INSTITUTE FOR WOMEN'S POLICY RESEARCH

Collision of Crises: The Triple Threat to Reproductive and Maternal Health Care

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Birthing While Black: The Urgent Fight for Maternal Health Reform Series

Introduction

The United States' Black maternal health crisis is the result of complex and overlapping factors, from barriers to accessing comprehensive reproductive health care to exposure to harmful social and economic determinants of health and historical, multigenerational gendered racism.[1]

The explicit attacks on reproductive health access that have proliferated in the wake of the Supreme Court's *Dobbs* decision[2] and in the first few months of the Trump administration[3] have multiplied these drivers and exacerbated negative outcomes.

In recent years, many mainstream conversations about maternal health have understandably focused on the ways explicit attacks on abortion have impacted health access and outcomes and have disproportionately harmed Black women. While calling attention to the growing harm of these attacks, we must also recognize how the intersection of various social and economic policies over the past 15 years swiftly—and sometimes quietly—chipped away at the reproductive health care system and contributed to the current Black maternal health crisis.

The efforts since the *Dobbs* decision have been so harmful in such a short period of time in part because of policy shifts that eroded the reproductive health infrastructure, tearing holes in what was already a fraying patchwork quilt system of care, particularly for communities of color.

This brief will explore three trends that together have significantly impacted the reproductive health landscape and, by extension, maternal health access and outcomes:

1. The implementation of family planning restrictions in the decade before the *Dobbs* decision.
2. The increasing privatization in the health sector that has fueled mergers and closures.
3. The proliferation of anti-choice policies since the 2022 *Dobbs* decision.

This brief illustrates the dangerous collision of policies that target and criminalize reproductive health with neoliberal economic policies that have disproportionately harmed Black women and their families. It is critical we understand how these socioeconomic changes have made women even more vulnerable in the post-*Dobbs* landscape. Restoring and ultimately expanding reproductive health and rights will require not only reversing these draconian anti-choice policies but also reshaping the broader health landscape to ensure high-quality, affordable, and culturally sensitive care for all.

TREND 1: Family planning restrictions that preceded the *Dobbs* decision began weakening the reproductive health system more than a decade ago.

Family planning is a bedrock of women's health.[4] **Access to high-quality, affordable, and culturally sensitive contraceptive care makes it possible for women to plan the timing and size of their families, care for their physical health, advance their education, and become economically mobile and more secure.**[5] Additionally, clinics that offer family planning also serve as trusted places of care for women seeking pregnancy-related health services and a range of other reproductive health needs. Like abortion, family planning is integral to maternal health.[6]

For most of the second half of the 20th century, there was a general bipartisan consensus on the social and economic benefits of family planning.[7] Support for contraception through federal programs expanded, as did the network of providers who could guarantee care. That consensus ended rather abruptly after the 2010 midterm elections, and the fabric of family planning programs and providers began to weaken in many states across the country. The attacks on family planning were an indication of the broader forthcoming threats to reproductive health and were a window into the disproportionate toll those threats would have on the health of women of color, low-income women, immigrant women, and young women.

> *The family planning attacks that came in the wake of the 2010 midterms were the beginning of a new front in the war on reproductive health care. Starting that year, a number of states began to make cuts to their family planning budgets,[8] and others cut their family planning line items altogether.[9]*

Texas made such significant cuts that it went from serving 212,000 patients in 2010 to just 75,000 in 2012 and roughly 47,000 the following year.[10] In March 2011 and again in March 2013, conservatives in Congress threatened to shut down the government over funding for Planned Parenthood and provisions in the Affordable Care Act (ACA) that expanded access to contraceptive coverage.[11] In 2011 and 2012, the House of Representatives passed (but failed to implement) legislation to eliminate funding for Title X—the national family planning program started under President Nixon and responsible for serving millions of patients every year.[12] In October 2013, conservatives succeeded in shutting down the federal government over its opposition to the ACA's reproductive health requirements.[13] The bipartisan support of the Nixon era was over.

