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Systematic Racism, Abortion and Bias in Medicine: All Threads Woven in the Cloth of Racial Disparity for Mothers and Infants

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**Systemic Racism, Abortion and Bias in Medicine: All Threads Woven in the
Cloth of Racial Disparity for Mothers and Infants**

Gabrielle Ploplis*

* J.D. May 2022, Cleveland-Marshall College of Law. I thank my parents, my sisters, and my family for their endless love and support throughout this journey. I wouldn't be where I am without it. I am also so grateful for the incredible Cleveland-Marshall professors that I had the pleasure of learning from these past three years, and for the opportunity to be a part of the Journal of Law and Health. So much time and effort has been put into making this Journal great, and making publication possible. I truly appreciate having had the opportunity to work with you all.

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I. INTRODUCTION

In 1978, the United States District Court for the District of Delaware reached a decision in a case that may have had far wider implications than were likely anticipated.¹ In *NAACP v. Wilmington Medical Center, Inc.* the court considered whether the relocation of most care components of Wilmington Medical Center from the inner-city hospital system to an outlying suburb was discriminatory as it related to health care available to underserved minorities.² The center planned to close two divisions completely and significantly reduce another division to eliminate maternal and infant care services (among many other types of services) at that location, and provide them solely at the new suburban division.³ In this case, the plaintiffs argued that relocating hospital services to the suburban location would cause disparities in the availability of quality medical care for the poor, the elderly, ethnic and racial minorities, and the handicapped.⁴ At that time, 72% of the county's black residents lived in the City of Wilmington where the care facilities were located.⁵ However, the District Court rejected this argument stating that the plaintiffs could not make a prima facie case that the relocation violated Title VI of the Civil Rights Act of 1964.⁶

¹ *NAACP v. Wilmington Med. Ctr., Inc.*, 453 F. Supp. 280 (D. Del. 1978).

² *Id.* at 284.

³ *NAACP v. Wilmington Med. Ctr., Inc.*, 491 F. Supp. 290, 298 (D. Del. 1980). The services to be provided exclusively at the suburban location included: all obstetrical, gynecological, pediatric, and support services such as high-risk prenatal and specialty pediatric clinic and the gynecological clinic. *Id.*

⁴ *Id.*

⁵ *Id.* at 302.

⁶ *Id.* at 330.

This case and others like it across the country⁷ highlight one of the most influential factors of disparities in health outcomes for racial minorities: the lack of quality care available.⁸ What these cases and courts may not have considered when reaching their decisions was how the lack of quality care has contributed to the alarming rate of infant and maternal mortality among black and indigenous women.

Although there is a deep-rooted and national issue of discrimination in many aspects of medical care, this article will address the disparities in black and indigenous infant and maternal mortality compared to that of white infants and mothers.⁹ This issue will be addressed on the national scale as well as the state level. Both state and federal law have contributed to the racial disparities in health outcomes for mothers and infants.

This note will argue that decisions like that of *Wilmington Medical Center, Inc.* have been one of many contributing factors in the disparity in mortality rates of both black and American Indian/Alaska Native newborns in comparison to white newborns across the country. Part II will examine the current state of the

⁷ *Bryan v. Koch*, 627 F. 2d 612 (2d Cir. 1980). This case dealt with a New York City hospital that served a population that was 98% black and Hispanic. The plaintiffs in this case asserted that closing Sydenham Hospital would violate Title VI of the Civil Rights Act of 1964. The lower court failed to issue an injunction to prevent closure of the hospital, and the United States Court of Appeals (2nd District) affirmed. *Id.*

⁸ Phil Galewitz, *When Hospitals Move, Who Gets Left Behind?*, THE ATLANTIC (Apr. 25, 2015), <https://www.theatlantic.com/health/archive/2015/04/when-hospitals-move-who-gets-left-behind/391412/>.

⁹ *Infant Mortality*, CDC (Sept. 10, 2020), [hereinafter *Infant Mortality*], <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm#:~:text=In%202018%2C%20the%20infant%20mortality,the%20United%20States%2C%202018>).

law regarding issues of discrimination, accessibility of health care, and relocation and closure of medical centers that has disproportionately affect minorities in the U.S.¹⁰ Part III will discuss the statistics of white, black, and American Indian/Alaska Native newborn and maternal mortality rates in the United States. Part IV will address the potential causes of this disparity, which include inadequate access to quality medical care for racial minorities, implicit racial bias, a demand for more minority doctors¹¹, and strict abortion restrictions¹². Part V will propose that a reduction in the racial disparities in mortality rates for black and indigenous mothers and infants can be achieved by implementing comprehensive state-level “public-private” collaborations, and increasing availability and coverage of more birthing resources like midwives. Lastly, Part VI will conclude that current condition of federal and state legislation has not eliminated the racial disparities in maternal and infant mortality rates, and further measures must be taken to achieve this goal.

¹⁰ 42 U.S.C.A. § 300 (West 2022); *see generally* Jackie Borchardt & Cameron Knight, *Planned Parenthood to close two Ohio clinics after rejecting federal funding*, USA TODAY (Sept. 9, 2019), <https://www.usatoday.com/story/news/nation/2019/09/09/two-planned-parenthood-clinics-ohio-close-amid-funding-loss/2269213001/>.

¹¹ Rob Picheta, *Black newborns more likely to die when looked after by White doctors*, CABLE NEWS NETWORK (Aug. 20, 2020), <https://www.cnn.com/2020/08/18/health/black-babies-mortality-rate-doctors-study-wellness-scli-intl/index.html>.

¹² Grace Panetta, *The states passing strict abortion bans have some of the highest maternal and infant mortality rates in the country*, BUSINESS INSIDER (June 1, 2019), <https://www.businessinsider.com/states-passing-abortion-bans-have-highest-infant-mortality-rates-2019-5>. States with strict abortion laws have correspondingly high infant and maternal mortality rates. As Ohio has some of the strictest abortion law in the country, it also has one of the highest infant mortality rates in the country as well. *Id.*

II. LEGAL HISTORY: DISCRIMINATION IN MEDICAL CARE FOR RACIAL AND ETHNIC MINORITIES

Racial discrimination, even after the end of the Civil War, has been pervasive in the United States. It was not until the 1960s that any major federal legislation was passed to deal with this discrimination. At that time, Title VI of the Civil Rights Act of 1964 was passed with the purpose of protecting people from discrimination on the basis of race, color, or national origin when participating in programs that receive federal funding.¹³ In addition, Title VII of the Civil Rights Act of 1964 addressed discrimination in employment.¹⁴

After the passage of the Civil Rights Act, a number of legislative efforts were made to address the different facets of racial discrimination. The Voting Rights Act of 1965 was passed in an attempt to address discriminatory voting practices¹⁵, the Fair Housing Act of 1968 was passed to address discrimination in housing¹⁶, the Equal Credit Opportunity Act was passed in 1974 to prevent lending discrimination based on sex or marital status, and amended in 1976 to address discrimination on the basis of race, color, religion, national origin, age¹⁷, and the Disaster Relief and Emergency Assistance Act was amended in 1988 to address discrimination in federally funded disaster assistance programs.¹⁸

¹³ 42 U.S.C.A. § 2000d (West 2022).

¹⁴ 42 U.S.C.A § 2000e-2 (West 2022).

¹⁵ Voting Rights Act of 1965, Pub. L. No. 89-110, 79 Stat. 437.

¹⁶ 42 U.S.C.A. §§ 3601-3619 (West 2022).

¹⁷ Brian Kreiswirth & Anna-Marie Tabor, *What you need to know about the Equal Credit Opportunity Act and how it can help you: Why it was passed and what it is*, CONSUMER FINANCE (Oct. 31, 2016), <https://www.consumerfinance.gov/about-us/blog/what-you-need-know-about-equal-credit-opportunity-act-and-how-it-can-help-you-why-it-was-passed-and-what-it/>.

¹⁸ 42 U.S.C. § 5151 (West 2022).

Although the government began to confront racial discrimination through legislative measures, black and indigenous people continued to face disadvantage due to the countless forms that discrimination can assume.¹⁹ For example, during Ronald Reagan's presidency, his administration made multiple budgetary changes that dramatically impacted black and indigenous people.²⁰ The Urban Institute conducted an analysis of the impact of the Reagan Administration's domestic policies, and found that black Americans in every income strata had "less disposable income in 1984 than in 1980".²¹ Although poverty for black Americans was high in 1980, that this number had significantly increased between 1980 and 1984.²² According to the Journal of Black Studies, "Of those Americans who fell into poverty since 1980, 22% were black even though [black Americans] ma[de] up only 12% of the U.S. population".²³ Additionally, "per capita

¹⁹ See generally Joe R. Feagin, *Excluding Blacks and Others From Housing: The Foundation of White Racism*, 4(3) CITY LANDSCAPE: A JOURNAL OF POLICY DEVELOPMENT AND RESEARCH 79 (1999). This author provides a historical overview of systemic racism, which is explained as "the system of domination and oppression and its consequent racial inequality that has been created, maintained, and legitimized by those who subscribe to the white supremacy ideology". *Id.*

²⁰ Ctr. on Budget and Pub. Priorities, *Falling Behind: A Report on How Blacks Have Fared Under Reagan*, 17 J. OF BLACK STUD. 163 (1986). Programs that suffered budget cuts included: Public Service Employment, Employment and Training, Work Incentive Programs, Child Nutrition, Legal Services, Compensatory Education, Pell Grants and Other Financial Aid for Needy Students, Food Stamps, Aid to Families with Dependent Children, and Subsidized Housing. *Id.* All of these programs had high percentages of black participants. *Id.* In addition, Reagan made budget cuts that impacted American Indians as well. It has been reported that "Reagan's administration held spending on Indian programs in check or reduced them outright. The budget of the [Bureau of Indian Affairs] fell from \$1.5 billion in 1983 to \$923 million in 1987. The 1987 federal budget reshuffled dollars for Indians, reducing, by \$340 million, direct funding for such services as education, construction, and the development of natural resources." Dean J. Kotlowski, *From Backlash to Bingo: Ronald Reagan and Federal Indian Policy*, 77 PACIFIC HISTORICAL REVIEW 617, 626 (2008).

²¹ *Id.* (citing URBAN INSTITUTE, THE REAGAN RECORD: AN ASSESSMENT OF AMERICA'S CHANGING DOMESTIC PRIORITIES (AN URBAN INSTITUTE STUDY) (John L. Palmer & Isabel V. Sawhill eds., 1984)).

²² Ctr. on Budget and Pub. Priorities, *supra* note 20, at 149-50.

²³ *Id.* at 154.

expenditures on Native Americans by the federal government declined from \$3,500 to \$2,500 between 1980 and 1990. Partly as a result, the poverty rate for Native Americans rose from 23.7 percent to 27.2 percent between 1979 and 1989”.²⁴

The Reagan administration also influenced a major change the country’s health system.²⁵ It has been asserted that the dramatic elevation of health care costs began with the Social Security Amendments of 1983²⁶, which established the Medicare hospital prospective payment system.²⁷ As described by the New York Times:

Before the early 1980s, payments by Medicare and other insurers were tied to costs. But then payers (private insurers and government health care programs like Medicare) began to shift financial risk to providers like hospitals and doctors. This approach later spread to other Medicare services and other payers, including private insurers. If providers could get costs down, they made money. If they could [not], they lost money.²⁸

²⁴ Kotlowski, *supra* note 20, at 627-28.

