INSTITUTE FOR WOMEN'S POLICY RESEARCH

# Working in Harm's Way: How Occupational Segregation Impacts Black Maternal Health

Research Brief #B402 | July 2025

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

## Executive Summary

Many conversations about Black maternal health—and about Black women's health overall—focus on their role as patients within a health system that has historically harmed them and continues to do so today. **However, the role of Black women who work within the health system is also a critical piece of this conversation.**

Black women are overrepresented in health care jobs, and while some are represented in high-quality, well-paying positions like registered nurses (RNs), as a result of occupational segregation, many occupy jobs that are low-paying, insecure, and often dangerous.[1] Black women are channeled into these positions for many reasons: historical exclusions, ongoing bias and discrimination, the devaluation of care work, and health care consolidation, among others.[2]

Unionization improves the quality of these low-wage jobs, but the majority of workers in these positions remain nonunionized. Occupational segregation of women in health care exacerbates income, wealth, and health disparities, and also impacts the care Black women receive. It plays a unique role in maternal health, both directly by impacting health outcomes for Black women workers and indirectly by reshaping care environments for patients. As we think about expanding community-based care to improve Black maternal health outcomes, we must also consider how to create more opportunities in higher-paying health care jobs and improve the conditions of all Black women health care workers. **Delivering equitable care requires an equitable health care labor market.**

> *Growing consolidation in the health care sector is fueling occupational segregation, suppressing already low wages for Black women workers, increasing work-related stressors, and reducing the power that Black women have in the workplace.*

## Key Findings

- **More than 1 in 5 Black women in the labor market work in the health care sector.**[3] While some women occupy steady, well-paying jobs in the field, many work in low-paying, insecure positions.
- **Unionization significantly improves the quality of these low-wage jobs**, but the majority of workers in these positions remain nonunionized.
- Roughly **10 percent** of registered nurses (RNs) are Black,[4] and these roles have a median annual wage of approximately **$93,600.**[5]
- **Roughly 40 percent of Black women in the health sector work in long-term care**, with hourly wages as low as $12.[6]
- Black women are also underrepresented in the field of midwifery, a field deeply rooted in Black and Indigenous communities. As of 2021, **Black women only represented 7 percent of certified nurse-midwives and certified midwives.**[7]
- **The occupational segregation Black women experience** is driven by historical exclusions, the ongoing devaluation of care work and Black women's labor, the costs of training and credentialing, and racial and gender discrimination in the workplace.
- **Growing consolidation in the health care sector is fueling occupational segregation,** suppressing already low wages for Black women workers, increasing work-related stressors, and reducing the power that Black women have in the workplace.
- **Black women care workers experience disproportionately high rates of negative physical health outcomes**, such as hypertension, which increases the risk of other negative health outcomes, including maternal morbidity and mortality.[8]

# Introduction

There are numerous intersecting factors that shape maternal health access and outcomes for Black women. They include medical system failures, harmful gender norms, restrictive reproductive health policies, medical racism, and a broad range of social determinants of health.

As we illustrate throughout this series, the economy itself is an often-overlooked factor at the root of the Black maternal health crisis. **One critical dimension of the economy that distinctly shapes this issue is occupational segregation in the health care labor market, which impacts Black women as both patients and workers.**

Like many other social determinants of health, the present-day labor market is the product of an economic system rooted in racism and sexism, and gendered racism specifically. Our labor market and the broader economy in which it is situated were built on the exclusion of—and extraction from—Black women since the earliest days of the nation. While the health sector provides opportunities for quality work for Black women (especially those in unionized workplaces), **they are disproportionately channeled into the lowest-paying, least secure, and often most dangerous jobs in the health sector,** including in care, serving, and cleaning roles.[9]

> *Black women represent a small fraction of individuals in higher-paying positions, and those who do secure such jobs often face discrimination and bias that impact their quality of work and overall well-being.*[10] *They are routinely locked out of jobs that offer good pay and benefits, such as health care, paid leave, and retirement.*[11]

The underrepresentation of Black women in higher-paying jobs in the health system not only impacts their wages and career advancement, but also affects Black women patients who do not see themselves reflected in their care providers. Occupational segregation contributes to a health environment that has historically been hostile toward Black women, fueling generations-old distrust in the formal medical system and Black women's desire to seek care outside of it.

