

Racial Capitalism and Black Maternal Mortality Rates in Chicago

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Abstract

Non-Hispanic, Black women in the United States experience the highest maternal morbidity and pregnancy-associated mortality rates. These rates hold for Chicago as well. On April 12, 2021, Illinois became the first state to expand Medicaid coverage from 60 days postpartum to 12 months postpartum when its Illinois Continuity of Care & Administrative Simplification 1115 Waiver was approved by the Centers for Medicare and Medicaid Services. The waiver should lower the number of Black women dying from pregnancy-associated causes. However, the policy only addresses the issues of access related to the social determinants of health, and not the heavily embedded biases rooted in anti-Black, structural racism. This paper uses the idea of racial capitalism to examine Chicago's high rates of Black morbidity and mortality rates surrounding pregnancy and the potential limitations of the state's expansion of Medicaid coverage for postpartum care.

Medicaid coverage plays a significant role in the limited care that many Black women receive, and a 2019 Chicago Department of Public Health (CDPH) report found that "women covered by Medicaid were nearly three times more likely to experience a pregnancy-associated death than women with private insurance" and 71% of women who experienced a pregnancy-associated death were on Medicaid (p.15). These rates of mortality for women on Medicaid are particularly concentrated among Black women.

Black mortality and morbidity rates remain a particularly urgent Chicago issue since the city experiences spatial inequalities when it comes to having quality healthcare, accessing healthy water and food sources, suffering exposure to pollution, and other social determinants of health (Kolak, et al., 2020). From 2016 to 2017, 527 women in Chicago experienced severe maternal morbidity at a rate of 74.1 per 10,000 deliveries, a rate about 45% higher than the rate for the state of Illinois (CDPH, 2019). In the same period, overall Chicago experienced only a marginally higher maternal mortality ratio than Illinois: 48.6 per 100,000 live births (CDPH, 2019). Together, the higher morbidity and mortality rates reveal the great risks for pregnant Black women in Chicago.

In April 2021, the Illinois Department of Healthcare and Family Services (HFS) proposal for expanded Medicaid coverage from 60 days- postpartum to 12 months-postpartum (HFS, 2020) was approved by the Centers for Medicare and Medicaid Services (CMS). The Illinois Continuity of Care & Administrative Simplification 1115 Waiver should provide a significant step toward decreasing the rates of maternal morbidity and pregnancy-associated mortality in Illinois, particularly for Chicago's non-Hispanic, Black women—who suffer the highest rates of such morbidity and mortality (CDPH, 2019).

However, Medicaid expansion alone will not prevent racial disparities in health outcomes related to pregnancy-associated deaths. To address those disparities, the state would need—in addition to expanding Medicaid coverage and eliminating barriers to access—to combat structural racism in the health-care system through other programmatic policies. In this paper, I will analyze the Illinois Waiver through the lens of racial capitalism to argue why this expanded Medicaid coverage alone will not do enough to eliminate Chicago's high Black maternal mortality and morbidity rates.

U.S. Political Economy as Racial Capitalism

The United States has a profit-driven health-care system. The system and its race-neutral language easily occludes the fact that Black women are dying in maternity-related “care” at an alarming rate. When this is acknowledged, moreover, maternal mortality rates and other health outcomes are cast as mere “disparities”—outcomes and not symptoms of a structural racism that works as the very foundation of the system as it currently operates.

Neoclassical economics argues that where there are racial imbalances, a natural, market-based correction will arise (Arrow, 1998). Becker’s (1971) model of taste-based discrimination offers the canonical neoclassical explanation of this supposed corrective, arguing that market preference accounts for market preference or “taste” for people and that tastes for less racial discrimination will self-correct over time due to open market competition. But as Arrow (1998) points out, such claims contradict the neoclassical expectation that employers serve as “simple profit-maximizers” (p. 94). He asserts that “personal interactions occur throughout the process, and therefore there is plenty of room for discriminatory beliefs and preferences to play a role” (p. 96). Arrow thus reminds us in a simple way that personal interactions and racialized beliefs can, and do, create different marketplaces for whites and Blacks.