²⁵ Austin Frakt, *Reagan, Deregulation and America’s Exceptional Rise in Health Care Costs*, N.Y. TIMES (June 4, 2018), <https://www.nytimes.com/2018/06/04/upshot/reagan-deregulation-and-americas-exceptional-rise-in-health-care-costs.html>

²⁶ *Id.* This article states that “it all started with a law that began affecting most hospitals in 1983, changing how Medicare paid hospitals to a fixed price per visit, regardless of the actual cost.” *Id.*

²⁷ Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65.

²⁸ Frakt, *supra* note 25.

In addition, the Reagan administration reduced Medicaid expenditures by over 18%, cut the Department of Health and Human Services Budget by 25%, and cut federal funding for maternal and child health by 18%.²⁹

These were not the only budgetary cuts that affected minorities during the Reagan Administration. The Title X Family Planning Program, a federal grant program through the U.S. Department of Health and Human Services designed to provide low-income individuals with family planning, reproductive and preventative health services, suffered significant budget cuts “as part of the broader Reagan Administration initiative to reduce federal spending on all social service programs... Title X funding dropped to \$120–140 million and remained flat until 1992”.³⁰ Further, Women, Infants, and Children (WIC) which provides “low-income pregnant women and children with formula and healthy food staples” could only serve a fraction of those eligible.³¹

As black Americans are three times as likely to participate in programs aimed at protecting those with low and moderate income, these budget cuts in particular have disproportionately affected the black community.³²

These budget cuts also resulted in hospital closures in urban areas.

²⁹ Olivia Campbell, *Here's what happened when Reagan went after healthcare programs. It's not good.*, TIMELINE (Sept. 13, 2017), <https://timeline.com/reagan-trump-healthcare-cuts-8cf64aa242eb>.

³⁰ NAT'L ACAD. OF SCI.: THE LEWIN GROUP, ORGANIZATION, FUNDING, AND MANAGEMENT OF THE TITLE X PROGRAM, app. J (2009). The budget was up to \$160 million in 1980. In addition, although the Clinton Administration steadily increased funding for Title X (reaching \$254 million by 2000) the program remained underfunded. The 2008 budget is included in this article as well. *Id.*

³¹ Frakt, *supra* note 25.

³² Ctr. on Budget and Pub. Priorities, *supra* note 20, at 161-62.

Between 1980 and 1991, 294 urban hospitals were shut-down.³³ The number of women who were not receiving prenatal care increased, the life-expectancy-at-birth of black Americans decreased, and the Native American community suffered dramatically.³⁴

In an attempt to address disparities in health for minority populations, Congress enacted the National Institutes of Health Revitalization Act of 1993 which established the Office of Research on Minority Health.³⁵ A number of years later, Congress enacted the Minority Health and Health Disparities Research and Education Act of 2000.³⁶ This legislation made recognition of the ongoing health disparities for black and indigenous people in the United States³⁷, and sought to reduce these racial disparities by establishing the National Center on Minority Health and Health Disparities.³⁸ The National Center on Minority Health and Health Disparities was to conduct scientific research on the issue, in order to eradicate health disparities for minorities and improve the overall health of minority populations.³⁹ Since establishment, this institute has created a number of different programs in pursuance of this goal.⁴⁰ Many of these programs focus on

³³ Campbell, *supra* note 29. In 1990, census data reveals that 84% of the black population lived in metropolitan areas and 57% lived in central cities. CLAUDETTE E. BENNETT ET AL., *WE THE AMERICANS: BLACKS* 3 (1993).

³⁴ *Id.*

³⁵ Health Revitalization Act of 1993, Pub. L. No. 103-43, 107 Stat. 122.

³⁶ Minority Health and Health Disparities Research and Education Act of 2000, Pub. L. No. 106-525, 114 Stat. 2495.

³⁷ §2, 114 Stat. 2495-97. In addition, this section recognizes a need for more minorities in “biomedical, clinical, behavioral, and health services.” *Id.*

³⁸ §101, 114 Stat. 2495.

³⁹ *National Institute on Minority Health and Health Disparities (NIMHD)*, NAT’L INSTS. OF HEALTH (Dec. 4, 2020), <https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-minority-health-health-disparities-nimhd>.

⁴⁰ *Id.*

research regarding conditions or diseases that disproportionately affect racial and ethnic minorities, rural and urban minority populations, individuals of low socioeconomic status, and poor or vulnerable populations.⁴¹ One program in particular, the Exploratory and Comprehensive Centers of Excellence, conducts research on infant mortality.⁴²

The Obama Administration attempted to undo some of the harm caused by previous administrations through the Affordable Healthcare Act.⁴³ The Affordable Care Act [hereinafter ACA] was passed in 2010 in order to “(1) to reform the private insurance market—especially for individuals and small-group purchasers, (2) to expand Medicaid to the working poor with income up to 133% of the federal poverty level, and (3) to change the way that medical decisions are made.”⁴⁴ The ACA also transitioned the National Center on Minority Health and Health Disparities to an institute.⁴⁵ Since then, it has remained one of the many institutes comprising the Centers of the National Institutes of Health⁴⁶. In addition, the ACA permanently reauthorized the Indian Health Care Improvement

⁴¹ *Id.*

⁴² *Id.*

⁴³ The Record, The White House: President Barack Obama, <https://obamawhitehouse.archives.gov/the-record/health-care> (last visited Dec. 17, 2020).

⁴⁴ J.B. Silvers, *The Affordable Care Act: Objectives and Likely Results in an Imperfect World*, 11(5) ANNALS FAM. MED. 402 (2013).

⁴⁵ *Ruffin Retires from Federal Service After Almost 24 Years*, NAT’L INST. ON MINORITY HEALTH AND HEALTH DISPARITIES, <https://www.nimhd.nih.gov/news-events/features/inside-nimhd/ruffin-retires.html> (last visited Mar. 30, 2021).

⁴⁶ *About NIMHD*, NAT’L INST. ON MINORITY HEALTH AND HEALTH DISPARITIES, <https://www.nimhd.nih.gov/about/> (last visited Mar. 30, 2021).

Act⁴⁷ which was enacted in 1976 to fulfill the federal responsibility to provide health care services and education to American Indians and Alaska Natives.⁴⁸

The ACA has had a positive impact on health care accessibility by helping to reduce racial and ethnic disparities in insurance coverage.⁴⁹ Evidence shows that the uninsured rates for minority populations significantly decreased from 2010 to 2016.⁵⁰ In 2010, 32% of American Indian/Alaska Natives were uninsured and 19.9% of the black population was uninsured.⁵¹ By 2016, the percentage of American Indian/Alaska Natives that were uninsured had dropped by 10% (and has continued to decrease into 2018), and the percentage of uninsured black Americans decreased by 9.2%.⁵² In addition, evidence suggests that black Americans ages 18 to 64 experienced a significant reduction in financial barriers to health care access, and an increase in the percentage of adults that had a regular source of health care.⁵³ However, from 2016 to 2018 coverage gains for the black population began reversing, and continued to increase into 2019.⁵⁴

⁴⁷ Donald Warne & Linda Bane Frizzell, *American Indian Health Policy: Historical Trends and Contemporary Issues*, 104 AM. J. OF PUB. HEALTH S265 (2014).

⁴⁸ Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (1976).

⁴⁹ Samantha Artiga, *Loss of the Affordable Care Act Would Widen Racial Disparities in Health Coverage*, KAISER FAMILY FOUNDATION (Oct. 1, 2020), <https://www.kff.org/policy-watch/loss-of-the-affordable-care-act-would-widen-racial-disparities-in-health-coverage/#:~:text=Further%2C%20research%20shows%20that%20the,individuals%2C%20particularly%20for%20measures%20of>; See also Jesse C. Baumgartner et al., *How the Affordable Care Act has Narrowed Racial and Ethnic Disparities in Access to Health Care*, COMMONWEALTH FUND (Jan. 16, 2020), <https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access>.

⁵⁰ Artiga, *supra* note 49.

⁵¹ *Id.*

⁵² *Id.*

⁵³ Baumgartner et al., *supra* note 49.

⁵⁴ Artiga, *supra* note 49.

Title V of the ACA specifically addresses medical support of maternal and child health. Under the act, each state is required to conduct a needs assessment “that identifies communities with concentrations of premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health”⁵⁵ Title V also provides federal funding to state maternal and child health agencies in order to provide access to quality healthcare for mothers and children, prenatal and postnatal care for women, preventative and child care, health assessments, and health promotion efforts to reduce infant mortality.⁵⁶

The ACA increased access to prenatal and postnatal care by expanding the Medicaid program.⁵⁷ An analysis of National Center for Health Statistics from 2006 to 2017 revealed that the increase in the maternal mortality ratio was considerably less in Medicaid expansion states than it was in non-expansion states.⁵⁸ The analysis revealed an estimated reduction of over 200 maternal deaths associated with the Medicaid expansion program when applied to the country’s

⁵⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2951, 124 Stat. 119, 334-43 (2010).

⁵⁶ *Title V Maternal and Child Health (MCH) Block Grant Program*, HEALTH RES. AND SERVS. ADMIN., <https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program> (last visited Dec. 17, 2020).

⁵⁷ Jamie R. Daw et al., *Medicaid Expansion Improved Perinatal Insurance Continuity for Low-Income Women*, 39 HEALTH AFFS. 1531 (2020). This study found that “Medicaid expansion improved insurance continuity in the perinatal period for low-income women” and suggested that this continued coverage could potentially help “improve the quality of perinatal health care.” *Id.* Further, the article asserts that “improvements in the stability of perinatal insurance for low-income women could have important implications for . . .maternal and infant health outcomes.” *Id.* at 1536; accord Erica L. Eliason, *Adoption of Medicaid Expansion is Associated with Lower Maternal Mortality*, 30 WOMEN’S HEALTH ISSUES 147 (Feb. 25, 2020).

⁵⁸ Eliason, *supra* note 57, at 147.

maternal death total in 2017.⁵⁹ The study also suggested that Medicaid expansion may be helping to a reduce racial disparities in maternal mortality for black mothers.⁶⁰ The program has been associated with 16.27 less maternal death per 100,000 live births, relative to non-expansion states.”⁶¹ Further, this study revealed significant reductions in relative disparities for non-Hispanic black infants in relation to white infants in Medicaid expansion states.⁶² Therefore, the Medicaid expansion of the ACA may be improving health outcomes for infants and mothers, and reducing racial disparities in maternal and infant mortality.

The Medicaid expansion program of the ACA has arguably had an indirect positive impact on the quality of perinatal care, as coverage gaps in insurance can affect care quality. However, it has presented only a “partial solution”.⁶³ In 2012, the United States Supreme Court found that the federal government could not require states to adopt the Medicaid expansion.⁶⁴ As a result, there are still 12 states that have not adopted the expansion plan.⁶⁵ In addition, the ACA has done “little to improve the quality of obstetrics *care*” that pregnant women receive.⁶⁶ In the past few years there has, been a legislative push towards resolving the

⁵⁹ *Id.* at 150.

⁶⁰ *Id.* at 149.

⁶¹ *Id.*

⁶² Clare C. Brown et al., *Association of State Medicaid Expansion Status with Low Birth Weight and Preterm Birth*, 321 J. OF THE AM. MED. ASS’N 1598, (2019).

⁶³ Valerie K. Blake & Michelle L. McGowan, *Filling a Federal Void: Promises and Perils of State Law in Addressing Women’s Health Disparities*, 48 J. L., MED. & ETHICS 485, 486 (2020).