This brief is the fourth in *IWPR's Birthing While Black: The Urgent Fight for Maternal Health Reform Series*. It explores how occupational segregation in health care impacts Black women both as workers and as patients. It examines the drivers of occupational segregation and details how consolidation in the health sector fuels this type of segregation and shapes wages and work opportunities. It explains how the underrepresentation of Black women in higher-paying roles within the health sector affects not only their wage and career advancement, but also Black patients who do not see themselves represented among their care providers.

There is a dearth of research that illuminates how occupational segregation specifically impacts the health and well-being of Black women health care workers, and even less about Black women in the maternal health workforce more specifically. Furthermore, we need more information about how the health of Black pregnant women working within the health system can be impacted by the conditions they face on the job. They experience racial and gender discrimination, are less likely than their White counterparts to have benefits such as health insurance and paid sick and family leave, and face job-related threats to their physical and mental health—**all of which contribute to the toxic stress that shapes Black women's pregnancy outcomes.**[12]

However, examining what we do know about the ways that Black women are channeled into the health sector, and the economic and health impacts they experience as a result, provides a window into the cost that Black women bear for providing critical care for individuals and families across the country.

## The scope of occupational segregation in the health sector.

Black women are overrepresented in the health sector. They make up roughly 7 percent of the US labor force overall, but nearly 14 percent of the health care workforce,[13] with many working in low-paying positions.

Approximately 40 percent of Black women in the health sector work in long-term care,[14] with a median hourly wage of approximately $15.[15] On the other end of the spectrum, Black women represent only 10 percent of registered nurses and less than 3 percent of physicians—two of the highest-paying roles in health care.[16]

Health care jobs represent the fastest-growing segment of the labor market, meaning that in the years to come, there will be a continued demand for workers to fill these positions. This presents an opportunity to expand pathways for Black women into higher-paying jobs in health care.

As a result of numerous barriers described throughout this series, Black women are underrepresented in higher-paying positions such as physicians, surgeons, and health care managers.[17] Black women are only 2.8 percent of the physician workforce and 0.8 percent of academic leadership roles at medical schools.[18] Even when they do reach higher echelons within the health sector, Black women doctors and nurses must still contend with discrimination[19] and bias[20] that impact the quality of their workplaces and their overall well-being.

**The lack of representation of Black women in leadership positions and physician roles not only impacts Black women as workers, but also the settings in which they and other Black women seek care.** The lack of Black women physicians contributes to the continued racial and gender discrimination experienced by Black women patients and perpetuates the distrust of the medical system more broadly.[21]

Black women are also underrepresented in midwifery—a field deeply rooted in Black and Indigenous communities.[22] As of 2021, Black women were only 7 percent of certified nurse-midwives and certified midwives, while White women accounted for nearly 86 percent of midwives in the United States.[23] In the face of the Black maternal health crisis, a growing percentage of Black women report a desire to have midwives oversee their pregnancies and childbirths.[24] Yet, even with access to midwifery care, Black women often struggle to find providers with their racial and cultural background.[25]

# What is driving occupation segregation in the health system?

Occupational segregation today is shaped by many factors that need to be acknowledged and addressed in order to create a more equitable labor market that provides more equitable care.

## Historical Exclusions

As we have described throughout this series, occupational segregation is the living legacy of the racial and gender exclusions that are at the very roots of the US economy.[26] From the earliest days of the United States, the work of caring for pregnant women, children, and the elderly was seen as the unpaid work of Black women, and as such, it has been underpaid and undervalued for centuries. In the early 1800s, White male physicians began to villainize Black midwives and disregard their knowledge, portraying them as irresponsible, unprofessional, and untrustworthy.[27] They implemented countless systemic barriers to Black women receiving "formal" medical education, training, and credentialing, **effectively seeding the occupational segregation that has been a steady feature of the US economy ever since.**

For centuries, this has shaped the labor market opportunities available to Black women, the quality of the jobs that Black women have been channeled into, and the care that has been available to Black women and their families. Past research and briefs have shown that in addition to these barriers to entering and advancing within maternal health professions, Black women also experience a lack of mentorship, financial constraints, and systemic bias.[28]

## Devaluing of Care Work

Care work has historically been regarded as the unpaid and unskilled labor of women broadly, and Black women specifically; as such, it has always been undervalued. This sentiment has permeated all aspects of care work in our economy, including health, child, and elder care. This has led to a mutually reinforcing cycle: **Black women's labor is disrespected and devalued, and they are disproportionately channeled into jobs that are regarded in the same way.** Care jobs outside the formalized medical system—especially those focused on women's health, such as midwives, doulas, and other kinds of community and birth workers—are, by extension, often unpaid or poorly paid, despite their essential role in communities.[29]

