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Infant Mortality and Race in the United States

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Katherine Legier

ABSTRACT

Infant mortality is globally recognized as an indicator for overall health in a population. The United States spends the most money per capita on health expenditures, a total of 17.1% of the budget in 2016 (cia.gov). Despite this, the United States' ranking for infant mortality is 174th (cia.gov). Moreover, rates of infant mortality are not experienced equally across racial groups. The rate of infant mortality for African Americans in the United States is compounded. African American infants are more than 2 times as likely to die before their first birthday than non-Hispanic white infants (West and Bartkowski 2019:1). The purpose of this literature review is to analyze how health care insurance coverage, birth education attainment, and structural racism contribute to the disparity of infant mortality amongst African Americans in the US. After defining these factors, I will discuss existing literature on how each contributes to infant mortality. Next, I will take a holistic approach on examining how these three factors interact with each other to sustain adverse health outcomes that disproportionately affect African Americans and other minority populations. Overall, the cyclical impact of these factors perpetuates the disparity of African American infant mortality rates.

INTRODUCTION

Infant mortality is defined as the number of deaths in children less than 1 year of age per 1000 live births in the same year and is globally recognized as an indicator for the health of a population (Chantel et al. 2019). The top three causes for infant mortality in the United States

include Respiratory Distress Syndrome, Sudden Infant Death Syndrome, and Congenital Anomalies (Frisbie et al. 2008). For African American populations, the infant mortality rate is considerably higher. In 2014, the African American infant mortality rate was 10.3 per 1000 live births while the Caucasian infant mortality rate was 5.1 (Woods et al. 20016:194).

Despite advances in birth care technology, the incidence rate of infant mortality is increasing and continues to disproportionately rise amongst African American populations (Ramraj et al. 2019). According to Ramraj and colleagues (2019), the rise in the national infant mortality rate is largely due to the number of infant deaths amongst African Americans. The factors that contribute to the infant mortality rate disparity that I will explore include health care insurance coverage, birth education attainment, and institutional racism.

Existing research in the field supports the claim that there is a significant relationship between race and infant mortality rates and that the disparity of birth outcomes among African Americans should be addressed with urgency. Still, much of the existing research leaves out women who are uninsured or are using alternative birth methods such as a doula or at-home midwife. This excludes certain populations, including African American mothers who are most affected by unemployment (Hamersma et al. 2018:729). Addressing the disparity requires considering these factors integral to the solution so that African American populations are not left behind.

The purpose of this review is to draw from existing sociological research on the factors that contribute to the infant mortality disparity to formulate suggestions on how the United States can address the disparity. Additionally, we can use infant mortality as an indicator of other societal inequalities. Many researchers argue that the disparities in infant mortality reflect existing social inequalities such as access to medical care and income rates (Green 2019). Exploring indicators of

health are integral to the study of sociology because the color of a person's skin, independent of health behaviors or access to care, will decide their health outcomes.

HEALTH CARE COVERAGE

Health care coverage is one of the main factors that contribute to the disparity of infant mortality rates. Having steady healthcare through an employer or Medicaid is essential to gaining access to birth care, especially because the US has the highest prenatal care costs in the world (Adams 2017). In this section, I will use the indicator of infant mortality to identify how health care coverage disproportionately affects adverse birth outcomes for African Americans.

A study by Hamersma and colleagues (2018) researched the influence of Medicaid and unemployment on adverse birth outcomes and how it varies across racial groups. Overall, they found that there is an association between unemployment and the prevalence of adverse birth outcomes in the US. This relationship, however, is weaker within states with higher Medicaid thresholds (Hamersma et al. 2018:740). Therefore, we can infer that higher Medicaid generosity could assist with reducing adverse birth outcomes. Additionally, when analyzing these results amongst racial groups, the study shows that African Americans are much more impacted by the effects of unemployment and Medicaid generosity on adverse birth outcomes (Hamersma et al. 2018:729). Health care coverage, as a result, is a key factor for closing the gap of adverse birth outcomes for African Americans.