In addition to budget cuts, states found other creative ways to restrict or eliminate access to comprehensive reproductive health care. Some established tiered systems that relegated family planning clinics to the end

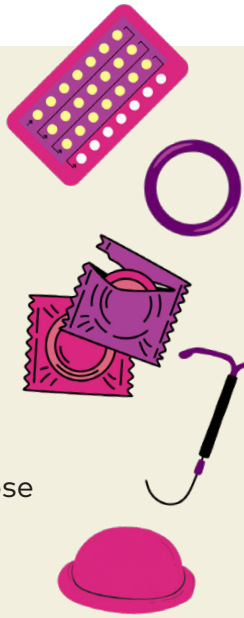
of a long list of reproductive health providers, prioritizing funding for those at the top of the list.[14] Some states prohibited family planning providers that were not affiliated with state health departments from receiving state and federal funding altogether.[15] Conservative lawmakers across the country implemented Targeted Regulations of Abortion Providers (TRAP laws) in efforts to eliminate abortion access, which ultimately led to the loss of family planning clinics where they were most needed.[16] **And throughout this decade, relentless legal attacks on the ACA attempted to chip away at requirements designed to make access to comprehensive reproductive health care universal.[17]**

In 2019, the Trump administration made changes that dramatically altered the intended nature of Title X.[18] Coined the "domestic gag rule," the changes prohibited Title X clinics from providing referrals for abortion and from sharing facilities with clinics that offer abortions.[19] They opened up funding to anti-abortion religiously based organizations that previously would not have qualified, including crisis pregnancy centers. As a result of the changes, more than 400 Planned Parenthood clinics and roughly 900 other providers—ultimately nearly one in three Title X clinics—exited the program, and it went from serving 3.9 million patients in 2018 to 1.5 million in 2020.[20]

As of October 2024, it was reported that Title X had not fully recovered from the restrictions put in place by the first Trump administration, despite the efforts of the Biden administration to restore the program and its network. At that time, it was serving roughly half of the number of patients compared to 2015, and the program's budget had remained flat despite inflation and vast unmet needs for family planning services.[21] The second Trump administration has already proposed significant cuts,[22] and it will likely reinforce similar rules, which will be even more harmful given the ways the *Dobbs* decision has hollowed out access to care.

Title X clinics are a critical resource that can and should be leveraged to tackle the United States' maternal health crisis. Not only does family planning allow women to plan the timing and size of their families—improving women's health if and when they do become pregnant—but it also enables women to prevent unintended pregnancies and avoid negative maternal health outcomes. Additionally, the comprehensive care offered by these clinics benefits the overall health of communities, leading to many positive trickle-down effects.

WHAT IS TITLE X?



Title X has been the foundation of the nation's reproductive health infrastructure for more than five decades.[23] It has been a trusted source of comprehensive sexual and reproductive health care, especially for Black women and other women of color, immigrants, LGBTQ patients, young people, those who are economically insecure or uninsured, and even for individuals who are insured but want to be sure their privacy is respected. As of 2022, 24 percent of Black women were reliant on Title X.[24]

The program—which provides funds to clinics all over the country—requires all funding recipients to meet a rigorous and comprehensive set of requirements and, as such, sets a high bar for family planning care. Clinics that are part of the Title X network have historically been required to provide other services such as pregnancy testing and counseling, breast and pelvic exams, cervical cancer screenings, testing for HIV and other sexually transmitted infections, and screening for diabetes, high blood pressure, and cholesterol.[25] Like other federal programs, the Title X statute explicitly prohibits the use of federal funding to pay for abortion provisions, though it has required physicians to provide pregnant women with information about the full range of pregnancy options.[26]

TREND 2: Over the last two decades, the increasing consolidation of the health sector has eroded maternal health infrastructure.

The health sector has experienced dramatic shifts over the last two decades. The increasing consolidation, privatization, and financialization[27] of the sector has eroded the landscape of maternal health care across the country and has had a negative impact on women as patients and workers. **This is just one of the many ways US economic policy prioritizes profits over people and has taken a disproportionate toll on the health and well-being of women of color.**

For years, private actors have claimed that mergers in the health sector improve access, quality, and the cost of care. However, a 2025 report published by the Department of Health and Human Services described how growing consolidation in the health sector has led to cost increases, service disruptions, and a reduction in quality of care.[28] This report also illustrated the extent to which consolidation now characterizes the health care landscape. In 1990, 65 percent of US Metropolitan Statistical Areas (MSAs) had hospital services that were considered highly concentrated; by 2006, that share had increased to 77 percent, and in 2016, it reached 90 percent.[29]

In addition to consolidation, hundreds of hospitals and hospital systems have closed altogether. Over the past two decades, more than 200 rural hospitals have closed their doors,[30] and since the beginning of 2023, 35 have eliminated inpatient services. Because of financial turmoil, more than 700 hospitals in rural communities—one-third of all rural hospitals in the country—are currently at risk of closing, with 320 at risk of immediate closure.[31] These closures not only lead to the immediate loss of a local source of care, but they also have numerous downstream effects, including job losses in the health care sector and throughout communities and an ultimate decline in GDP.[32] The COVID-19 pandemic exacerbated these trends, and for Black women living in rural communities, they have been particularly harmful.