Neoliberal economics have further complicated the perpetuation of racial inequities (Mele, 2013). Focusing on the example of urban development in a way that can instruct us on the dynamics in health care, Mele (2013) observes that many of neoliberalism’s urban policies and practices use colorblind discourse and race-neutral rhetoric. He further argues that this discourse “ultimately deflect[s] responsibility for problems of structural inequality from society to the individual and ignore[s] the persistence of structural and systemic racism” (p. 600). The framework of racial capitalism challenges the promotion of neoliberal urban policies and practices that remain complacent to continuing racial inequities and racial harm.

Black Women and Pregnancy-Associated Death in Chicago

Black women in Chicago experience the highest rates of maternal mortality and morbidity rates in the city, according to the Chicago Department of Public Health's 2019 *Maternal Morbidity & Mortality in Chicago*. The five most common, severe maternal morbidity indicators are: disseminated intravascular coagulation, acute renal failure, hysterectomy, sepsis, and adult respiratory distress syndrome. The report found that the women experiencing these higher maternal morbidity and mortality rates came from neighborhoods with higher economic hardship or worsening economic conditions. Indeed, neighborhood-level determinants show very different rates of access to quality obstetric care, which can make a woman more likely to experience severe morbidity during pregnancy or post-partum. The CDPH's city map of severe maternal morbidity and high economic hardship shows that zip codes on the South Side experienced both increased maternal morbidity rates per 10,000 deliveries and economic hardship compared to the city's North Side zip codes (CDPH, 2019)—disparate outcomes that parallel the overall racial segregation of the city (Janevic, et al., 2020).

Taylor (2020) acknowledges that factors like the neighborhood-level determinants listed in the CDPH report certainly impact Black women, their overall health, and their higher risk of maternal morbidity and mortality, but emphasizes the urgency to highlight structural racism as the “powerful social determinant of maternal health” (p. 507). She argues that policies which enhance social determinants are not enough because in the case of Black women, positive social determinants do not serve as protective factors since providers and the healthcare system have historically been steeped in racism, discrimination, and bias. As proof, Taylor recounts the fate of a highly educated Black woman who gave birth at a top medical facility in April 2016, only to die of a post-partum hemorrhage because she didn't get medical attention until seven hours after her husband first informed the medical team that her catheter had blood in it.

Therefore, it is true that not expanding Medicaid coverage would continue the harmful effects, and negative health and wellbeing

impacts on Black women and that Illinois' current policy to only provide Medicaid coverage for 60 days after giving birth increases the likelihood Black women will continue to experience high rates of health complications post-partum. But even if Medicaid were to expand to 12 months of post-partum coverage, she argues, it would not be enough (Taylor, 2020).

Illinois Continuity of Care & Administrative Simplification 1115 Waiver

The Illinois Continuity of Care & Administrative Simplification 1115 Waiver lists three goals: (1) extending postpartum coverage from 60 days to 12 months; (2) managed care reinstatement within 90 days, and (3) waiving Hospital Presumptive Eligibility (HPE) (HFS, 2020). The extended postpartum coverage will provide full Medicaid benefits for women up to 200% of the federal poverty level (FPL), which is the income threshold for the Medicaid pregnant women category of eligibility in Illinois. It will align continuous eligibility for the impacted mother and newborn baby, so that both would be eligible for coverage for 12 months after delivery. Additionally, if a woman applies during her 12-month postpartum period, Illinois will enroll her in the pregnant women category of eligibility for the remainder of her 12-month postpartum period (HFS, 2020). These additional two goals not only remove administrative burden, but help ensure that new, low-income mothers have uninterrupted access to full Medicaid benefits throughout their critical, postpartum period. It is clear that the HFS is trying to establish a necessary, policy-driven foundation for lowering the risk of Black women dying from pregnancy-associated causes since “the decision not to expand Medicaid has a disproportionately harmful impact on the health and wellbeing of African Americans” (Taylor, 2020, p. 513). It is important that we use the current Medicaid waiver tools at our disposal.

While doing so, HFS's waiver does name the racial disparities involved in its maternal mortality rates. The waiver highlights the systemic issues that lead to the state's racial disparities in maternal health

outcomes, drawing attention to the social determinants of health. The application emphasized how Black women's varied access to housing, employment, education, health literacy, childcare, and neighborhood safety impacts their overall health conditions, as well as their accessibility to seek and receive quality health care (HFS, 2020). However, the waiver demonstration only discusses racial disparities in light of outcomes and not how systemic racism is embedded in our U.S. health care system. More explicitly tackling structural racism as a social determinant to maternal health outcomes might more effectively confront the "historical foundations of racism and reproductive oppression" and how they "set the stage for manifestations of structural racism seen in the present against the backdrop of ongoing patterns of perpetual and persistent racial inequity in health care" (Taylor, 2020, p. 515). HFS's waiver will not usher in a one-step solution.