Another aspect of health care coverage that affects the infant mortality disparity includes prenatal health behaviors and access to health services. Mathews and colleagues (2002) identify the time in which prenatal care begins as an important factor in determining infant mortality rates. They found that "in 2000 infants of mothers who began prenatal care after the first trimester of pregnancy or not at all had an infant mortality rate of 8.8 per 1,000, which was 44 percent higher

than the rate for those whose care began in the first trimester" (Mathews et al. 2015:5). African American women are particularly disadvantaged when it comes to early prenatal care because not only are they more likely to be uninsured throughout adulthood, they are also more likely to have inconsistent coverage when it does exist (Sohn 2016:182). Additionally, having inconsistent insurance coverage limits the ability to build an ongoing relationship with a health care provider (Sohn 2016:182). The difficulty to build this relationship because of inconsistent healthcare coverage further puts African Americans at a disadvantage because building a relationship is a crucial step to overcoming the negative effects of racism that exist in health care settings (West 2019, Bartkowski 2019).

This trickle-down relationship illustrates how the quality of our health care system determines health outcomes and infant mortality rates. This is especially true for African Americans who are most sensitive to the relationship between health care coverage and birth outcomes. All parts of the United States healthcare system, from generosity to interpersonal relationships between care providers and patients must be considered to attempt to solve the infant mortality disparity amongst African Americans.

BIRTH EDUCATION ATTAINMENT

Birth education has been identified as a possible factor that determines infant mortality. Hoyert (2018) lists education of mothers in high-risk groups as one of the critical solutions to preventing adverse birth outcomes for African Americans. There are, however, conflicting perspectives about the extent to which birth education improves or worsens infant mortality rates for African Americans. In this section, I will identify the results of existing birth education programs in the US, explain the extent to which they affect infant mortality rates for African

Americans, and then analyze other resources that discount birth education as an effective way to close the infant mortality disparity.

An example of a birth education program includes a case study on infant mortality, race, and the impact that an educational program called Women, Infants, and Children (WIC) had on birth outcomes in Kansas (Woods 2016). The researchers found that the education program had a substantial impact on birth outcomes for African American mothers as they had significantly lower infant mortality rates than those who did not participate in the study (Woods 2016:196). However, the individuals that benefited from the educational program most likely were more educated and had access to more resources to be a participant in the study. This is conclusive with other research on the effectiveness of birth education programs. Green and Hamilton (2019) found in their research that non-Hispanic white people experience greater benefits from educational programs whereas African Americans benefit from them the least (2019:713). We can therefore conclude that birth education programs aren't as big of a factor for the significant infant mortality disparity in the US.

Additionally, educational programs that appear to be successful at alleviating the infant mortality disparity in one community might not be successful for another community. Birth education programs must consider each unique community that is affected by the infant mortality disparity. Savage and colleagues (2007:216) found that adverse birth outcome prevention programs that are effective in one setting are sometimes not effective or "detrimental" in other settings. They suggest that possible birth education solutions are unique to each population. As a result, we cannot yet uniformly conclude that birth educational attainment is a significant factor for the infant mortality disparity in the US.

A sociological theory that can be used to explain the conflicting perspectives around birth education attainment is the medicalization theory. This is described as the societal shift of viewing pregnancy and birth as a natural process to one that is highly specialized and an interventionist issue (Adams 2017:12). In all of the articles that focus on birth education programs, researchers focus their hypothesis on the mother's responsibility to change or perfect their individual habits to avoid adverse health outcomes rather than looking at the underlying structural factors that cause inequalities in access to health.

STRUCTURAL RACISM

The third factor I've identified that contributes to the infant mortality disparity in the US is structural racism. Research has suggested that racial discrimination is a major contributor to health disparities and adverse birth outcomes for African Americans (Adams and Thomas 2017:3). In this section, I will discuss research on the effect structural racism has on infant mortality and our healthcare system and discuss how it creates barriers to quality care for African Americans.

Current literature that connects institutional racism to adverse health outcomes is fairly limited. Most research focuses on the stress of unfair treatment of racial minorities that leads to health disparities rather than structural racism (Bailey et al. 2017:1543). Despite this, Bailey and colleagues raise the point that society must look at the structural factors of racism in our institutions, especially within our health system, to find the source of health inequity (Bailey et al. 2017:1543). Institutional racism is defined as "the totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes" (Bailey et al. 2017:1454). Structural racism and social inequities

lead to disproportionately poorer health outcomes for African Americans, including infant mortality.