> *These trends have had a direct impact on maternity care, as obstetrics and gynecology departments are often among the first to be cut when hospitals are facing staffing shortages, budgetary pressure, or are on the path to merger or closure.*[33]

Between 2010 and 2022, 537 labor and delivery departments closed in the United States—238 in rural areas and 299 in urban areas.[34] In 2024 alone, there were 37 maternity unit closures in rural and urban areas alike, and health care leaders across the sector reported being "very concerned" about these trends.[35]

Labor and delivery units are inherently expensive to run and, for a number of reasons, are often poorly reimbursed. Rural areas tend to have a higher share of patients covered by Medicaid (relative to private insurance), and the public insurance program generally has much lower rates of reimbursement than private insurance.[36]

Sometimes, larger hospital systems that subsume smaller community hospitals decide to shutter one labor and delivery unit because they determine that having one at another facility is sufficient to meet the needs of the local population. **These decisions are often made by individuals who are not located in the community and who have little understanding of the residents' greatest needs or of the implications of these decisions on communities that are already experiencing maternal health crises.**

The loss[37] of maternity care compounds preexisting care avoidance,[38] increases delays in accessing care, and often requires patients to travel further distances to access care.[39] This places a heavy burden on individuals with low incomes, those without paid leave or affordable child care, and those without access to transportation. Increased distances have also been correlated with higher mortality rates for patients experiencing severe conditions.[40]

The lack of access to prenatal, postnatal, and emergency maternity care that accompanies hospital closures puts women and their pregnancies at risk.[41] As Flynn and Mabud wrote, "As a result of this distance, some pregnant women delay seeking care, skip prenatal care appointments, and schedule caesarian sections to avoid going into labor and not being able to get to a hospital quickly. Adding to this problem is the fact that when hospitals close in rural areas, ambulatory services also tend to decline, ultimately making it increasingly difficult for women to get to other sites of care quickly in emergency situations. It's not hard to imagine how this situation would quickly spiral into a crisis for women who do not have reliable transportation or a support network that can get them to the closest hospital. The continued loss of obstetric care threatens to exacerbate these outcomes."[42]

In addition to the challenges and potential dangers posed by increased travel times, closures often require patients to leave their long-term physician—either because the physician has been pushed out of the practice, has been relocated, or is no longer in-network—and navigate the difficult process of finding a new place of care. Finding a trusted provider can be difficult for any patient, but it is especially fraught for Black women, who have been historically harmed[43] by the medical system and still experience ongoing discrimination in health care.[44] It is also often a time-consuming and lengthy process.

Compounding all of these trends is the growing influence of large religious health institutions as they acquire and merge with smaller providers and hospital systems.[45] Religious hospitals are often unwilling to provide certain kinds of sexual and reproductive health care, particularly contraception,[46] abortion,[47] and trans-inclusive[48] health care. When the only health facility in a rural area is one that is religiously affiliated, it means patients may not have access to a range of important services.

> *Experts often explain mergers and closures as if they are a natural outcome of financial challenges. But this explanation only stands if we accept that health care is a private commodity and not a public good, as it is in so many of our peer countries. Hospital closures and the health care deserts they leave in their wake are not inevitable. They reflect a lack of political will and disregard for the needs of individuals, families, and communities.*

TREND 3: Anti-abortion legislation has accelerated the erosion of the reproductive health infrastructure and maternal health workforce.

The changes in the health care landscape wrought by attacks on reproductive health providers and by hospital mergers and closures have been exacerbated by an ever-expanding slate of anti-abortion legislation. The shrinking health system described in the previous section has been the backdrop for a rapid and continuing reduction in the number of sexual and reproductive health care providers in states with the greatest need for those services. **The *Dobbs* decision has weakened the landscape in many ways, including by forcing the closure of reproductive health clinics and by creating entire geographies in which physicians no longer want to practice.**

In the aftermath of the *Dobbs* decision, many clinics around the country closed. The Abortion Care Network reported that between 2022 and 2024, 76 independent abortion clinics closed, not only eliminating access to abortion care but also the full spectrum of sexual and reproductive health care that is increasingly difficult for women to find elsewhere.[49] Many of these closures took place in states where maternal mortality and morbidity rates are already high, where the rate of hospital consolidation and closures has been high and has chipped away at the care landscape, and where previous and coming attacks on family planning have already eroded care and will continue to do so.

