Background Research on Health Equity

Reproductive health equity is an important part of general health. To understand the possible causes of reproductive health inequities and what reproductive health programs should look like, a solid understanding of what constitutes health equity, reproductive health and therefore reproductive health equity is vital.

Health and health equity are complex. Both nebulous concepts require the consideration of multiple factors. Amartya Sen, in his essay, “Why Health Equity?” offers a tri-dimensional way of thinking about health equity. The first way he offers to look at health equity is as a measure of the health achievements of each individual, accounting for the opportunities and ability each person has to attain these health achievements. The second way to look at health equity is the level of access a person has to health care and any inequalities that may exist within the distribution of health care. Finally, health equity is concerned with “the allocation of social arrangements link health with other features of states of affairs.” [1]

Health Equity Solutions, Inc. defines health equity as fairly distributing health determinants and resources while removing barriers that prevent access to health care that results in optimal health for each individual regardless of racial or ethnic differences. In this definition, health is given a broad interpretation, to mean a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in accordance with the definition provided by the World Health Organization. It is important to note that a health inequity and a health inequality are not the same things. Inequities are normative values, whereas an inequality implies only that there is a difference. There are some inequalities that are not unfair, such as an older person having more health problems that a twenty-year-old. Health inequities are, therefore, health inequalities that are unfair . Despite the differences in the meanings of the [2] terms, inequalities are important to understanding inequities in health for a variety of reasons. Most centrally to this white paper, the notion that there should be equality in access to opportunities to be healthy . More specifically health inequities can be defined as a difference in [3] health that is closely linked with social or economic disadvantage. It is important as well, to consider the different goals that pure health equality and health equity work toward. When pursuing health equality, the objective is to create equal health statuses between individuals. This could be ostensibly accomplished by causing a deterioration of the health of some to create equality. On the other hand, in advancing the cause of health equity, one works toward eliminating the unjust distribution of health to raise the level of health for all individuals . [4] Reproductive health, in keeping with the definition above, is the state of complete physical, mental and social well-being as it

relates to reproductives processes, functions and systems during all stages in life. While reproductive health is relevant to people of all ages and genders, it is of special importance to women of reproductive age . Moreover, just as health is [5] concerned with more than just access to health care, reproductive health constitutes more than access to reproductive health care, although that is an important part. In “Guidelines on Reproductive Health,” the United Nations states implicit in the ideas of reproductive health is

[1] Sen, Amartya. "Why Health Equity?" *Health Economics* 11, no. 8 (2002): 659-66. [2] Braveman, P., and S. Gruskin. "Defining Equity in Health." *Journal of Epidemiology and Community Health (1979-)* 57, no. 4 (2003): 254-58. [3] Braveman, P., and S. Gruskin. "Defining Equity in Health." *Journal of Epidemiology and Community Health (1979-)* 57, no. 4 (2003): 254-58. [4] Sen, Amartya. "Why Health Equity?" *Health Economics* 11, no. 8 (2002): 659-66. [5] United Nations Population Information Network (POPIN). Guidelines on Reproductive Health. (1995). Retrieved from http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html

that “people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.” In combining definitions [6] for both reproductive health and health equity, reproductive health equity comes to mean a fair distribution of the determinants of reproductive health and the removal of barriers to individual attainment of reproductive health including access to reproductive health care.

In the United States, several reproductive health disparities exist between racial and ethnic groups. In the year 2000, the mortality rate for black infants was 14.0 deaths per 1,000 live births, a figure considerably higher than that for white women, 5.7 live deaths per 1,000 live births . Black women are also four times more likely than white women to die from pregnancy [7] complications and “black women have an increased risk of PTD [preterm delivery] caused by... less access to health care services and resources.” Additionally, the rate of unintended [8] pregnancies and unintended births among minority women, was found to be more than twice that of white women in a study by Lawrence Finer and Mia Zolna. In the year 2017, African [9] Americans represented 13% of the U.S. population, but accounted for 43% of new HIV diagnoses . Black women are 40% more likely than white women to die of breast cancer, in part [10] because black women do not receive follow-up care after their mammograms as quickly as white women do, and fewer black women receive the treatments they need compared to white women[11] . Social inequities, communication barriers, and biased assumptions on the part of the care provider can negatively impact relations between doctor and patient. Furthermore mounting evidence in research indicates that racial biases on the part of physicians contribute to a lower level of healthcare for minorities than whites . Those are only some of the numerous [12] reproductive health disparities

that exist between racial and ethnic groups in the United States.