There are a multitude of ways in which structural racism exists that directly contributes to poor health outcomes for African Americans. Health care inequalities on the organizational level that stem from structural racism occur when care providers possess lower expectations from patients with marginalized identities based on race, class, gender, or education (Abercrombie 2008). One study revealed that "one in five women of color report poor treatment from hospital staff based on their cultural background, language, race, and ethnicity" (West 2019:2). This poor treatment is revealed in overt and covert ways. Of the participants in a study, black mothers who faced explicit racism in their birth process characterize their experience as being restricted to certain positions, being denied pain management methods and medications, being dismissed, and being given procedures and medications without consent (West et al. 2019:17). One study by Collins and colleagues (2004) highlights the connection between structural racism and poor birth outcomes by stating that "the lifelong accumulated experiences of racial discrimination by African American women constitute an independent risk factor for preterm delivery" (Collins et al. 2014:2132).

West and colleagues (2019) also found that the representation of doctors that share their identities was a big factor in the outcome of the birth-giving experience (West 2019), and rightfully so. According to Abercrombie (2008), minority patients are more comfortable with a health care provider of a similar race or ethnicity. In the US, however, only 6% of all health physicians and surgeons are African American (Data USA). While we cannot say that a lack of representation directly results in infant mortality, research suggests that it does inhibit one's perceived ability to access the same quality of care as their white counterparts (Abercrombie 2008). This lack of

representation compounded by institutional racism that exists within health spaces leads to a concept called weathering. Weathering is defined as a "cumulative experience of racism and sexism, especially during sensitive developmental periods, trigger a chain of biological processes[...] that undermine African American women's physical and mental health" (Taylor 2019). As a result of the weathering process, the psychological toll on African American bodies harbored by structural racism leads to adverse birth outcomes, including infant mortality. West and colleagues attribute the weathering effect to poor birth outcomes by stating that the weathering process "can affect Black American women's navigation of the healthcare system and may make them less likely to acquire medical help, thus leading to poorer health and birth outcomes" (West et al. 2019:2). In regards to infant mortality, one study determined "structural racism consisting of inequities in unemployment, education, and median household income" was associated with an increased infant mortality rate for African Americans (Ramraj 2019:287). Structural racism, therefore, is identified as one of the greatest possible contributors to the infant mortality disparity in the US.

CONCLUSION: IMPLICATIONS, POLICY DEBATE, AND FUTURE RESEARCH

In conclusion, all of the literature suggests that the infant mortality disparity must be treated as a public health crisis. We must address institutional racism in all its facets that include, but are not limited to, access to healthcare, affordable housing, and economic opportunity (Taylor 2019). All parts of power imbalances that exist in society must be addressed to begin to solve the public health crisis of infant mortality in the US. In this section, I will use my findings to discuss the implications on sociology and make suggestions on policy and future research.

The body of literature cited in this review implies that solutions must have an intersectional approach that addresses all the factors of Medicare coverage, birth education, and structural

racism. Within the realm of Medicaid coverage and structural racism, much overlap exists around the issue of access to alternative birth care options. The sources in this paper suggest that expanding and strengthening existing health programs, including Medicaid, to include options such as using a doula or midwife care provider could present a way to avoid the negative effects of racism (Adams 2017, West 2019).

Another solution that takes into account all three factors outlined in this review focuses on diversifying and training the medical care workforce on the unique experiences of African Americans. When it comes to birth education, local policymakers should consider mobilizing individual communities to formulate unique solutions that work best to address the infant mortality disparity. On the more interpersonal level, medical care professionals should be trained on how to treat patients with dignity and respect and acknowledge and remove racial bias from their practice. Only when the entire system from national to interpersonal is addressed, we will be able to make an impact on getting rid of the infant mortality disparity.

West and colleagues (2019) suggest that initiatives should be put in place by our government to diversify midwifery and birth care providers in the US. This is an important step at negating structural racism's effect on infant mortality rates (West et al. 2019:18).

In conclusion, great efforts should be made at every level of society to use existing research on the infant mortality disparity to make care more equitable for all. Multiple peer-reviewed sources suggest that most infant deaths are preventable (Howell 2018, Krishnaswami 2019), therefore sociologists must continue to make efforts in researching and finding solutions to the public health issue. Sources conclude that health care insurance coverage and structural racism should be central to the intersectional approaches to shrinking the disparity of infant mortality amongst African Americans in the US.

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