## Cost of Training and Credentialing

Pathways to higher-paying roles—and even to roles like certified nurse midwife (CNM) or licensed midwife (LM)—require credentials that are expensive and time-consuming. **Black women face numerous financial barriers to pursuing these credentials:** race and gender wage gaps, intergenerational wealth disparities, a shortage of scholarships, and a lack of professional networks that can help open doors into the sector.[30]

Credentialing and training processes are significant barriers to midwifery, but so too is access to actual schooling. Today, there are fewer than 50 accrediting programs nationwide, and some states do not have any programs at all.[31] Individuals who wish to be accredited at the highest level to meet the doctorate of midwifery requirements must often take on more debt to pay for the high costs of education and training.[32]

Unions help workers overcome these barriers. Many provide access to training, mentorship, and educational reimbursement. One Service Employees International Union (SEIU) program offers financial assistance for tuition and all related program costs, as well as educational support services, such as tutoring, career counseling, paid time off to attend classes, and job placement assistance.[33] These are all critical benefits that provide workers with a bridge to overcome barriers to training and credentialing.

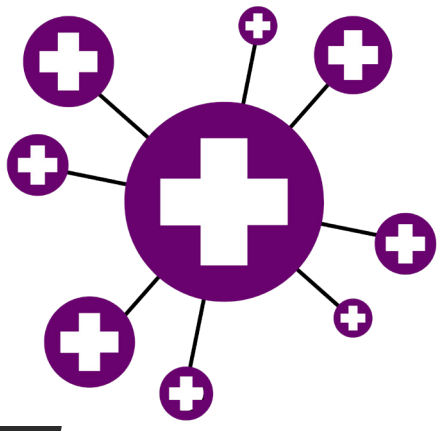
## Racial and Gender Discrimination

Explicit racial and gender discrimination was outlawed in the 1960s, and for many decades, affirmative action worked to counter systemic exclusions that kept Black Americans out of the health system.[34] While affirmative action helped to increase the number of students of color accepted to and enrolled in medical school, **implicit bias, cultural stereotypes, and institutional racism and sexism continued to drive the underrepresentation of Black women in health care.**

Research has shown the occupational segregation of Black women in health care cannot be "fully explained by correlations with education, marital status, age, or immigration status."[35] Once Black women are hired into health care jobs, they often face biases and discrimination that lead to isolation, higher attrition rates, and stalled career advancements.[36] Current attacks on diversity, equity, and inclusion (DEI) efforts will only make these trends worse.[37]

## Health Care Consolidation

Growing consolidation in the health sector is fueling occupational segregation. Throughout this series, we have shown the various ways consolidation has been harmful to patients.[38] However, it can also be harmful to workers, and **given Black women's overrepresentation in health care jobs, these trends can have a significant negative impact on their physical, emotional, and economic well-being**. When health care systems shrink through mergers and closures, the labor market becomes characterized by monopsony. As a result, the number of employers decreases, employment opportunities are reduced, wages decline, and workers have less bargaining power in the workplace.



Research shows that consolidation often leads to reductions in wage growth for health care workers.[39] In one study that tracked wage trends four years after a hospital merger, wages for skilled workers were 4 percent lower, and for nursing and pharmacy workers, wages were 7 percent lower.[40] And a survey by the American College of Emergency Physicians found that after a merger, 60 percent of emergency room physicians saw their wages reduced, with 40 percent experiencing a reduction of over 20 percent. In the same study, individuals who saw an increase in wages reported some significant tradeoffs, such as cuts to other forms of compensation like benefits, insurance, and retirement.[41]

> *For Black women, who are already in lower-paying jobs in the health sector, any decline in wages matters significantly. Lower wages limit access to quality health care, increase financial and job-associated stressors, contribute to poorer health outcomes, and make it even harder for Black women working in health care to achieve economic mobility and stability.*

These trends contribute to persistent racial and gender wage gaps.[42] In addition to reductions in wages, health care workers report concerns about changes to job satisfaction and work environments after a merger. Nurses have pointed to increased workloads and reduced staffing levels as contributing to burnout and decreased job satisfaction. As a study by Equitable Growth explained, after a merger, nurses experience increases in the number of patients they see, which correlates with poor job satisfaction and intentions to leave.[43] Increases in workload trickle down to lower-level nursing staff, putting more on their plates at a time when their wages might already be declining.

