Addressing Racial Disparities of Black Infant Mortality

Paige Schmitt

3/12/25

Introduction

Black infant mortality remains a significant public health crisis in the United States, with Black infants experiencing disproportionately high rates of death compared to White infants. According to the Centers for Disease Control and Prevention (CDC), the Black infant mortality rate was 10.6 deaths per 1,000 live births in 2020, more than twice the rate for White infants, which stood at 4.5 per 1,000 live births (CDC, 2023). Black infants are more likely to be born prematurely and with low-birth weight, both major contributors to neonatal and post-neonatal mortality (Mathews & Driscoll, 2023). Additionally, Black mothers are also three times more likely to die from pregnancy-related complications, further exacerbating risks for Black infants (Petersen et al. 2019). Geographic disparities compound this issue, as states with high Black populations, such as Mississippi and Alabama, report even higher infant mortality rates (March of Dimes, 2022). Despite medical advancements, these disparities have persisted for decades, underscoring systematic failures in maternal and infant healthcare. The Institute of Medicine (IOM) aims of equity, safety, effectiveness, and patient-centered care are not being met. Equity is violated as Black infants experience a mortality rate more than double that of White infants. Safety is compromised due to inadequate prenatal and postnatal care, leaving mothers and infants vulnerable to preventable health complications (Howell, 2018). Effectiveness is

undermined as existing healthcare programs fail to close the racial mortality gap, and patient-centered care is lacking due to implicit bias and inadequate access to culturally competent services (Braveman et al., 2019).

Current policies and programs have not effectively reduced these disparities. Medicaid, which covers approximately 65% of Black births, often provides only limited postpartum care, failing to ensure continuity of maternal and infant health services (Howell, 2018). The Hyde Amendment restricts federal funding for abortion services, disproportionately impacting low-income Black women who may require reproductive healthcare (March of Dimes, 2022). Additionally, maternity ward closures in predominantly Black communities have reduced access to prenatal and postnatal care. Increasing reliance on overburdened emergency departments (Braveman et al., 2019). Implicit bias in healthcare leads to disparities in pain management and clinical decision-making, as studies show Black mothers receive fewer timely interventions during labor and are less likely to be given adequate postpartum follow-up care (Petersen et al., 2019*)*. These failures contradict multiple of the IOM *Rules for Redesign*, including ensuring continuous healing relationships (due to gaps in postpartum care), customization based on patient needs (as implicit bias results in suboptimal care for Black patients), evidence-based decision-making (as racial disparities persist despite known interventions), transparency (as racial disparities in care are often unacknowledged or inadequately addressed), and cooperation among clinicians (as fragmented care systems fail to address the needs of Black mothers and infants) (IOM, 2001).

Context and Importance of the Problem

Black women are disproportionately affected by adverse social determinants of health, including economic instability, inadequate healthcare access, and chronic stress from racial discrimination (Braveman et al., 2019). The cumulative impact of these factors, known as "weathering," contributes to adverse birth outcomes such as preterm births and low birth weights, exacerbating infant mortality rates (Bailey et al., 2017). Additionally, Black mothers frequently encounter medical racism, which can result in delayed interventions, undertreatment of pain, and dismissal of their concerns during pregnancy and childbirth.

The failure of the healthcare system to address these disparities contradicts the IOM's Six Aims for Improvement: safety, effectiveness, patient-centered care, timeliness, efficiency, and equity. For example, inequities persist in clinical decision-making, leading to inadequate treatment of Black mothers and infants. The lack of culturally competent care further alienates Black patients, reducing trust in medical institutions and contributing to worse health outcomes (Howell, 2018). While numerous initiatives aim to reduce maternal and infant mortality, systemic gaps in implementation and policy enforcement continue to hinder progress.

Critique of Current Policy/Policies

Several existing policies and programs aimed at reducing Black infant mortality have failed due to inconsistent implementation and systemic barriers. Medicaid, which covers approximately 65% of Black births, often lacks continuity in maternal and infant care due to limited postpartum coverage (Garfield et al., 2020). The 2021 American Rescue Plan Act introduced a policy allowing states to extend Medicaid postpartum coverage from 60 days to 12

months, but this provision remains optional, and as of 2023, several states have **not** adopted the expansion. This policy gap disproportionately affects Black mothers, leaving them without critical postpartum care that could prevent complications such as postpartum hemorrhage, infections, and mental health crises (March of Dimes, 2022).