⁶⁴ Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

⁶⁵ *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Mar. 31, 2021) <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>. Of the 39 states that have adopted the Medicaid expansion, there are two that have not yet implemented it. *Id.*

⁶⁶ Blake & McGowan, *supra* note 63, at 486.

country's exceptionally high maternal mortality rates.⁶⁷ The Center for Disease Control and Prevention [hereinafter CDC] had gone over a decade without releasing reports on maternal mortality in the United States, due to the absence of federal mandate for a maternal-related death specification on death certificates.⁶⁸ Once published, this data received national attention, and may have influenced legislative action on the issue.

One notable piece of legislation has influenced a movement among states. The Preventing Maternal Deaths Act of 2018 was enacted to encourage and support states to work to improve and sustain the health of mothers during and after pregnancy in an effort “to eliminate disparities in maternal health outcomes for pregnancy-related and pregnancy-associated deaths” and “identify solutions to improve health care quality and health outcomes for mothers”.⁶⁹ This legislation provides federal funding for state and tribal maternal mortality review committees.⁷⁰ However, maternal mortality has continued to increase in the United States despite legislative efforts. Further, the dramatic racial disparities in both maternal and infant mortality still exist.

⁶⁷ See generally Gaby Galvin, *How America is Combating Maternal Mortality*, U.S. NEWS (JUNE 19, 2019, 10:16AM), <https://www.usnews.com/news/health-news/articles/2019-06-19/whats-being-done-to-fight-maternal-mortality-in-america>.

⁶⁸ *After 10+ Years, CDC is Finally Reporting Maternal Mortality Again. (The News Still isn't Good.)*, ADVISORY BOARD (Feb. 24, 2020), <https://www.advisory.com/en/daily-briefing/2020/02/04/maternal-mortality>.

All 50 states did not incorporate the maternal-related death checkbox until 2017. *Id.*

⁶⁹ Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, 132 Stat. 5047 (2018).

⁷⁰ *Id.*

III. DISPARITIES IN HEALTH OUTCOMES FOR BLACK AND INDIGENOUS WOMEN: MATERNAL AND INFANT MORTALITY

Even with the passage of the ACA and other federal legislation, racial and ethnic minorities receive lower quality of care than white patients, and experience significant disparity in health outcomes. These disparities are particularly apparent in maternal and infant mortality rates. Maternal mortality rates have decreased across the world in other developed countries, with the exception of the United States.⁷¹ The United States is the only developed country whose maternal mortality rates have steadily increased over the last three decades.⁷² Maternal mortality rates have more than doubled in the U.S., from 10.3 per 100,000 live births in 1991 to 23.8 in 2014.⁷³

Unfortunately, within these shocking statistics there are enormous racial disparities. “Black women are three to four times more likely to die in childbirth than white women — regardless of education, income, or any other socioeconomic factors.”⁷⁴ According to the CDC, pregnancy-related deaths for Non-Hispanic black women was 41.7 per 100,000 live births from 2014 to 2017.⁷⁵ This

⁷¹ Suzanne Delbanco et al., *The Rising U.S. Maternal Mortality Rate Demands Action from Employers*, HARV. BUS. REV. (June 28, 2019), <https://hbr.org/2019/06/the-rising-u-s-maternal-mortality-rate-demands-action-from-employers?ab=hero-subleft-2>. See also Michael Ollove, *A Shocking Number of U.S. Women Still Die of Childbirth. California is Doing Something About That*, THE WASH. POST (Nov. 4, 2018, 12:00 PM), https://www.washingtonpost.com/national/health-science/a-shocking-number-of-us-women-still-die-from-childbirth-california-is-doing-something-about-that/2018/11/02/11042036-d7af-11e8-a10f-b51546b10756_story.html.

⁷² Delbanco et al., *supra* note 71.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Pregnancy Mortality Surveillance System*, CDC (Nov. 25, 2020), [hereinafter *Pregnancy Mortality Surveillance System*], <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>. A new coding method recommended by the National Center for Health Statistics (and implemented in 2017) found that 658 women died of maternal causes in 2018. Black women experienced 37.1 deaths per 100,000 as opposed to white

number is more than triple that of Non-Hispanic white women who experienced 13.4 pregnancy-related deaths per 100,000 live births from 2014 to 2017.⁷⁶ The CDC puts Non-Hispanic American Indians or Alaska Natives as second highest with regard to pregnancy-related mortality, with 28.3 pregnancy-related deaths per 100,000 live births from 2014 to 2017.⁷⁷ Thus, Non-Hispanic American Indians or Alaska Natives are twice as likely to experience pregnancy-related mortality than white women.⁷⁸

To make matters worse, these racial disparities exist in U.S. infant mortality rates as well. Although infant mortality rates have been decreasing⁷⁹, the death rate of Non-Hispanic black infants in 2018 per 1,000 live births was still more than double that of Non-Hispanic white infants.⁸⁰ The death rate for American Indian or Alaska Native infants was also significantly higher than that of Non-Hispanic white infants, dying at a rate of 8.2 per 1,000 live births in

women who experienced 14.7 deaths per 100,000. Although the racial disparities are smaller than those demonstrated by the CDC data spanning 2014-2017, black women still died 2½ times more often than white women. See Elizabeth Chuck, *The U.S. Finally has Better Maternal Mortality Data. Black Mothers Still Fare the Worst*, NBCNEWS (Jan. 30, 2020), <https://www.nbcnews.com/health/womens-health/u-s-finally-has-better-maternal-mortality-data-black-mothers-n1125896>.

⁷⁶ *Pregnancy Mortality Surveillance System*, *supra* note 75.

⁷⁷ *Id.* The CDC 2018 data information does not appear to indicate what these numbers are for American Indian/Alaska Native women specifically. *Maternal Mortality*, CDC, <https://www.cdc.gov/nchs/maternal-mortality/index.htm> (last visited Apr. 2, 2021).

⁷⁸ *Id.*

⁷⁹ Gopal K. Singh & Stella M. Yu, *Infant Mortality in the United States, 1915-2017: Large Social Inequalities have Persisted for Over a Century*, 8 INT'L J. MCH AND AIDS 19, 21 (2019). Figure 2 shows infant deaths per 1,000 live births from 1915 to 2017. See also Lauren M. Rossen & Kenneth C. Schoendorf, *Trends in Racial and Ethnic Disparities in Infant Mortality Rates in the United States, 1989-2006*, 104 AM. J. PUB. HEALTH 154 (2014). This study analyzes infant mortality rates from 1989 to 2006.

⁸⁰ *Infant Mortality*, *supra* note 9.

2018.⁸¹ Further, these numbers may be even higher as “American Indian and Alaska Natives’ medical records and birth and death certificates are plagued by racial misreporting and racial misclassification”.⁸² Thus, despite past legislative efforts, black and indigenous people have continued to face disparate health outcomes, those of which are exceptionally prevalent in rates of infant and maternal mortality.

IV. POTENTIAL CAUSES OF RACIAL DISPARITIES IN MATERNAL AND INFANT MORTALITY RATES: WHY DO MINORITY COMMUNITIES SUFFERS MOST?

A. The Lack of Accessibility to Quality Obstetrics

1. Hospital Closures and Redlining

The disparities in health outcomes for black and indigenous Americans may be due in part to limitations on accessibility of quality medical care in certain areas throughout the country.⁸³ The issue of accessibility is partially attributable to the hospital closures in particular areas, as these closures typically “have a disproportionate impact on certain patient populations”.⁸⁴ One study conducted by the National Bureau of Economic Research [hereinafter NBER] found that urban

⁸¹ *Id.*

⁸² Lucy Truschel & Cristina Novoa, *American Indian and Alaska Native Maternal and Infant Mortality: Challenges and Opportunities*, CTR. FOR AM. PROGRESS, (Jan. 9, 2018, 11:00 AM), <https://www.americanprogress.org/issues/early-childhood/news/2018/07/09/451344/american-indian-alaska-native-maternal-infant-mortality-challenges-opportunities/>. This is a concern for both maternal and infant mortality data. *Id.*

⁸³ Wayne J. Riley, *Health Disparities: Gaps In Access, Quality And Affordability Of Medical Care*, 123 TRANSACTION AM. CLINICAL AND CLIMATOLOGICAL ASS’N 167 (2012).

⁸⁴ Joseph P. Williams, *Code Red: The Grim State of Urban Hospitals*, U.S. NEWS (July 10, 2019, 11:23 AM), <https://www.usnews.com/news/healthiest-communities/articles/2019-07-10/poor-minorities-bear-the-brunt-as-urban-hospitals-close>.

hospital closures do not increase inpatient mortality for certain conditions in urban areas⁸⁵, and another study revealed no negative impact on “efficiency, coverage, and equality measures for geographic access” when only a few hospitals are closed within a state.⁸⁶ However, an article from the DePaul Journal of Law and Health explained why closures may seem to have no impact on minority health:

The magnitude of the harm suffered by minority communities may not be immediately obvious because our health care system is a complex patchwork of private and public actors without clearly defined duties. The effects of closure depend in large part on the availability and willingness of other hospitals to help fill the community's needs. In theory, closure of a facility will not adversely affect care, if there are other facilities in the community that can adequately provide needed care in a timely manner. However, a number of factors... undermine the ability or willingness of other hospitals to adequately fill this need. Moreover, hospital closures can trigger a domino effect that threatens longer term access and quality of care for remaining hospitals, and the maintenance of a quality primary care network of providers for minority communities.⁸⁷

⁸⁵ Kritee Gujral & Anirban Basu, *Impact of Rural and Urban Hospital Closures on Inpatient Mortality*, (Nat'l Bureau of Econ. Rsch., Working Paper No. 26182, 2019).

⁸⁶ Mark L. Burkley et al., *The Impact of Hospital Closures on Geographical Access: Evidence from Four Southeastern States of the United States*, 4 OPERATIONS RSCH. PERSP. 56 (2017).

⁸⁷ Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1031 (2015).

Further, the NBER’s study revealed that *rural* hospital closures impacted urban patient mortality.⁸⁸ Rural hospital closures create “spillover effects”, putting strain on urban hospitals⁸⁹ and may eventually cause them to deteriorate. Thus, this study actually provides support for the asserted “domino effect” described in by the DePaul Journal of Law and Health. Although urban hospital closures are infrequent in comparison to closures of rural hospitals⁹⁰, “urban hospital closures are more apt to happen in racially segregated communities and especially in [black] neighborhoods”.⁹¹ In fact, evidence suggests that hospital closures throughout the country may be more likely to occur in areas where a high percentage of black Americans reside.⁹²

The Hospital Readmissions Reduction Program, established by the ACA⁹³, requires the Centers for Medicare and Medicaid Services “to reduce payments to Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions, beginning with discharges after October 1, 2012”.⁹⁴ A study analyzing data for 3,168 hospitals from 2013 to 2017 revealed that the probability of being penalized by the Medicare program (reduction in payments) increases as the percentage of

⁸⁸ Gujral & Basu, *supra* note 85, at 14.

⁸⁹ *Id.*

⁹⁰ Jordan Rau & Emmarie Huetteman, *Urban Hospitals of Last Resort Cling to Life in Time of COVID*, KAISER FAM. FOUND., (Sept. 17, 2020), <https://khn.org/news/urban-hospitals-of-last-resort-cling-to-life-in-time-of-covid/>.

⁹¹ Williams, *supra* note 84.