Strengths and Weaknesses of Pending Waiver Application

The greatest strength of the Illinois Continuity of Care & Administrative Simplification 1115 Waiver is the expansion of eligibility to cover the entire 12-month postpartum period. In the two-year period from 2016 to 2017, out of the 78% of the pregnancy-associated deaths, 50% of maternal, pregnancy-associated deaths took place more than 42 days after childbirth, while 28% took place within the immediate postpartum period (CDPH, 2019). The American Medical Association and the American College of Obstetricians and Gynecologists have recommended the expansion of Medicaid coverage for the entire postpartum period to lower postpartum "pregnancy-related tragedies" (Shriver Center, 2020).

The old eligibility requirement of 60-days postpartum was negligent to the challenges that low-income, Black mothers faced medically during the majority of their 12-month postpartum period and added to the challenges of a lack of employer-sponsored insurance or knowledge, affordability, and/or ability to navigate the Health Insurance Marketplace. The primary strength of this extended care is to ensure

that low-income mothers have full, uninterrupted Medicaid benefits for the complete postpartum period, especially as low-income, non-Hispanic Black mothers also have the most chronic issues that place them at higher risk during pregnancy. As the HFS application laid out: “continuous eligibility for the postpartum period will prevent mothers from having to switch providers during a medically vulnerable time due to different provider networks, will prevent disruption in courses of treatment during the postpartum period, and will increase access to needed care, follow-up visits, and medications when health issues arise during the postpartum period” (HFS, 2020, p. 12).

However, as indicated above, although the Illinois demonstration waiver application explicitly named the racial disparities seen in maternal mortality and morbidity rates, it did not account for structural racism as a cause of these outcomes. The expansion of Medicaid coverage will play a significant role in removing barriers of access especially for low-income, Black mothers during their postpartum period, but as Taylor (2020) emphasizes, this important step in Medicaid programmatic efforts “must [also] entail eliminating health provider bias and racism which manifests in a lack of compassion and support for Black women interacting with the health care system” (p. 514).

Taylor (2020) therefore asserts that “health care providers must be adequately trained in order to ensure an antiracist health care system,” which can include trauma-informed care training, antiracism training, training on cultural competency, and training related to unconscious racial bias (p. 514). Taylor names the current power dynamics and hierarchal provider-patient relationship and recommends that “the standard should be health care providers working in partnership and collaboration with patients and families to devise treatment plans, consider personal histories, and adhere to health care preferences” (p. 514). The Illinois Continuity of Care & Administrative Simplification 1115 Waiver is a significant step toward lowering the high risk of Black maternal mortality and morbidity rates

for Chicago and the entire state. However, until structural racism within the health care system is also addressed through additional policy initiatives, Black women under racial capitalism will still be at risk for not receiving equitable care as addressing the social determinants of health is not enough to prevent racial disparities in health outcomes.

Conclusion

Even though the Illinois Continuity of Care & Administrative Simplification 1115 Waiver is one step in reducing Chicago's as well as the entire State's high maternal mortality rates—especially for non-Hispanic, Black women—the demonstration waiver's expansion of Medicaid coverage only addresses the social determinants of health related to inequitable access and health outcomes; it does not address historically embedded structural racism in our health care system and the individuals providing care. A racial capitalist approach to political economy attempt to bring urgency in understanding that the neoclassicist, self-regulating market will not dismantle systemic racism on its own. Although Chicago certainly remains highly segregated between neighborhoods in housing discrimination, medical racism, environmental racism, food access, education quality, and other social determinants of health that increase alarmingly higher rates of maternal mortality for Black women, we should therefore echo Taylor's argument that addressing these determinants alone will not prevent more Black women from dying of maternity-related death. The Centers for Medicare and Medicaid Services (CMS) should create more specific guidelines for healthcare providers to attend reoccurring trainings on trauma-informed care, antiracism, cultural competency, and unconscious racial bias. What's needed now are specified policies and regulations to address structural racism in the U.S. health care system, and with those, Chicago will be more likely to comprehensively address and lessen its disturbingly high Black maternal mortality rates.

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