Research confirms that mergers in the health sector fuel higher turnover rates. A Fidelity Investments study found that nearly 50 percent of health care employees consider leaving their job following a merger or acquisition, often due to increased stress and distrust in senior management.[44] For patients who seek obstetric care in a hospital setting, nurses are a critical part of the birth process, and staffing shortages can have a significant impact on their experiences and labor and delivery.[45]

**When the standard or integrity of care is compromised due to nursing shortages, birthing patients can suffer.** Nurses report a range of issues that arise because of care shortages, including missing critical aspects of maternity care, not recognizing potential evolving maternal deterioration, and failure to rescue—a significant factor in maternal deaths and morbidity among women of color.[46]

# The benefits of unions for Black women health care workers.

While Black women are disproportionately channeled into low-wage work in the health sector, unionization can have a significant positive impact on the wages, job security, and working conditions of these positions.[47]

Nearly 15 percent of Black health care workers are unionized, compared to nearly 12 percent of White health care workers. Unions are particularly important for Black women health care workers, given that they comprise an overwhelming percentage of health care workers overall.[48]

**Union membership does not necessarily make all health care jobs *good* jobs, but it certainly makes them *better* jobs.** Research has shown that unionized health care workers in low-wage roles (like nursing assistants, home health aides, and support staff) earn significantly more than their nonunionized counterparts.

- Unionized Black workers overall earn **15 percent more** than nonunionized Black workers in similar roles.[49]
- Unionized health care workers **had higher mean weekly earnings** ($1,165) compared to nonunionized workers ($1,042).[50]
- Unionized workers in direct care occupations earn **10 percent more** in average hourly wages than their nonunionized peers.[51]
- Unionized certified nursing assistants (CNA) earn nearly **13 percent more** than nonunionized CNAs, with top earners making up to 24 percent more.[52]


In addition to having higher earnings, unionized health care workers have reported:[53]

- A greater likelihood of having a **pension or other retirement benefits** at work (57.9 percent vs. 43.4 percent).
- Greater likelihood of **employer-sponsored health insurance** (22.2 percent vs. 16.5 percent).
- **More work hours** per week (37.4 percent vs. 36.3 percent).
- Significantly smaller **racial and gender differences in pay** than their nonunionized counterparts.
- **Greater job protection**, safer working conditions, and lower injury rates.

**Unions help to protect against racial and gender discrimination that is prevalent across the US labor market.** They enforce antidiscrimination clauses in contracts and provide legal recourse for harassment or racial bias. They can also support grievance procedures that help Black women workers collectively hold employers accountable in a way that might not be possible individually. Union workers benefit from contract guarantees such as transparent promotion pathways and other mechanisms for preventing favoritism or bias.

Unions can also offer on-ramps to new career pathways for Black women. Some contracts provide access to training, mentorship, and educational reimbursement provisions.[54] Opportunities like the SEIU Career Pathways Program help Black women in health care overcome barriers that might otherwise

prevent them from participating in training and development programs that can open doors to new job opportunities.[55]

The collective bargaining power workers gain helps them negotiate not just wages, but also policies affecting workloads, scheduling, and respect and safety on the job.

> *Research shows that the unionization of health care workers doesn't just improve worker safety, but also patient outcomes by ensuring safe nurse-to-patient staffing ratios, better paid sick leave, and less worker turnover.*[56]

The challenge moving forward—particularly as the need and demand for these jobs grow—is to expand unionization opportunities for health care workers. The vast majority of health care workers (and care workers more broadly) are still not unionized. Right-to-work efforts have made unionizing in many states much more difficult,[57] and dynamics such as health care consolidation have also suppressed labor organizing efforts.[58] However, the increase in labor organizing[59]—and union wins—are hopeful trends. In 2023, the largest health care strike in history resulted in 75,000 Kaiser Permanente workers agreeing to a contract that included 21 percent in wage increases over four years.[60]

## Low-paying, insecure jobs are bad for Black women's health.

The jobs that Black women are disproportionately channeled into not only harm their economic security but also threaten their health and overall well-being.

There are multiple pathways through which specific jobs lead to negative health impacts, including a lack of benefits such as health insurance and paid sick and family leave, and job-related threats to physical and mental health.