⁹² Darrell J. Gaskin et al., *Racial and Ethnic Composition of Hospitals’ Service Areas and the Likelihood of Being Penalized for Excess Readmissions by the Medicare Program*, 56 MED CARE 934 *passim* (2018).

⁹³ § 3025, 124 Stat. 119, 408-13.

⁹⁴ Gaskin et al., *supra* note 92, at 3.

black residents in the hospital service area increases.⁹⁵ This evidence raises concern that the Medicare Hospital Readmissions Reduction Program “may have the unintended consequence of increasing racial and ethnic disparities in healthcare”.⁹⁶

Medicare’s Hospital Readmissions Reduction Program may be putting safety-net hospitals at a disadvantage.⁹⁷ Safety-net hospitals primarily serve vulnerable populations⁹⁸ and typically endure greater financial stress than other hospitals⁹⁹. An analysis conducted by the Commonwealth Fund in 2012 revealed that safety-net hospitals were 30% more likely to have 30-day hospital readmission rates for acute myocardial infarction, heart failure, and pneumonia above the national average.¹⁰⁰ In addition, an assessment of 2,066 hospital in 2018 revealed that “safety-net hospitals were more likely than non-safety-net hospitals to treat a greater percentage of racial and ethnic minorities”.¹⁰¹ Therefore, when safety-net hospitals are penalized for high readmission rates, and the financial strain of continuous penalty is too significant for the hospital to remain open¹⁰²,

⁹⁵ *Id.* at 2.

⁹⁶ *Id.*

⁹⁷ Matlin Gilman et al., *Safety-Net Hospitals More Likely than Other Hospitals to Fare Poorly Under Medicare’s Value-Based Purchasing*, 34 HEALTH AFFS. 398, 399 (2015). Additionally, this study found that safety-net hospitals were also more likely to suffer under Medicare’s value-based purchasing program. Accord Jeff Lagasse, *Value-Based Payment Penalties Disproportionately Impact Safety Net Hospitals*, HEALTHCARE FIN., (July 10, 2020), <https://www.healthcarefinancenews.com/news/value-based-payments-disproportionately-impact-safety-net-hospitals>.

⁹⁸ Ioana Popescu et al., *Comparison of 3 Safety-Net Hospital Definitions and Association with Hospital Characteristics*, 2 J. AM. MED. ASS’N 1, 2 (Aug. 7, 2019).

⁹⁹ Lagasse, *supra* note 97.

¹⁰⁰ Julia Berenson & Anthony Shih, *Higher Readmissions at Safety-Net Hospitals and Potential Policy Solutions*, 34 COMMONWEALTH FUND 1, 4 (2012).

¹⁰¹ Popescu, *supra* note 98, at 5.

¹⁰² Joseph S. Ross et al., *Mortality and Readmission at Safety Net and Non-Safety Net*

its closure is more likely to negatively impact minority populations than the white population.

President and Chief Executive Officer of St. Bernard Hospital, Charles Holland, recently discussed the challenges of operating a safety net hospital¹⁰³ on the southside of Chicago, and the hurdles that members of the Englewood community (a predominantly black community) face in seeking quality treatment.¹⁰⁴ Safety net hospitals, like St. Bernard’s Hospital, mainly service patients who are either uninsured or present Medicaid or Medicare as their payment source.¹⁰⁵ However, providers are often unable to maintain practice in particular areas, like Chicago’s south side, when many of their patients pay with Medicaid or Medicare because the costs of running their practice are not necessarily covered by reimbursement.¹⁰⁶ Holland stated that “patients are more

Hospitals for Three Common Medical Conditions, 31HEALTH AFFS. (MILLWOOD) 1739, 1740 (2012). In addition, this continuous penalty may impact the quality of care being provided to minority patients. *Id.*

¹⁰³ INST. OF MED.’S COMM. ON THE CHANGING MKT, MANAGED CARE, AND THE FUTURE VIABILITY OF SAFETY NET PROVIDERS, AMERICA’S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 25 (Marion Ein Lewin & Stuart Altman eds., 2000) [hereinafter INST. OF MED.]. The Institute of Medicine defined safety net providers as “providers that organize and deliver a significant level of both health care and other health-related services to the uninsured, Medicaid, and other vulnerable populations,” as well as providers “who by mandate or mission offer access to care regardless of a patient’s ability to pay and whose patient population includes a substantial share of uninsured, Medicaid, and other vulnerable patients”. *Id.*

¹⁰⁴ *Viewing Health Justice Through the Lens of Public Health Crisis*, LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW BEAZLEY INSTITUTE FOR HEALTH LAW AND POLICY (Oct. 30, 2020) <https://www.luc.edu/law/events/beazley-symposium/> [hereinafter BEAZLEY INSTITUTE].

¹⁰⁵ INST. OF MED., *supra* note 103, at 25.

¹⁰⁶ Peter Cunningham et al., *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes*, KAISER FAM. FOUND. (June 9, 2016), <https://www.kff.org/report-section/understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes-issue-brief/>. “Since payment rates are either negotiated (with health plans) or set by the federal government for Medicare or state governments for Medicaid fee-for-service, payments that hospitals receive for patient care do not necessarily reflect what hospitals charge for those services or the cost of providing those services.” *Id.*

likely to be readmitted to the hospital for chronic conditions... and those readmissions can penalize safety net hospitals like St. Bernard, as reimbursement can be negatively impacted if readmissions are too high”.¹⁰⁷ In addition, Holland highlighted the substantial health disparities between south side residents and residents of northern neighborhoods in Chicago.¹⁰⁸ He stated that there is a 30-year gap in life expectancy, a higher maternal death rate, and infant mortality rates that are 10 times higher than that of northern residents.¹⁰⁹

Structural racism¹¹⁰ has contributed significantly to infant mortality, and the racial disparities in health outcomes that exist for black infants.¹¹¹ In an effort to address the country’s housing shortage in the 1930s, the federal government developed a program that was designed to both increase and segregate the country’s housing stock.¹¹² Federal agencies used a policy called “redlining” to distinguished neighborhoods based on their racial demographics, and provide

¹⁰⁷ BEAZLEY INST., *supra* note 104.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ Structural racism is defined as “a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time.” *Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis*, ASPEN INST., <https://www.aspeninstitute.org/wp-content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf> (last visited Apr. 2, 2021).

¹¹¹ Nancy Krieger et al., *Structural Racism, Historical Redlining, and Risk of Preterm Birth in New York City, 2013-2017*, 110 AM. J. PUB. HEALTH 1046 (July 2020).

¹¹² Terry Gross, *A ‘Forgotten History’ Of How The U.S. Government Segregated America*, NPR, (May 3, 2017, 12:47 PM), <https://www.npr.org/2017/05/03/526655831/a-forgotten-history-of-how-the-u-s-government-segregated-america>. Specifically, these efforts were designed to make housing available for the white middle-class and lower-middle-class population. *Id.*

instruction on which areas were “safe” or “hazardous” to insure mortgages.¹¹³ Specifically, areas were graded based on: “age and condition of housing, transportation access, closeness to amenities such as parks or disamenities like polluting industries, the economic class and employment status of residents, and their ethnic and racial composition”.¹¹⁴ This practice created significant disadvantage for the black population, and crippled opportunity for healthy living and access to quality health care.¹¹⁵ The National Community Reinvestment Coalition performed an analysis of the lasting impact of the redlining practices of the Home Owners’ Loan Corporation [hereinafter HOLC], and found that areas that had been marked “hazardous” (grade D) are far more likely to have a lower-income, minority population of residents.¹¹⁶

A study conducted by the American Journal of Public Health on New York City, revealed an association between present-day risk of preterm birth and historical redlining of the HOLC.¹¹⁷ The study examined births that occurred before 37 weeks of gestation from January 1, 2013 to December 31, 2017, and data from the birth certificates regarding the mother’s race/ethnicity, age when

¹¹³ *Id.*

¹¹⁴ Bruce Mitchell & Juan Franco, *HOLC “Redlining” Maps: The Persistent Structure of Segregation and Economic Inequality*, NAT’L CMTY REINVESTMENT COAL., https://ncrc.org/wp-content/uploads/dlm_uploads/2018/02/NCRC-Research-HOLC-10.pdf (last visited March 31, 2021).

¹¹⁵ Nancy Krieger, *supra* note 111, at 1047.

¹¹⁶ Tracy Jan, *Redlining was Banned 50 Years Ago. It’s Still Hurting Minorities Today.*, WASH. POST (March 28, 2018, 6:00 AM), <https://www.washingtonpost.com/news/wonk/wp/2018/03/28/redlining-was-banned-50-years-ago-its-still-hurting-minorities-today/> (summarizing Mitchell & Franco, *supra* note 114, at 4-5).

¹¹⁷ Nancy Krieger, *supra* note 111, at 1046.

she gave birth, nativity, and educational level.¹¹⁸ The evidence revealed that the infants born in New York City from 2013 to 2017 in grade D versus grade A were more likely to be preterm.¹¹⁹ The study also revealed that “the proportion of census tracts in the worst tercile for racialized economic segregation (high concentration of non-Hispanic Black low-income households) was 0% in HOLC grade A versus 49% in HOLC grade D.”¹²⁰ This study highlights the dramatic impact of housing redlining on the disparities between black and white infant mortality rates, and reveals the continuing impact of discriminatory practices that have been banned for decades.¹²¹

2. *Accessibility for Rural Residents*

Rural populations face unique challenges in accessing quality medical care.¹²² The challenges in delivery of rural health care include “those related to more complex patient health status and poorer socioeconomic conditions, as well as physician workforce shortages”.¹²³ In addition, rural residents must often travel significant distances to obtain medical care.¹²⁴ The National Center for Health

¹¹⁸ *Id.* at 1047.

¹¹⁹ *Id.* at 1050. Grade A areas were colored in green on the HOLC’s color-coded maps and were deemed to be the most desirable and mortgage credit-worthy areas. These areas were predominantly white and more affluent. Grade D areas were colored in red and were deemed more hazardous. These were minority communities where the residents were primarily minority populations.

¹²⁰ *Id.* at 1049.

¹²¹ Jan, *supra* note 116.

¹²² U.S. GOV’T ACCOUNTABILITY OFF., GAO-18-580, INDIAN HEALTH SERVICE: AGENCY FACES ONGOING CHALLENGES FILLING PROVIDER VACANCIES 8 (2018).

¹²³ *Id.*

¹²⁴ *Id.*

Statistics reported that “the primary care physician-to-patient ratio in rural areas in 2012 was 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas”.¹²⁵ According to the First Nations Development Institute’s 2017 report, approximately 54% of American Indians/Alaska Natives live in rural and small-town areas.¹²⁶ Women living in rural areas are at elevated risk of maternal mortality and morbidity.¹²⁷ Further, pregnant American Indian/Alaska Native women living in rural areas face a significantly higher risk of death or serious childbirth complications compared to that of non-Hispanic women or urban women.¹²⁸ An analysis of hospital discharge data from 2012 to 2015 showed that rates for severe maternal mortality and morbidity for indigenous women were significantly higher than that of both rural and urban white women.¹²⁹ Evidence also suggests that American Indian/Alaska Native women in rural locations may fare worse than those in urban settings.¹³⁰ The maternal mortality and morbidity rate for indigenous women living in rural

¹²⁵ *Id.*

¹²⁶ Sarah Dewees & Benjamin Marks, *Twice Invisible: Understanding Rural Native America*, FIRST NATIONS DEV. INST., Apr. 2017, at 3. It is important to note that many sources state that a majority of American Indian/Alaska Native women live in urban areas. However, this article states that “[the] federal government has more than 15 different definitions of ‘rural,’ which can lead to confusion when trying to understand the diverse communities found in America’s rural areas and small towns. Given that many people don’t look at how federal agencies are defining ‘rural’ and ‘urban’ areas, statistics are used inaccurately. This has led to a degree of confusion among funders, federal agencies and supporters, and a belief that the majority of Native people live in urban areas.” *Id.*

¹²⁷ Katy B. Kozhimannil, *Indigenous Maternal Health – A Crisis Demanding Attention*, J. AM. MED. ASS’N HEALTH FORUM, (May 18, 2020), <https://jamanetwork.com/channels/health-forum/fullarticle/2766339>.