In addition to the loss of brick-and-mortar facilities, the post-*Dobbs* environment has caused a growing number of physicians to leave or avoid training in states where abortion has essentially been outlawed and where treating pregnant women comes with increasing threats of criminalization.[50] As the American College of Obstetricians and Gynecologists (ACOG) reported, findings from recent studies are staggering:[51]

- In one survey of nearly 500 medical students across specialties, close to 60 percent of respondents reported being unlikely to apply for residency in a state with abortion restrictions.[52]
- In a survey of roughly 600 practicing OB-GYNs, 55 percent of respondents said they were concerned about how abortion restrictions would impact the decisions of new providers to enter the field.[53]
- In a survey of OB-GYN residents, 17.6 percent of respondents said the *Dobbs* decision changed where they wanted to practice.[54] This survey data showed "those who initially intended on practicing in restrictive states were over eight times more likely than those initially intending on practicing in protected states to have changed their intended practice location."[55]

- Over two-thirds of Texas-based OB-GYN physicians and residents feel it is impossible to practice evidence-based medicine in the state, with 60 percent fearing legal consequences due to abortion restrictions and 44 percent considering relocating or having already changed where they practice.[56]

- In a study of Indiana medical students, 70 percent of respondents reported being less likely to pursue residency in a state with abortion restrictions, and more than half said they were less likely to pursue OB-GYN as a specialty as a result of abortion restrictions.[57]

It is critical to remember that these new trends in provider decision-making and related provider shortages are often taking place in communities already considered—or vulnerable to becoming—maternal health deserts. Birth workers such as midwives and doulas can successfully meet the needs of pregnant women, but those workers face the same fears and constraints outlined above, in addition to many other barriers to becoming providers.[58] Based on the data described here, we can anticipate provider shortages will only grow under the new presidential administration, which has indicated a willingness to expand current abortion restrictions and enforcement mechanisms.

> *The spread of maternal health deserts will continue to have a disproportionately negative impact on Black women—particularly those in rural areas—as well as immigrant women, Native women, young women, and women with low incomes.*

The bans that have driven these care dynamics are universally unpopular and are causing concern for parents and workers across the country. An IWPR study[59] found that nearly 60 percent of parents and those planning to have children in the next decade are concerned about access to abortion, OB-GYN services, and prenatal care, and 20 percent of adults planning to have children in the next decade have moved or know someone who has moved to another state due to abortion restrictions. The study also found that 57 percent of individuals likely to have children in the next 10 years say they are more likely to apply for or accept a job with reproductive health care benefits, and 51 percent of employed adults believe companies should speak out in support of reproductive rights.

Conclusion

Conversations about abortion, family planning, maternal health care, and health care consolidation are often siloed without real consideration for the ways policies and practices in each field intersect to impact access and outcomes for Black women and their families.

The policymakers protecting corporate power in the health sector are often also those advancing restrictions to reproductive health care and economic policies that are bad for women and families. Women living and working in communities that have lost local hospitals are the same women whose local family planning clinics have closed and who can no longer access comprehensive health care.

We have painted a picture of a health care landscape that, in many parts of the country, has been hollowed out in ways that have made it increasingly difficult for pregnant individuals to access the care they need. This is to say nothing of the other factors that impact maternal health care access and outcomes in direct and indirect ways: a longstanding and ever-growing housing crisis, the erosion of good-paying, stable jobs, the extraordinary costs of child care, threats to immigrant families, and so much more. **For Black women—who shoulder a disproportionate burden of these socioeconomic inequities and the related barriers to care—this landscape is becoming increasingly dangerous.**

As we consider ways to improve the maternal health outcomes of Black women, we must take a holistic view of the root causes driving this crisis and think broadly about how to address it.

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To see more from IWPR's *Birthing While Black: The Urgent Fight for Maternal Health Reform Series*, visit iwpr.org/birthingwhileblack/.

To learn more about IWPR's federal policy recommendations on maternal health, visit iwpr.org/maternal-health.

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