Moreover, restrictive policies such as the Hyde Amendment further limit access to comprehensive maternal care by prohibiting federal funds from covering abortion services, disproportionately affecting low-income Black women who rely on Medicaid. These policy gaps contribute to adverse birth outcomes, reinforcing structural inequities that increase Black infant mortality rates. Additionally, the closure of maternity wards in predominantly Black communities—especially in rural areas—has significantly reduced access to perinatal services, forcing reliance on overburdened emergency departments that lack continuity in maternal care. The loss of obstetric units in underserved regions has been linked to increased preterm births and poor infant health outcomes (Braveman et al., 2019). Implicit bias in healthcare settings further exacerbates these disparities. Research shows that Black mothers are less likely to receive pain management, timely labor interventions, or adequate postpartum follow-ups, directly impacting infant health outcomes (Petersen et al., 2019). These failures contradict multiple IOM aims, particularly equity, patient-centered care, and effectiveness, as racial disparities in healthcare persist despite available evidence on best practices.

The Hyde Amendment, which restricts federal funding for abortion services, disproportionately impacts low-income Black women who may require reproductive healthcare (March of Dimes, 2022). This policy limits access to comprehensive maternal care, potentially leading to adverse birth outcomes and increased infant mortality rates. Additionally, maternity

ward closures in predominantly Black communities have significantly reduced access to prenatal and postnatal care, increasing reliance on overburdened emergency departments that are ill-equipped for continuous maternal care. The closure of maternity wards in predominantly Black communities—especially in rural areas—has significantly reduced access to perinatal services, forcing reliance on overburdened emergency departments that lack continuity in maternal care. This reduction in access to comprehensive care has been linked to higher rates of adverse birth outcomes, such as preterm births and poor infant health outcomes (Braveman et al., 2019).

Implicit bias within healthcare settings leads to disparities in pain management and clinical decision-making. Studies indicate that Black mothers receive fewer timely interventions during labor and are less likely to receive adequate postpartum follow-up care (Petersen et al., 2019). This failure contradicts multiple IOM aims, including ensuring continuous healing relationships (due to gaps in postpartum care), customization based on patient needs (as implicit bias results in suboptimal care for Black patients), evidence-based decision-making (as racial disparities persist despite known interventions), transparency (as racial disparities in care are often unacknowledged or inadequately addressed), and cooperation among clinicians (as fragmented care systems fail to address the needs of Black mothers and infants) (IOM, 2001).

The REAIM framework assesses policy effectiveness through five dimensions: reach, effectiveness, adoption, implementation, and maintenance. Current policies fail to adequately ***reach*** Black mothers and infants, particularly in states that have not expanded Medicaid postpartum coverage, leaving many without critical follow-up care. Additionally, maternity ward closures disproportionately impact Black communities, forcing mothers to travel long distances for perinatal services, further limiting accessibility.

Despite federal and state-level initiatives, policies remain ineffective in reducing Black infant mortality rates, as demonstrated by persistent racial disparities. Programs intended to reduce maternal and infant mortality often fail due to lack of enforcement, poor funding allocation, and the absence of targeted interventions addressing structural inequities.

The adoption of evidence-based solutions, such as culturally competent care models, remains inconsistent across healthcare institutions. Many providers do not receive training to address implicit biases, resulting in continued disparities in maternal treatment. Similarly, the implementation of policy changes, including Medicaid expansion, has been uneven, with some states failing to allocate necessary resources to Black maternal health programs.

Finally, maintenance remains a challenge. Many maternal health programs designed to address disparities face sustainability issues due to funding limitations and shifting political priorities. Without stable financial support and ongoing policy enforcement, existing programs fail to create lasting change.

The persistent racial disparities in Black infant mortality rates highlight systemic failures in maternal and infant healthcare. Despite medical advancements, Black infants continue to face mortality rates more than **twice** as high as White infants, signaling the need for urgent policy intervention. Current healthcare policies fail to align with the IOM's Six Aims for Improvement, particularly in ensuring equity**,** effectiveness**,** and patient-centered care.