¹²⁸ *Id.*

¹²⁹ Katy B. Kozhimannil et al., *Severe Maternal Morbidity and Mortality Among Indigenous Women in the United States*, 135 OBSTETRICS & GYNECOLOGY 294, 297 (2020).

¹³⁰ *Id.*

settings was 2.3%, while the rate for urban indigenous women was 1.8%.¹³¹

Therefore, a significant portion of the American Indian/Alaska Native population faces an elevated risk of maternal death.

The Indian Health Service [hereinafter IHS] is a department within the Department of Health and Human Services that provides health services to “approximately 2.56 million of the nation’s estimated 5.2 million American Indians and Alaska Natives”.¹³² Most IHS facilities are in rural (“isolated and underserved”) areas on or near reservations.¹³³ The goal of the IHS department is to make quality, culturally centered health services available to indigenous Americans that belong to any of the 574 federally recognized tribes.¹³⁴ However, the IHS is historically underfunded.¹³⁵ According to the National Counsel for Urban Indian Health, “before COVID-19, the IHS was already so underfunded that expenditures per patient were just one-fourth of the amount spent in the veteran’s health care system and one-sixth of what is spent for Medicare”.¹³⁶ Further, a briefing report conducted by the United States Commission on Civil Rights in 2018 revealed that \$32 billion in funding would be required to meet the

¹³¹ *Id.*

¹³² *Fact Sheet*, INDIAN HEALTH SERV. (Oct. 2019) <https://www.ihs.gov/newsroom/factsheets/disparities/>.

¹³³ U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 122, at 5.

¹³⁴ *About IHS*, INDIAN HEALTH SERV., <https://www.ihs.gov/aboutihs/> (last visited March 29, 2021).

¹³⁵ Andrew Siddons, *The Never-Ending Crisis at the Indian Health Service*, ROLL CALL, (March 5, 2018, 5:04 AM), <https://www.rollcall.com/2018/03/05/the-never-ending-crisis-at-the-indian-health-service/>.

¹³⁶ Sahir Doshi et al., *The COVID-19 Response in Indian Country*, CTR. FOR AM. PROGRESS, (June 18, 2020, 9:08 AM), <https://www.americanprogress.org/issues/green/reports/2020/06/18/486480/covid-19-response-indian-country/#fn-486480-35>.

health care needs of the IHS.¹³⁷ As a result, many patients seeking care through the IHS receive insufficient quality of care.¹³⁸ For example, several government investigations revealed that patients seeking care at Sioux San Indian Health Service Hospital in Rapid City, South Dakota, had received inadequate care and misdiagnosis.¹³⁹ The severity of these issues caused Congress and the IHS to close the emergency room and inpatient unit at the facility in 2017.¹⁴⁰

According to the IHS, inadequate workforce was their biggest hurdle in providing patients with timely primary care in 2016.¹⁴¹ An analysis of government data conducted by the New York Times indicates vacancies in ¼ of the medical positions within the IHS.¹⁴² In some areas, this issue is even more substantial with almost ½ of medical positions within the IHS unoccupied.¹⁴³ These high vacancy rates pose concern that the IHS is unable to meet the health needs of American Indian/Alaska Native people.¹⁴⁴ Underfunding and understaffing of the IHS has forced hospital administrators to limit the availability of services for their

¹³⁷ *Broken Promises: Continuing Federal Funding Shortfall for Native Americans*, U.S. COMM’N CIV. RTS. 67 (2018). In addition, the report revealed that the IHS was the only federally funded health care program that was subject to full sequestration, while all other major federal direct-care programs are exempt. *Id.* at 68.

¹³⁸ Mark Walker, *Fed Up With Deaths, Native Americans Want to Run Their Own Health Care*, N.Y. TIMES (last updated Jan. 3, 2021), <https://www.nytimes.com/2019/10/15/us/politics/native-americans-health-care.html>.

¹³⁹ *Id.*

¹⁴⁰ *Id.* In 2021 the Great Plains Tribal Chairmen’s Health Board took over the Sioux San facility and has since developed a plan to reopen both the emergency room and inpatient unit. Unfortunately, this plan would require millions of dollars in funding to execute.

¹⁴¹ U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 122, at 2.

¹⁴² Walker, *supra* note 138; *See also, Id.*

¹⁴³ *Id.*

¹⁴⁴ U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 122, at 2.

patients.¹⁴⁵ Although there are more than 100 IHS facilities throughout the U.S.¹⁴⁶, only 13 of those facilities offer obstetric services and are deemed “baby friendly”.¹⁴⁷ A United States Government Accountability Office report revealed concerns regarding persistent vacancies and their negative impact on patient accessibility to quality medical care:

[O]fficials from the Rosebud Hospital stated the facility has diverted obstetrics patients to other facilities since July 2016 due to a shortage of physicians, nurses, and nurse anesthetists. During the diversion, those patients were referred to other hospitals in Valentine, Nebraska, and Winner, South Dakota—about 45 miles away.¹⁴⁸

American Indian and Alaska Native women are 3 to 4 times more likely to begin prenatal care in the third trimester of pregnancy than white women¹⁴⁹, which can

¹⁴⁵ Mary Smith, *Native Americans: A Crisis in Health Equity*, ABA, https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/native-american-crisis-in-health-equity/, (last visited March 29, 2021).

¹⁴⁶ *Locations*, INDIAN HEALTH SERV., <https://www.ihs.gov/locations/#:~:text=The%20Indian%20Health%20Service%20is,day%2Dto%2Dday%20basis> (last visited March 30, 2021); see also, Elena Saavedra Buckley, *Indian Health Service Provider Vacancies a ‘Never-ending Cycle,’* HIGH COUNTRY NEWS, (Oct. 8, 2018), <https://www.hcn.org/articles/tribal-affairs-indian-health-service-provider-vacancies-a-never-ending-cycle>.

¹⁴⁷ *All 13 IHS Obstetric Facilities Designated as Baby-friendly*, INDIAN HEALTH SERV., (Dec. 8, 2014), <https://www.ihs.gov/newsroom/pressreleases/2014pressreleases/all13ihsobstetricfacilitiesdesignatedbabyfriendly/>. “Baby-friendly” means that new mothers are given information and guidance regarding breastfeeding. *Id.*

¹⁴⁸ U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 122, at 18.

¹⁴⁹ *American Indian and Alaska Native Women’s Maternal Health: Addressing the Crisis*, NAT’L P’SHIP FOR WOMEN & FAMS, Oct. 2019, at 2, (citing Adrian Dominguez et al., *Community Health Profile: National Aggregate of Urban Indian Health Program Service Areas*, URB. INDIAN HEALTH INST., Oct. 2016, at 37).

create a higher risk for negative birth outcomes.¹⁵⁰ A study conducted on 58 American Indian women in a Northern Plains Tribe revealed how their experiences at IHS facilities may have interfered with pursuance or continuation of prenatal care.¹⁵¹ The study uncovered that some of the barriers to timely and continued prenatal care included long waiting times that sometimes spanned more than 2 hours¹⁵², transportation issues¹⁵³, and difficulties in communication with physicians¹⁵⁴. One woman speaking on her experience, stated that a miscommunication with her physician led to her being in labor for 4 days unnecessarily even though she was initially told that she was supposed to have a C-section rather than a natural birth.¹⁵⁵ In addition, most of the women were unable to build a strong relationship with a physician as many of them saw different physicians for each prenatal appointment.¹⁵⁶

B. Lower Quality of Care Attributable to Hospital Preparedness and Implicit Racial Bias Influencing Medical Decisions

Often times, the disparity in health outcomes for minority populations in the United States is attributed to socioeconomic factors like income, education, and employment.¹⁵⁷ In addition, the location or community in which individuals live

¹⁵⁰ Jessica D. Hanson, *Understanding Prenatal Health Care for American Indian Women in a Northern Plains Tribe*, 23 J. TRANSCULTURAL NURSING 1, 2 (2012)

¹⁵¹ *Id.* at 4.

¹⁵² *Id.* at 6.

¹⁵³ *Id.* at 7.

¹⁵⁴ *Id.* at 6.

¹⁵⁵ *Id.*

¹⁵⁶ Hanson, *supra* note 150, at 7.

¹⁵⁷ *Socioeconomic status*, APA, <https://www.apa.org/topics/socioeconomic-status>, (last visited Dec. 17, 2020). Explaining that “Socioeconomic status is the social standing or class of an individual or group. It is often measured as a combination of education, income and occupation.” *Id.*

is considered to be an important factor in assessing disparities in health outcomes for black and indigenous women.¹⁵⁸ Although these factors are essential to equation, they are not the only factors that must be considered. Disparity in maternal mortality rates does not disappear for black and American Indian/Alaska Native mothers of higher socioeconomic standing.¹⁵⁹

Studies have revealed an association between area-level income inequality and infant mortality.¹⁶⁰ In addition, socioeconomic inequality and state policies “may play a larger role in women’s health as compared to men’s health as they shape access to services and resources (i.e. prenatal care, affordable housing, children’s health care, family leave) that are especially central in women’s lives”.¹⁶¹ Evidence demonstrates a significant association between income inequality and pregnancy-related death for black women, where “increasing income inequality was associated with a 14-15% increase in pregnancy-related mortality”.¹⁶² Both American Indian/Alaska Native women and black women experience the highest poverty rates in the country.¹⁶³ However, there is also

¹⁵⁸ See generally *Id.*

¹⁵⁹ *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths*, CDC, (Sept. 5, 2019, 1:00 PM) <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>.

¹⁶⁰ Dovile Vilda et al., *Income Inequality and Racial Disparities in Pregnancy-related Mortality in the US*, 9 SOC. SCI. & MED. POPULATION HEALTH, Dec. 2019, at 1, 2. Income inequality is “the degree of unequal distribution of income within a population.” *Id.*

¹⁶¹ *Id.* at 3.

¹⁶² *Id.* at 4.

¹⁶³ Robin Bleiweis et al., *The Basic Facts About Women in Poverty*, CTR. FOR AM. PROGRESS (Aug. 3, 2020), <https://www.americanprogress.org/issues/women/reports/2020/08/03/488536/basic-facts-women-poverty/>.

evidence that shows a tendency for minority patients to receive a lower standard of care than white patients.¹⁶⁴

One contributing factor in decreased care quality for black mothers is lower performance by hospitals.¹⁶⁵ An analysis by the Journal of Women's Health found that hospitals serving black populations had "a lower level of performance on delivery-related indicators" than hospitals that serve white and Hispanic populations".¹⁶⁶ Another study conducted by the Association of Women's Health, Obstetric and Neonatal Nurses [hereinafter AWHONN] assessed the relationship between the existence of "hospital preparedness elements to effectively respond to postpartum hemorrhage" and the patient population served for 136 hospitals in New Jersey and Georgia.¹⁶⁷ The team assembled by the AWHONN found the following: "For every 10% increase in the total percentage of black women who gave birth, there was a decrease in one of the elements of hospital preparedness to respond to the obstetric emergency".¹⁶⁸ This suggests that hospitals are less prepared when caring for black mothers, and are thus providing lower quality obstetric care.

