many patients still find that cultural barriers can hinder access to high-quality medical care. One way to counteract these barriers, especially for African American women and other women of

color, can be the use of doulas and midwives throughout pregnancy and birth. Several organizations—such as Mamatoto Village in Washington, D.C., and Ancient Song Doula Services in New York City—have increased access to doulas and other professionals for low-income women and women of color. These organizations have also seen very promising outcomes for both women and infants. Along with classes and other services, these organizations work to provide women with tools throughout pregnancy, particularly regarding their interactions with the health care system, and often act as both a support and an advocate for women throughout the process.

Ancient Song Doula Services: Serving women and families in New York City

Ancient Song Doula Services is a community-based full spectrum doula organization that offers trainings, workshops, and maternal care to women and communities of color in New York City. Ancient Song provides counseling, peer support, and educational resources, such as classes in childbirth and infant feeding, among other services, to help women throughout preconception, pregnancy, and their childbirth experience. Through courses like "Know Your Rights," which prepares women to advocate for themselves when receiving care in a hospital, Ancient Song provides tools to help women of color make informed health care decisions and works to address disparities in maternal and infant health as well as health care. In fiscal year 2014-15, 85 percent of women who received care at Ancient Song gave birth vaginally, and 97.5 percent initiated breastfeeding within five days of giving birth. There were zero maternal deaths.[14]

Conclusion

To begin to eliminate disparities in maternal and infant mortality, several steps must be taken to increase access to high-quality medical care for women of color, particularly during pregnancy, and make sure that all care is patient-centered, culturally appropriate, and listens to women's needs. Some promising steps have been taken, including the availability of safety bundles from the Council on Patient Safety in Women's Health Care that address various aspects of maternal health. These bundles range from maternal mental health care to obstetric care for women experiencing opioid use disorder, with one such bundle addressing ways to reduce peripartum racial and ethnic disparities.[15] Among many other recommendations, it suggests that health systems record self-identified race, ethnicity, and primary language and provide education on root causes of peripartum racial and ethnic disparities to all staff. Patients, families, and staff should have a clear way to report inequitable care or miscommunication or disrespect, and clinicians should use best practices for shared decision-making with patients regarding health care decisions.[16]

Promising models such as this, along with programs working on the ground to reduce disparities, are changing the way health care is delivered and working to both close the racial gap in maternal mortality and, ultimately, eliminate it altogether. Continuous efforts to combat the effects of racism and sexism are key within the fight to keep all mothers and babies healthy throughout pregnancy, birth, and the postpartum period.

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Endnotes

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