The REAIM framework further exposes shortcomings in policy reach, effectiveness, and sustainability, demonstrating that existing interventions are insufficient to address the crisis. Addressing Black infant mortality requires a multifaceted approach that combines policy change, healthcare reform, and systemic accountability. Without immediate and sustained intervention,

racial disparities in infant mortality will persist, further entrenching inequities in maternal and child health

Recommendations

To effectively address the crisis of Black infant mortality, specific policy changes should be implemented by the Centers for Medicare & Medicaid Services (CMS), state governments, and the U.S. Congress. First, CMS should mandate the extension of postpartum Medicaid coverage from the current optional 60 days to a minimum of 12 months nationwide. Achieving this policy change requires advocacy efforts coordinated by organizations such as the March of Dimes, Black Mamas Matter Alliance, and the National Birth Equity Collaborative. These advocacy groups can collaborate to pressure policymakers by presenting evidence-based research and mobilizing public opinion through awareness campaigns, lobbying, and testimony before legislative bodies. Extending postpartum Medicaid coverage will allow continuous maternal healthcare, reduce postpartum complications, and ultimately decrease infant mortality rates by addressing healthcare continuity gaps (Steenland & Wherry, 2023).

Secondly, the U.S. Congress should pass legislation to federally mandate and fund implicit bias training and culturally competent care programs specifically targeted at healthcare providers serving Medicaid recipients. Implementing standardized training on implicit bias and culturally competent care is critical for reducing healthcare disparities faced by Black mothers and infants. The American Medical Association (AMA) and American College of Obstetricians and Gynecologists (ACOG) should lead efforts to incorporate these training programs into provider certification and accreditation processes, supported by federal legislation ensuring accountability and consistent funding. Mandatory implicit bias training has been demonstrated to enhance patient-provider interactions, reduce medical racism, and improve trust and engagement

with healthcare services, thereby directly contributing to reduced maternal and infant mortality disparities (Gordon, M., & Fink, A., 2023).

Through coordinated advocacy efforts, targeted legislative changes, and systemic accountability, these recommendations can significantly reduce racial disparities in infant mortality rates and enhance health equity for Black mothers and infants nationwide.

Works Cited

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *Lancet (London, England)*, *389*(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X

Berwick, D. M., Nolan, T. W., & Whittington, J. (2002). The triple aim: Care, health, and cost. *Health Affairs, 27*(3), 759-769. https://doi.org/10.1377/hlthaff.27.3.759

Braveman, Paula, et al. "Racial Disparities in Adverse Birth Outcomes: The Role of Chronic Stress and Socioeconomic Factors." *American Journal of Obstetrics & Gynecology*, vol. 221, no. 6, 2019, pp. 564-570. https://www.ajog.org.

Centers for Disease Control and Prevention. "Infant Mortality Statistics from the 2020 Period Linked Birth/Infant Death Data Set." 2023. https://www.cdc.gov.

Garfield, R., Orgera, K., & Damico, A. (2020). The coverage gap: Uninsured poor adults in states that do not expand Medicaid. *Kaiser Family Foundation*. http://resource.nlm.nih.gov/101717244?_gl=1*j9dsv0*_ga*NTc0NDMxMzQyLjE3NDIxODA3NTg.*_ga_7147EPK006*MTc0MjM4ODkwMS4xLjEuMTc0MjM4ODk2Mi4wLjAuMA..*_ga_P1FPTH9PL4*MTc0MjM4ODkwMS4xLjEuMTc0MjM4ODk2Mi4wLjAuMA

Gordon, M., & Fink, A. (2023). *Healthcare Worker Implicit Bias Training and Education*. In *Making Healthcare Safer IV: A Critical Analysis of Existing and Emerging Patient Safety Practices*. Agency for Healthcare Research and Quality (US). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK600156/

Howell, Elizabeth A. "Reducing Disparities in Severe Maternal Morbidity and Mortality." *Clinical Obstetrics and Gynecology*, vol. 61, no. 2, 2018, pp. 387-399. https://journals.lww.com.

Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academies Press, 2001. https://nap.nationalacademies.org/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the.

March of Dimes. "The Prematurity and Infant Mortality Crisis Among Black Babies." 2022. https://www.marchofdimes.org.

Mathews, T.J., and Anne K. Driscoll. "Trends in Infant Mortality in the United States, 2000-2020." National Center for Health Statistics, 2023. https://www.cdc.gov/nchs.

Petersen, Emily E., et al. "Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007-2016." *Morbidity and Mortality Weekly Report*, vol. 68, no. 35, 2019, pp. 762-765. https://www.cdc.gov/mmwr.

Steenland, Maria W., & Wherry, Laura R. (2023). “Medicaid Expansion Led to Reductions in Postpartum Hospitalizations.” https://doi.org/10.1377/hlthaff.2022.00819