¹⁶⁴ Christopher Lang, *Maternal Mortality in the United States*, 22 BEST PRAC. & RES. CLINICAL OBSTETRICS AND GYNECOLOGY 517, 522 (2008).

¹⁶⁵ Debra Bingham et al., *Postpartum Hemorrhage Preparedness Elements Vary Among Hospitals in New Jersey and Georgia*, 45 J. OF OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 227 (2016) (citing Andreea A. Creanga et al., *Maternal Mortality and Morbidity in the United States: Where Are We Now?*, 23 J. WOMEN'S HEALTH, Jan. 1, 2014, at 3, 9).

¹⁶⁶ Debra Bingham et al., *supra* note 165, at 227-28.

¹⁶⁷ *Id.* at 227.

¹⁶⁸ *Id.*

Another factor likely to play a significant role in care quality for black and American Indian/Alaska Native patients is racial bias. A John Hopkins study conducted in 2011, revealed that almost 70% of medical students that were surveyed “exhibited implicit preferences for white people”.¹⁶⁹ Further, there are other studies published in 2000 that revealed that physicians had a tendency to rate “[black] patients more negatively than white [patients] on a number of registers, including intelligence, compliance, and propensity to engage in high-risk health behaviors”.¹⁷⁰ Another study, published by the Journal of Racial and Ethnic Health Disparities, revealed that healthcare providers had negative implicit attitudes and stereotypes of American Indian patients as well.¹⁷¹ Further, implicit racial bias has been found to exist in IHS physicians specifically.¹⁷² This implicit racial bias highlighted in past studies, may lead to a lower standard of care administration by physicians, as research suggests that implicit bias may influence

¹⁶⁹ Emily A. Benfer et al., *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL’Y, L., AND ETHICS 122, 142 (2020) (citing Kimani Paul-Emile, *Patients’ Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. REV. 462, 492 (2012)).

¹⁷⁰ Benfer et al., *supra* note 169.

¹⁷¹ Colin A. Zestcott et al., *Health Care Providers’ Negative Implicit Attitudes and Stereotypes of American Indians*, 8 J. RACIAL AND ETHNIC HEALTH DISPARITIES 230 (2020).

¹⁷² Janice A. Sabin, *Clinicians’ Implicit and Explicit Attitudes about Weight and Race and Treatment Approaches to Overweight for American Indian Children*, 11 CHILDHOOD OBESITY 456, 463 (2015). It is important to note that this study only found “weak” implicit bias. *Id.* However, this article suggests that this may be due to the fact that the physicians studied were long-term providers who exclusively saw American Indian/Alaska Native patients. *Id.*

physician decision-making about patient medical care.¹⁷³ Specifically, implicit bias may be linked to disparate health outcomes for minority infants.¹⁷⁴

A study conducted by George Mason University between 1992 and 2015 revealed a “newborn–physician racial concordance is associated with a significant improvement in mortality for black infants”.¹⁷⁵ The evidence analyzed 1.8 million births in the state of Florida, and revealed that black infants have a greater chance of surviving childbirth when they were cared for by black doctors.¹⁷⁶ Further, black infants were “three times more likely than white babies to die when looked after by white doctors” while the mortality rate for white babies was generally unaffected.¹⁷⁷ Although the study also found that concordance with physicians who have additional formal training may “reduce the magnitude of the black mortality penalty” it did not eliminate it.¹⁷⁸ This may suggest that racial bias is impacting black infant health outcomes.¹⁷⁹

¹⁷³ Zestcott et al., *supra* note 171, at 231; see Janice A. Sabin & Anthony G. Greenwald, *The Influence of Implicit Bias on Treatment Recommendations for 4 Common Pediatric Conditions: Pain, Urinary Tract Infection, Attention Deficit Hyperactivity Disorder, and Asthma*, 102 AM. J. PUB. HEALTH 988 (2012); Alexander R. Green et al., *Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231 (2007) (stating that unconscious biases may contribute to racial disparities in the use of certain medical procedures).

¹⁷⁴ See Brad N. Greenwood et al., *Physician-patient Racial Concordance and Disparities in Birthing Mortality for Newborns*, 117 PROC. OF THE NAT'L ACAD. OF SCI. OF THE U.S. 21194 (Sept. 1, 2020); see generally Rob Picheta, *Black Newborns More Likely to Die when Looked after by White Doctors*, CNN (Aug. 20, 2020), <https://www.cnn.com/2020/08/18/health/black-babies-mortality-rate-doctors-study-wellness-scli-intl/index.html> (discussing the research findings of this study conducted by George Mason University).

¹⁷⁵ Greenwood et al., *supra* note 174, at 21194.

¹⁷⁶ *Id.*

¹⁷⁷ Picheta, *supra* note 174.

¹⁷⁸

¹⁷⁹ *Id.*

C. The Irony of “Pro-Life” Abortion Restrictions: They may be Killing Mothers and Infants

The United States Supreme Court legalized abortion in 1973.¹⁸⁰ Yet, women have faced significant challenges in exercising that right ever since then. Recently, a number of states have passed abortion legislation that dramatically impacts the availability of abortion services, by prohibiting abortion once the fetal heartbeat can be detected.¹⁸¹ Therefore, abortion can only be obtained for approximately 6-8 weeks in at least 6 states across the country.¹⁸²

Evidence suggests that a number of states with the harshest abortion restrictions have some of the highest infant or maternal mortality rates in the country.¹⁸³ “Nearly all of the states who have recently passed restrictive bans on abortion rank in the top 10 states for maternal mortality, infant mortality, or both.”¹⁸⁴ According to the CDC, Ohio (which recently passed aggressive abortion legislation) had one of the highest infant mortality rates in the country in 2018.¹⁸⁵

¹⁸⁰ *Roe v. Wade*, 410 U.S. 113, 169 (1971).

¹⁸¹ K.K. Rebeca Lai, *Abortion Bans: 9 States Have Passed Bills to Limit the Procedure This Year*, N.Y. TIMES (May 29, 2019), <https://www.nytimes.com/interactive/2019/us/abortion-laws-states.html?mtref=www.google.com&assetType=REGIWALL>.

¹⁸² *Id.* Alabama has an absolute ban on abortion. *Id.* In addition, Louisiana may be on its way to an absolute ban after the previous 2020 state elections. *Id.*; see, Becca Andrews, *Louisiana Just Passed an Amendment to Pave the Way to Decimating Abortion Rights*, MOTHERJONES (Nov. 3, 2020), <https://www.motherjones.com/2020-elections/2020/11/louisiana-abortion-constitutional-amendment-passed/>.

¹⁸³ Panetta, *supra* note 12; see also, Lai, *supra* note 37.

¹⁸⁴ Panetta, *supra* note 12; see also, Jennifer L. Heck et al, *Maternal Mortality Among American Indian/Alaska Native Women: A Scoping Review*, 30 J. WOMEN’S HEALTH 220, 226 (Nov. 2, 2021) (citing Christie L. Palladino et al., *Homicide and Ssuicide During the Perinatal Period: Findings from the National Violent Death Reporting System*, 118 OBSTETRICS AND GYNECOLOGY 1056 (2011) which asserts that 45% of American Indian/Alaska Native deaths are being misclassified as a different race, likely resulting in an underestimation of maternal mortality rates for American Indians and Alaska Natives).

¹⁸⁵ *Infant Mortality Rates by State*, CDC, https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm, (last visited Apr. 24, 2020).

Ohio had 982 infant death in 2017 and 938 infant deaths in 2018 according to the Ohio Department of Health.¹⁸⁶ Although the “overall infant mortality rate decreased at an average of 1.2% per year” from 2010 to 2019, the black infant mortality rates “have not experienced a significant change during the past 10 years”.¹⁸⁷ In 2019, black infants still died at 2.6 times the rate of white infants.¹⁸⁸

An article from the International Journal of Environmental Research and Public Health, analyzed data on almost 12 million infants and mothers from “the US Cohort Linked Birth/Infant Death Data Files on infants born 2008-2010, which is provided by the National Center for Health Statistics”.¹⁸⁹ The central exposure measure was restrictive state abortion laws.¹⁹⁰ The study analyzed the status of five different types of abortion laws for all 50 states and the District of Columbia, and the correlation of those laws with infant mortality.¹⁹¹ The study also presented the race and socioeconomic characteristics of the infants from 2008 to 2010.¹⁹² The study found “a significant relationship between the number of restrictive abortion laws and infant mortality risk, indicating a potential additive

¹⁸⁶ Catherine Candisky, *Ohio Infant Deaths Decline, but Racial Disparity Persists*, COLUMBUS DISPATCH (Feb. 26, 2020), <https://www.dispatch.com/news/20200225/ohio-infant-deaths-decline-but-racial-disparity-persists>.

¹⁸⁷ 2019 INFANT MORTALITY ANNUAL REPORT, OHIO DEP’T OF HEALTH ANNUAL INFANT MORTALITY 6 (2019). The Ohio Department of Health did not account for American Indian or Alaska Native mortality rates among infants. *Id.*

¹⁸⁸ Candisky, *supra* note 186. This has changed very little since 2009, when it was 2.2. *Id.*

¹⁸⁹ Roman Pabayo et al., *Laws Restricting Access to Abortion Services and Infant Mortality Risk in the United States*, 17 INT’L J. OF ENVTL. RES. AND PUB. HEALTH 1, 3 (May 26, 2020).

¹⁹⁰ *Id.*

¹⁹¹ *Id.* It is important to note that none of these five restrictions were so-called “heartbeat bills.” The restrictions included: Medicaid funding restrictions, parental involvement laws, mandatory counseling, mandatory waiting periods, and two-visit laws. *Id.*

¹⁹² *Id.* at 5, 6.

effect”.¹⁹³ “Infants born in states with three or more restrictive laws were significantly more likely to die before their first birthday” than the infants born in states that had no abortion restriction laws.¹⁹⁴ Of the states with all five of the abortion restriction laws studied, four of them (Louisiana, Mississippi, Missouri and Ohio) just recently passed “heartbeat bills” in 2019 adding even tighter restrictions on the reproductive options for women.¹⁹⁵

Although abortion restrictions are impacting all mothers and infants, these laws may exacerbate racial disparities in mortality rates. Infants born to black mothers in states that had “Medicaid restrictions and parental involvement laws were more likely to die than those born in states without these laws”.¹⁹⁶ Black Americans make up 20% of the total nonelderly Medicaid enrollees in the nation, yet nonelderly black Americans only make up 11% of the total population in the United States.¹⁹⁷ In 2018, 12.9% of women were living in poverty opposed to 10.9% of men.¹⁹⁸ Further, black women represent 22.3% of the women in poverty despite comprising only 12.8% of the total United States population.¹⁹⁹ This could suggest that black women are more likely to be negatively impacted by a Medicaid restriction on abortion than white women. Moreover, state Medicaid

¹⁹³ *Id.* at 10.

¹⁹⁴ Pabayo et al., *supra* note 189, at 10.