The causes for reproductive health disparities are wide-ranging and include: level of economic stability, the physical environment, and neighborhood in which one lives, level of and access to education, access to food, the social and community context of an individual, and health care access. Due to the complex nature of health inequities “causal assumptions should not be made based on observed associations between particular measures of social advantage and any given health outcome.” For example, a reproductive health inequity may be associated with [13] lower income, but caused by another factor related to having a lower income, such as access to reliable transportation to visit a doctors office. As such, effective reproductive health programs look different in different communities. That said, some approaches to improve reproductive health equity include the creation of peer support networks, enhancing and strengthening social networks, and increasing the access that vulnerable groups have to health resources and services.

[6] United Nations Population Information Network (POPIN). Guidelines on Reproductive Health. (1955). Retrieved from http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html [7] Anachebe, and Sutton. "Racial Disparities in Reproductive Health Outcomes." *American Journal of Obstetrics and Gynecology* 188, no. 4 (2003): S37-42. [8] Anachebe, and Sutton. "Racial Disparities in Reproductive Health Outcomes." *American Journal of Obstetrics and Gynecology* 188, no. 4 (2003): S37-42. [9] Finer, Lawrence B, and Mia R Zolna. "Shifts in Intended and Unintended Pregnancies in the United States, 2001-2008." *American Journal of Public Health* 104 Suppl 1, no. 1 (2014): S43-8. [10] Centers for Disease Control and Prevention. HIV and African Americans. (2019). Retrieved from https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html [11] Centers for Disease Control and Prevention.Black Women Have Higher Death Rates from Breast Cancer Than Other Women. (2012). Retrieved from https://www.cdc.gov/vitalsigns/breastcancer/index.html [12] Schroeder, M.. Racial Bias in Medicine Leads to Worse Care for Minorities. *U.S. News* (2016). Retrieved from https://health.usnews.com/health-news/patient-advice/articles/2016-02-11/racial-bias-in-medicine-leads-to-worse-care-for-minorities

[13] Braveman, P., and S. Gruskin. "Defining Equity in Health." *Journal of Epidemiology and Community Health (1979-)* 57, no. 4 (2003): 254-58.

Reproductive health and the creation of programs to serve this need are complicated and [14]should be evaluated not just quantitatively, but qualitatively, in a way that values the input of the groups most affected by policies. [15]

Medicaid and Doula Care

Studies have shown that women of color are systematically disadvantaged by

current medical processes regarding childbirth. According to the Center for Disease Control and Prevention, complications during birth are three to four times more likely to affect black women. These complications include cesarean sections, preterm births, low birthweight, and infant mortality. Additionally, black women are twelve times more likely to die during childbirth than [16] white women. One proven solution to these problems is the implementation of doula care. [17]

Doula assistance is an immediate and effective solution to decrease the infant and mother mortality rate among women of color. Doulas are trained to provide physical, emotional, and informational support to women during labor, birth, and in the immediate postpartum period. [18] Doula-supported mothers had significantly lower rates of preterm birth (6.3% to 12.4%) and low birthweight (6.5 to 11.1%) as well as shorter lengths of labor. All mothers in the same study, [19] [20] By My Side (BMS) were surveyed by a BMS employee who did not know the doula or client. The results showed that 95.5% participants would recommend the program or use it again in the future. Other mothers in labor surveyed that they expected nurses to give 53% of their time, but [21] test results proved nurses only offered 6% - 10% of their time engaged in labor support activities. Thus, doula support would provide the emotional, physical, and knowledge those mothers [22]expected and needed as they gave birth.. In addition, the New York based non-profit Choices in Childbirth found that 69% of women of color wanted but did not have doula support. [23]

Anecdotally, women have also found doulas to be effective advocates when faced with unresponsive hospital staff. An article in the *Intelligencer* tells about a doula who helped bridge the gap between hospital staff and the mother, potentially saving the mother's life from preeclampsia in the process. *The Washington Post* also writes about a black woman who was in [24] severe pain during a caesarean section, but her pain was undermined by the doctors due to her race. After the traumatic experience, the mother decided to hire a doula for her second

[14]Price, Neil L, and Kirstan Hawkins. "A Conceptual Framework for the Social Analysis of Reproductive Health." *Journal of Health, Population, and Nutrition* 25, no. 1 (2007): 24-36 [15] United Nations Population Information Network (POPIN). Guidelines on Reproductive Health. (1955).Retrieved from http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html [16] Hosseini, Sarah. "Black women are facing a childbirth mortality crisis. There doulas are trying to help." *The Washington Post* , February 28, 2019. [17] Martin, Nina, and Renee Montagne. "Nothing Protects Black Women From Dying in Pregnancy and Childbirth." *ProPublica* . December 8, 2017. [18] Gruber, Kenneth J, et al. "Impact of Doulas on Healthy Birth Outcomes" *National Center for Biotechnology Information (NCBI)* , The Journal of Perinatal Education, Winter 2013. [19] Thomas, Mary-Powel, and NYC Department of Health and Mental Hygiene. "Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population ." *National Center for Biotechnology Information (NCBI)* , Maternal and Child Health Journal, December 2, 2017. [20] Meyerson, Collier. "Every

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pregnancy. Ultimately, multiple studies have shown that doulas are a needed, effective, and [25] valuable asset during and after pregnancy, especially for women of color.