¹⁹⁵ *Id.* at 4; *see*, Blake & McGowan, *supra* note 63, at 487; *see also*, Panetta, *supra* note 12. Specifically, the state of Ohio has reportedly implemented 16 “abortion-restrictive regulations since 2011, which has coincided with the closure of more than half of the abortion clinics in the state.”

¹⁹⁶ Pabayo et al., *supra* note 189, at 11.

¹⁹⁷ *African Americans and Medicare*, NAT’L COMM. TO PRESERVE SOC. SEC. & MEDICARE (January 28, 2021), <https://www.ncpssm.org/documents/medicare-policy-papers/medicare-medicaid-important-african-americans/>.

¹⁹⁸ Bleiweis et al., *supra* note 163.

¹⁹⁹ *Id.*

restrictions may also disproportionately impact American Indian/Alaska Native women as well, since the American Indian/Alaska Native population also experiences high rates of poverty²⁰⁰ and Medicaid coverage.²⁰¹

In addition, a national “turn away study” explored the impacts of denial of wanted abortion services in approximately 1,000 women seeking abortion²⁰² from 30 different facilities in the United States.²⁰³ The study revealed that 6.3% of the women who gave birth experienced life-threatening complications.²⁰⁴ Further, 9.4% of the women who were denied abortion care experienced gestational hypertension during the following five years, compared to only 4.2% in women who had second-trimester abortions and 1.9% in women who had first-trimester abortions.²⁰⁵ Diane Greene Foster explained the importance of these numbers:

At first glance, this finding is not surprising since women denied abortions remained pregnant for many more months after they were denied abortion. But...many women have pregnancies in the following five years, so this index pregnancy was [not] the only opportunity to develop gestational

²⁰⁰ *Id.*

²⁰¹ Samantha Artiga, *Medicaid and American Indians and Alaska Natives*, KAISER FAM. FOUND., (Sept. 7, 2017), <https://www.kff.org/medicaid/issue-brief/medicaid-and-american-indians-and-alaska-natives/#:~:text=Nearly%205%20million%20nonelderly%20individuals,of%20the%20total%20nonelderly%20population.>

²⁰² DIANA GREENE FOSTER, *THE TURNAWAY STUDY: TEN YEARS, A THOUSAND WOMEN, AND THE CONSEQUENCES OF HAVING--OR BEING DENIED AN ABORTION* (2020). It is important to note that many women who initially agreed to participate had dropped out throughout the course of the study. Therefore, the pool of participants that the study examined was much smaller at the end of the study than it was at the first interview stage. *See Id.*

²⁰³ *Id.* at 19.

²⁰⁴ *Id.*

²⁰⁵ *Id.* at 148.

hypertension. Having gestational hypertension in one pregnancy puts women at increased risk for having it in subsequent pregnancies. So, denial of abortion may put subsequent pregnancies at higher risk.²⁰⁶

According to Columbia University Department of Medicine, 10 to 25% of women with gestational hypertension can progress to having preeclampsia,²⁰⁷ a condition that disproportionately affects American Indian/Alaska Native²⁰⁸ and black women.²⁰⁹ In addition, the Turnaway Study revealed an exceptionally high maternal death rate of 1 per 100 deliveries.²¹⁰ This maternal death rate is 100 times that of the national maternal mortality rate.²¹¹ Although the participation sample is very small, these numbers could expose a potential link between abortion restrictions and maternal death. In addition, as both black and indigenous mothers already face heightened risk of maternal death, denial of an abortion can put them at an even greater risk for negative health outcomes.

Shortly after the Supreme Court's decision in *Roe*, Congress enacted the Hyde Amendment²¹² which prohibited the use of *federal* funding for abortion services, with a few very limited exceptions (rape, incest, or the pregnancy

²⁰⁶ *Id.*

²⁰⁷ *Preeclampsia and Gestational Hypertension*, COLUM. U. DEP'T OF MED., [https://www.columbiacardiology.org/patient-care/womens-heart-center/about-heart-disease-women/pregnancy-and-heart-disease/preeclampsia-and-gestational-hypertension#:~:text=A%20percentage%20of%20women%20\(10,can%20progress%20to%20having%20preeclampsia,\(last%20visited%20Apr.%202,2021\).](https://www.columbiacardiology.org/patient-care/womens-heart-center/about-heart-disease-women/pregnancy-and-heart-disease/preeclampsia-and-gestational-hypertension#:~:text=A%20percentage%20of%20women%20(10,can%20progress%20to%20having%20preeclampsia,(last%20visited%20Apr.%202,2021).)

²⁰⁸ Anna Zamora-Kapoor, *Pre-eclampsia in American Indians/Alaska Natives and Whites: The Significance of Body Mass Index*, 20 *MATERNAL HEALTH J.* 2233 (2016).

²⁰⁹ Masako Tanaka et al., *Racial Disparity in Hypertensive Disorders of Pregnancy in New York State: A 10-Year Longitudinal Population-Based Study*, 97 *AM. J. PUB. HEALTH* 163 (2007).

²¹⁰ FOSTER, *supra* note 202, at 150.

²¹¹ *Id.*

²¹² Hyde Amendment, Pub. L. No. 94-439, 90 Stat. 1434 (1976).

endangers life of the mother).²¹³ This amendment has disproportionately impacted minority women, as it severely restricts coverage of abortion services through Medicaid²¹⁴ and other federal programs like the IHS.²¹⁵ American Indian and Alaska Native women are especially affected by the Hyde Amendment because they are entitled to receive services through a federal agency (the IHS), and the use of federal funds for abortion through the IHS is prohibited. As a result, “in 20 years of recordkeeping (1981-2001), the IHS performed 25 abortions.²¹⁶ Further, a 2002 study published by the Native American Women’s Health Education Resource Center reported:

85% of IHS facilities were not in compliance with IHS and Hyde Amendment regulations [meaning] did not have abortion services available or did not refer to abortion providers even for women in the permitted circumstances. Only 5% of IHS facilities actually provided abortion services onsite, and no facility-based IHS pharmacies kept Mifeprex (RU-486), a medication used for nonsurgical abortion, in stock.

²¹³ Alina Salganicoff et al., *The Hyde Amendment and Coverage for Abortion Services*, KAISER FAM. FOUND. (March 5, 2021), <https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/>. This amendment has been renewed each year by Congress as an appropriations bill for the Department of Health and Human Services (HHS).

²¹⁴ *Id.* In addition, it is important to note that the Hyde Amendment’s restriction on Medicaid funding differs from the Medicaid restrictions discussed in the beginning portion of this section. *See supra* pp. 35-36. The Hyde Amendment prohibits the use of federal funds for abortion services through Medicaid (and all other all Department of Health and Human Services programs), while state restrictions prohibit the use of *state* Medicaid funding.

²¹⁵ Jessica Aarons & Madina Agenor, *Separate and Unequal: The Hyde Amendment and Women of Color*, CTR. FOR AM. PROGRESS (2010) (citing *Medicaid’s Role for Women*, KAISER FAM. FOUND. (March 28, 2019), <https://www.kff.org/womens-health-policy/fact-sheet/medicaids-role-for-women/>)).

²¹⁶ Shaye B. Arnold, *Reproductive Rights Denied: The Hyde Amendment and Access to Abortion for Native American Women Using Indian Health Service Facilities*, 104 AM. J. PUB. HEALTH 1892 (2014).

[Additionally] 62% of IHS personnel interviewed reported that IHS funds could not be used for abortion even in the case of a threat to the mother's life.²¹⁷

All of this evidence could suggest that abortion restrictions, could be exacerbating the racial disparities in maternal and infant mortality.

V. Solutions: Confronting Racial Disparities in Maternal and Infant Mortality in the United States

A. Learn from the Success of other Developed Countries: Increase Employment and Utilization of Midwives by Financing Health Care to Cover Community Health Workers

The utilization of midwives for childbirth and maternity care has been growing in popularity²¹⁸ – especially in light of the COVID-19 pandemic²¹⁹. Generally, midwives are trained professions who support women during pregnancy, childbirth, and the postpartum period.²²⁰ However, there is variation in licensing, training, and educational background depending on what type of midwife is being used.²²¹ Although the utilization of midwives in the United

²¹⁷ *Id.*

²¹⁸ Carrie Murphy, *Midwives Are Growing in Popularity. Here's What You Need to Know*, HEALTHLINE (Oct. 31, 2008), <https://www.healthline.com/health/midwives-growing-in-popularity-what-to-know#The-4-types-of-midwives,-at-a-glance>.

²¹⁹ Wendy Kline & Hermine Hayes-Klein, *COVID-19 Exposes the Need for Midwives*, (May 5, 2020, 6:00 AM), <https://www.washingtonpost.com/outlook/2020/05/05/midwives-tale/>; *see also* Bev Theil, *Popularity of Midwives Rising with the Coronavirus*, (May 30, 2020, 12:01 AM), <https://www.the-daily-record.com/news/20200530/popularity-of-midwives-rising-with-coronavirus>.

²²⁰ *What is a Midwife?*, MIDWIVES ALL. N. AM., <https://mana.org/about-midwives/what-is-a-midwife>, (last visited May 14, 2021).

²²¹ Murphy, *supra* note 218. There are four different types of midwives: Certified Nurse Midwives, Certified Midwives, Certified Professional Midwives, and Traditional Unlicensed Midwives. Certified nurse midwives have completed nursing school and have obtained a graduate degree in midwifery. They are qualified to work in all birthing settings. Certified midwives have obtained the same education and training as certified nurse midwives, but their educational background is in a field outside of nursing specifically. Certified professional midwives work exclusively in birth centers and in the home birthing setting. They have completed “coursework

States has been increasing in recent years, use of midwives for childbirth is still fairly rare overall.²²²

In many other developed countries with much lower maternal mortality rates, midwives dramatically outnumber ob-gyns.²²³ In the Netherlands, there are 25 midwives per 1,000 live births compared to only 10 ob-gyns.²²⁴ The maternal care workforce in Australia consists of 68 midwives per 1,000 live births compared to only 7 ob-gyns.²²⁵ In Norway there are 53 midwives and 12 ob-gyns, in New Zealand 46 midwives and 8 ob-gyns, and in Sweden 66 midwives and only 12 ob-gyns per 1,000 live births.²²⁶ This differs significantly from the composition in the United States, where *ob-gyns* outnumber midwives.²²⁷

and apprenticeship, and a national certifying exam.” *Id.* Lastly, traditional midwives are unlicensed and typically work in the home setting. *Id.*

²²² In 1989, certified nurse midwives attended only 3.3% of all births. However, by 2009 they attended 7.6% of all births in the U.S. Eugene Declercq, *Trends in Midwife-Attended Births in the United States, 1989-2009*, 57 J. MIDWIFERY & WOMEN’S HEALTH 321 (2012). In 2013, certified nurse midwives attended 8.2% of all births in the U.S. Joyce A. Martin et al., *Births: Final Data for 2013*, 64 CDC: NAT’L VITAL STATS REPS 46 (Jan. 15, 2015). In 2014, a study conducted in 47 states and Washington, DC found that this number jumped to 8.3%. Marian F. MacDorman, & Eugene Declercq, *Trends and Characteristics of United States Out-of-Hospital Births 2004-2014: New Information on Risk Status and Access to Care*, 43 BIRTH: ISSUES IN PERINATAL CARE 116, 118 (2016). In 2019 (the most recent data), the CDC reported that certified nurse midwives attended 9.8% of all births in the U.S. Joyce A. Martin et al., *Births: Final Data for 2019*, 70 CDC: NAT’L VITAL STATS REPS 32 (Mar. 23, 2021).