Doulas, especially those who are experienced, can cost large amounts of money, and are rarely covered by insurance programs. An experienced doula from the New York Doula Collective can cost up to $2400 out of pocket, which is preventive for many women and [26] families. This is the higher end of the spectrum, with a study finding doulas in Arizona that cost up to $1,500 per birth and a report in *HHS Public Access* found that nationwide doulas can cost [27] up to $1,200. While not expensive to some, these costs can prevent the vulnerable, those who [28] need doulas the most, from hiring a doula.

The government-sponsored healthcare for the impoverished, Medicaid, insures nearly half of mothers within the United States. A study found that on average, a publicly funded birth [29] cost $12,770 in prenatal care, labor and delivery, postpartum care and the first 12 months of infant care; care for months 13–60 cost, on average, another $7,947, for a total cost per birth of $20,716. Currently, Medicaid programs cover doula care in only three states: New York , [30] [31] Minnesota, and Oregon . A study in the midwest region found that doulas save $986 per birth [32] due their role in decreasing use of epidurals, preterm births, and cesarean sections - including doula cost. If implemented nationwide, doula care could save taxpayers large sums of money in [33] addition to providing substantive care for at-risk mothers.

Many other states have made the decision to incorporate doula services into their Medicaid programs. Two states, Minnesota and Oregon, have allowed reimbursement through the Medicaid program for doula assistance. Minnesota, Oklahoma, and Washington state have also expanded their reproductive health care by ensuring incarcerated women have access to doula care. Lastly, Washington D.C. and Oregon have established doulas as part of their maternal mortality review committees and Louisiana established doulas as a part of their maternal mortality and disparities council.

Minnesota allows Medicare to reimburse the licensed provider for up to $410 per birth and for up to 7 visits with a doula. However, there are substantial bureaucratic delays in reimbursement which has hurt the potential market of providers. Oregon offers $350 per birth, which includes two visits pre-birth and two after. Oregon’s

Medicaid for-fee options, called Coordinated Care Organizations (CCOs), also sometimes refuse to negotiate to include doulas in their plans. These reimbursement rates are unfortunately far below the market rate for most [34] doulas, which results in an undersupply of doulas who are willing to work for Medicaid patients.

[25] Hosseini, Sarah. “Black women are facing a childbirth mortality crisis. There doulas are trying to help.” *The Washington Post* , February 28, 2019. [26] NYC Doula Collective Inc. "Doula Services & Fees." NYC Doula Collective. 2019. [27] Mohan, Prashanthinie, Anne Roubal, Elizabeth A. Calhoun, and Will Humble. *Doula Coverage to Help Minimize Arizona’s Birth Woes* . Issue brief. Health Sciences, University of Arizona. Tucson, AZ: Center for Population Science & Discovery, 2016. [28] Kozhimannil, Katy B and Rachel R Hardeman. “Coverage for Doula Services: How State Medicaid Programs Can Address Concerns about Maternity Care Costs and Quality” *Birth (Berkeley, Calif.)* vol. 43,2 (2016): 97-9. [29] Gifford, Kathy, et al. “Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey.” *The Henry J. Kaiser Family Foundation* , April 2017. [30] Ingraham, Christopher. “Unplanned pregnancies cost taxpayers $21 billion each year.” *The Washington Post* , March 3, 2015. [31] Mehra, Renee, Shayna D. Cunningham, Jessica B. Lewis, Jordan L. Thomas, and Jeannette R. Ickovics. 2019. “Recommendations for the Pilot Expansion of Medicaid Coverage for Doulas in New York State.” *American Journal of Public Health* 109 (2): 217–19. [32] Chen, Amy. *Routes to Success for Medicaid Coverage of Doula Care* . Report. National Health Law Program, University of California - San Francisco. San Francisco, CA: Preterm Birth Initiative, 2018. [33]Kozhimannil, Katy B., Rachel R. Hardeman, Fernando Alarid-Escudero, Carrie A. Vogelsang, Cori Blauer-Peterson, and Elizabeth A. Howell. "Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery." *Birth* 43, [34] Chen, Amy. *Routes to Success for Medicaid Coverage of Doula Care* .

Expansion of Medicaid is instrumental to providing access to doulas to women that need them most. Only a few states have committed to expanding Medicaid coverage to doula coverage and those that have limit the reimbursement amount to under $400. This amount is too low to incentivize a doula market, as the market rate for most doulas is at least $1000. Therefore, if Connecticut implements Medicaid coverage for doulas, then the amount for reimbursement should be higher.

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