²²³ Roosa Tikkanen, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, COMMONWEALTH FUND, (Nov. 18, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>.

²²⁴ *Id.*

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.* Additionally, it is important to note that the number of *both* midwives and ob-gyns per 1,000 live births in the United States is noticeably lower than the workforce available in many other developed countries. In total, there are only 15 providers per 1,000 live births. *Id.*

Australia, Sweden, Norway, and the Netherlands are a few developed countries that have implemented a midwife-led care model.²²⁸ Evidence suggests that maternity care which includes a midwife as the main care provider leads to improved birth outcomes.²²⁹ One study revealed that women who received randomized “midwife-led” continuity of care were less likely to experience fetal loss and preterm birth.²³⁰ Research also shows that incorporation of midwives in the maternal health sphere “has been associated both with a rapid and sustained decrease in maternal and newborn mortality, and with an improvement in quality of care”.²³¹ Further, this model has been shown to reduce the risk of hypertensive disorders including pre-eclampsia and eclampsia²³² – both of which are a leading cause of maternal death for black and American Indian/Alaska Native women.²³³

Section 2301 of the ACA requires Medicaid coverage of freestanding birth centers²³⁴, where the practice of midwifery is the exclusive model of care.²³⁵

²²⁸ Alba Ricchi et al., *The Midwifery-led Care Model: A Continuity of Care Model in the Birth Path*, 90 ACTA BIOMED FOR HEALTH PROS 41, 43 (2019).

²²⁹ Joyce K. Edmonds et al., *Midwife Led Units: Transforming Maternity Care Globally*, 86 BIOMANNALS GLOBAL HEALTH 1 (2020).

²³⁰ Jane Sandall et al., *Midwife-led Continuity Models Versus Other Models of Care for Childbearing Women*, COCHRANE DATABASE OF SYSTEMIC REVIEWS (2016). Preterm birth is one of the leading causes of infant mortality. See *Infant Mortality*, *supra* note 9. Further, preterm birth disproportionately impacts black and American Indian/Alaska Native infants. *Preterm Birth*, CDC (last updated Oct. 30, 2020), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm>; see Truschel & Novoa, *supra* note 82.

²³¹ Mary J. Renfrew et al., *Midwifery and Quality Care: Findings from a New Evidence-informed Framework for Maternal and Newborn Care*, 384 LANCET 1129, 1130 (Sept. 20, 2014).

²³² *Id.* at 1136-37.

²³³ Gianna Melillo, *Racial Disparities Persist in Maternal Morbidity, Mortality and Infant Health*, AM. J. MANAGED CARE (June 13, 2020), <https://www.ajmc.com/view/racial-disparities-persist-in-maternal-morbidity-mortality-and-infant-health>; see Heck, *supra* note 184, at 226.

²³⁴ § 2301, 124 Stat. 119.

²³⁵ *What is a Birth Center?*, AM. ASS’N BIRTH CTRS, https://www.birthcenters.org/page/bce_what_is_a_bc (last visited May 14, 2021). A birth center is a healthcare facility that provides childbirth care, and is “free standing” in the sense that it is not

However, licensure is required for Medicaid reimbursement and depends on adherence to state regulations.²³⁶ A national evaluation of Strong Start for Mothers and Newborns II, found that approximately one-third of patients at participating birth center sites (Strong Start birth centers) were enrolled in Medicaid.²³⁷ Some centers reported that two-thirds of their patients were enrolled in Medicaid.²³⁸ Further, many of these birthing centers reported that service reimbursement, inability to contract with Medicaid managed care organizations, coverage limitations and state and local licensure laws²³⁹ presented challenges in serving Medicaid patients.²⁴⁰ Approximately half of the birth centers included in the study reported that they struggled to provide care for women on Medicaid due to inadequate reimbursement.²⁴¹ Therefore, the study concluded that women

considered a hospital. *Id.* Further, certified nurse midwives were covered under Medicaid in all states in 2018. *Medicaid Benefits: Nurse Midwife Service*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/nurse-midwife-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited May 14, 2021).

²³⁶ *Improving Maternal Health Access, Coverage, and Outcomes in Medicaid*, INST. FOR MEDICAID INNOVATION (2020), https://www.medicaidinnovation.org/_images/content/2020-IMI-Improving_Maternal_Health_Access_Coverage_and_Outcomes-Report.pdf.

²³⁷ Brigitte Courtot et al., *Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care*, 98 A MULTIDISCIPLINARY J. POPULATION HEALTH AND HEALTH POL'Y 1091, 1100 (2020). Strong Start Mothers and Newborns is an initiative designed to test the effectiveness of enhanced prenatal care models. These models are meant to reduce the prevalence of low birth weight among infants of pregnant Medicaid beneficiaries. Elizabeth E. Krans & Matthew M. Davis, *Strong Start for Mothers and Newborns: Implications for Prenatal Care Delivery*, 26 CURRENT OP. OBSTETRICS AND GYNOCLOGY 511 (2014). Enhanced prenatal care models refers to “evidence-based non-medical enhancements in care, such as counseling in nutrition and parenting, and childbirth and breastfeeding preparation and support through midwifery-led models of care (with a focus on CNM/CM care) including in the hospital and certified freestanding birth centers.” See INST. FOR MEDICAID INNOVATION, *supra* note 236, at 29.

²³⁸ Courtot et al., *supra* note 237, at 1100.

²³⁹ Only 26 states and the District of Columbia allow certified nurse midwives to practice independent of physicians. Four states require physician supervision and 20 require collaborative practice agreements. See INST. FOR MEDICAID INNOVATION, *supra* note 236, at 33.

²⁴⁰ Courtot et al., *supra* note 237, at 1102.

²⁴¹ *Id.* at 1101.

enrolled in Medicaid had less access to birthing centers (and thus less access to midwife-led care) than privately insured women.²⁴²

As approximately 50% of all births in the United States are covered by Medicaid²⁴³, one way to increase access to midwife-led care is to reimburse certified nurse midwives and birthing centers at the same rate as other providers who are providing exactly the same care²⁴⁴:

Reimbursement methodologies should determine the relative value of the payment made for those services based on the resources required to provide the service, not the type of provider rendering the care. To reimburse at a reduced rate relative to what is paid to physicians...inappropriately disadvantages midwives relative to their colleagues and discourages their participation in the provider networks of such payers.²⁴⁵

It is estimated that a substantial increase in coverage of midwife-delivered interventions could avert 41% of maternal deaths per year by 2035 worldwide.²⁴⁶ Further, evidence suggests that states that permit independent midwifery practice have a larger midwife workforce, and a greater proportion of certified nurse

²⁴² *Id.* at 1091.

²⁴³ INST. FOR MEDICAID INNOVATION, *supra* note 236, at 12.

²⁴⁴ *Id.* at 40.

²⁴⁵ *Id.*

²⁴⁶ Andrea Nove et al., *Potential Impact of Midwives in Preventing and Reducing Maternal and Neonatal Mortality and Stillbirths: A Lives Saved Tool Modeling Study*, 9 LANCET 24 (2021).

midwife-attended births than states that require collaborative practice agreements between midwives and physicians.²⁴⁷

Therefore, states should loosen the existing midwife restrictions to increase the midwife workforce in the United States and permit expecting mothers to utilize different birthing options. Permitting certified nurse midwives to practice independently and increasing Medicaid reimbursement for midwife-led birthing centers can increase access to beneficial birthing options for expecting mothers.²⁴⁸ Greater access to midwife-led care for Medicaid enrollees could be particularly beneficial for black and indigenous populations, who are significantly more likely to be enrolled in Medicaid²⁴⁹ and face greater risk of maternal and infant mortality²⁵⁰.

B. Learning from California

In 2006, California decided to utilize federal funding available from the Title V Maternal and Child Health Services Block Grant Program to develop the California Pregnancy-Associated Mortality Review [hereinafter CA-PAMR].²⁵¹ Since then, California's maternal mortality rates have decreased dramatically, despite the maternal mortality rates continued increase for the United States as a

²⁴⁷ INST. FOR MEDICAID INNOVATION, *supra* note 236, at 33.

²⁴⁸ *Id.*

²⁴⁹ *Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, (last visited May 14, 2021).

²⁵⁰ *Pregnancy Mortality Surveillance System*, *supra* note 75.

²⁵¹ Blake & McGowan, *supra* note 63, at 486.

whole.²⁵² In fact, “California has cut its rate nearly in half, from 13.1 per 100,000 live births, on average, in the baseline period of 2005-09 to a three year average of 7.0 during 2011-13”.²⁵³ A number of steps have been identified as crucial in maintaining this improvement:

Linking public health surveillance to actions steps; mobilizing a broad set of public and private partners to work collaboratively; establishing a low-burden, rapid-cycle data system to support improvement efforts; and implementing multi-partner, large-scale interventions that integrate clinical providers with public health services.²⁵⁴

This approach has been described as a “public-private collaborative” and serves as a model to be replicated by other states.²⁵⁵ The CA-PAMR reports on state maternal death numbers, and provides this data to other organizations within the collaboration. The organizations then conduct research and collect data from hospitals within the state to determine the cause and preventability of the death, the factors that contributed to each death, and how quality improvements can be made to prevent these deaths in the future.²⁵⁶ In addition, organizations within the collaborative develop “quality improvement toolkits” to guide state physicians in preventing future maternal deaths.

²⁵² Elliott K. Main, *Addressing Maternal Mortality And Morbidity In California Through Public-Private Partnerships*, 37 HEALTH AFFS 1484, 1485 (2018).

²⁵³ *Id.* at 1485.

²⁵⁴ *Id.*

²⁵⁵ Blake & McGowan, *supra* note 63, at 486.

²⁵⁶ *Id.*

The Preventing Maternal Deaths Act of 2018 provides states with federal funding, in order to replicate the positive results exhibited in California.²⁵⁷ In order for a Maternal Mortality Review Committee to be supported by funding from this legislation, the committee must include:

[M]ultidisciplinary and diverse membership that represents a variety of clinical specialties,”¹¹⁹ such as health officials, epidemiologists, statisticians, and other representatives from medical specialties that provide care to pregnant and postpartum women. They might include individuals such as obstetricians, family practice physicians, certified nurse midwives, medical examiners, and a plethora of others whose work revolves around peripartum or postpartum care.²⁵⁸

Nearly all states now have formal maternal review committees or legislation that requires review of maternal deaths.²⁵⁹ These committees should put special emphasis on the racial disparities in health outcomes for mothers and infants.

VI. Conclusion

Black and indigenous women and infants continue to experience disadvantage in quality and access of medical care. As a result, they experience much higher mortality rates than that of white women and infants. The law as it stands today is

²⁵⁷ *Id.* at 486.

²⁵⁸ Khouloude Abboud, *Why the United States Is Failing New Mothers and How It Can Counteract Its Rapidly Climbing Maternal Mortality Rates*, 30(1) HEALTH MATRIX: J. L. AND MED. 407, 428 (2020).

²⁵⁹ *Maternal Mortality Review Committees*, GUTTMACHER INST. (MARCH 1, 2021), <https://www.guttmacher.org/state-policy/explore/maternal-mortality-review-committees>.

unequipped to address the racial disparities in maternal and infant mortality rates. Therefore, legislative change and program development, such as reducing restrictions for midwives, is required to address this issue and reduce the racial disparities in health outcomes for women and infants in the United States.