Low-paying, insecure jobs often do not offer the full range of critical benefits such as insurance coverage and paid sick and family leave, and weak and eroding public programs are failing to fill the gaping holes left by employers. As of 2022, 34 percent of Black women overall did not have access to paid sick leave,[61] and, in a given year, nearly 40 percent of Black women who need paid leave do not take it.[62]

Research indicates that health care support workers often do not have employer-based or private health insurance.[63] For Black women health care workers living in states that did not expand Medicaid, a lack of employer-based health insurance can be particularly dangerous. As of 2019, approximately 810,000 women of reproductive age with incomes below the poverty line were uninsured in the 12 states that had not expanded Medicaid. Among these women, about 29 percent were Black.[64]

**The work-related stress that Black women shoulder compounds these structural disadvantages and can translate into negative health outcomes for Black women.** This is particularly concerning when it comes to hypertension. Research shows that Black health care workers experience higher hypertension rates than their White peers,[65] and that health care workers employed in positions considered "high demand, low control, and low support"—which would characterize many of the positions that Black women are disproportionately channeled into—carry the greatest risk of hypertension.[66]

Hypertension contributes to a number of maternal complications such as stroke, heart attack, organ failure, seizures, preterm birth, and low birth weight. As Nichele Washington notes, "Not only does systemic racism create the preconditions for hypertension, but also—because systemic racism itself is violent, traumatic, stressful, and permeating—research suggests that being subjected to its experiences and perpetrators can, on its own, physically manifest as hypertension in its victims."[67]

> *Given the role hypertension plays in maternal mortality, morbidity, and miscarriage, the job-related risks faced by health care workers can be particularly dangerous for Black women before, during, and after pregnancy.*

Hypertension is one of the three major complications that account for 3 in 4 maternal deaths.[68] Individuals with hypertension are at increased risk of other complications, including preeclampsia. Hypertension increases the risk of postpartum cardiomyopathy, a form of heart failure, which Black women are six times more likely to develop than White women.[69] It is also the primary risk factor for pregnancy-associated hemorrhage, which Black women are twice as likely as White women to experience.[70]

## Looking Ahead

As we have illustrated throughout this series, the economy is a powerful driver of maternal health access and outcomes for Black women. Occupational segregation in the health care labor market is a critical and often overlooked dimension of the economic determinants of health, one that has a unique impact on Black women—both as workers and as patients. There are some important questions to consider as we look at ways to improve health care access and outcomes for Black women.

Health care jobs—particularly those that are low-wage—are among the fastest-growing in the economy. **What will this mean for Black women health care workers, especially during a time of potentially sweeping changes to economic and social policies and programs that have provided an already insufficient foundation of well-being for Black women and their families?** The economic shifts introduced by the current administration present an acute threat to the employment of Black women.[71] Slashing the federal workforce, removing antidiscrimination protections, attacking labor rights, and rolling back health care rights and access will only increase the inequities and precarity of the low-income jobs that Black women are already channeled into.

In addition, the changing economic landscape for Black women will mean fewer options for employment and less leverage to fight for better wages and working conditions. As discussed previously, the increase in labor organizing and the wins secured by unions in recent years present an important opportunity to counter some of these harmful trends.

**How will recent changes to affirmative action impact the inclusion of Black students and practitioners in the health sector?** For many decades, affirmative action worked to counter systemic racism that kept Black Americans out of the health system. This set of policies helped increase the number of students of color accepted to and attending medical school, building (however slowly) a deeper bench of medical students that more accurately represented the US population.

But even with robust affirmative action policies in place for more than five decades, admission rates among Black students lagged. And the recent Supreme Court decision striking down affirmative action has led to a roughly 11 percent decline in admissions of Black students to medical school.[72] Combined with shifts in economic policy and cuts to social programs and policies—all of which will take a disproportionate toll on young Black people—it will be even more difficult for Black students to make the choice to attend medical school and/or receive medical training, let alone be accepted into the programs that are required to enter the field. Unfortunately, the constellation of recent and ongoing policy and political shifts will exacerbate social determinants that impact health access and outcomes for Black communities, increasing the need for more representative, culturally sensitive care across the health spectrum.

**How will the growing threats to reproductive health care providers impact Black women in health care jobs?** Research has shown there is growing reluctance among emerging practitioners to take up residence in states with restrictive reproductive health policies.[73] There is also a growing need and demand for birth workers of color, and more and more Black women are taking on these roles. However, Black birth workers and health care professionals could face heightened criminalization, especially when outcomes are poor or when care practices fall outside what is considered mainstream. The same women who bring community knowledge and trust into health care could be the most vulnerable to legal punishment.

**Allowing the jobs that Black women disproportionately occupy to continue to be poorly paid, under-protected, and uncertain will mean continuing to build a health care workforce on the backs of Black women while exacerbating their own economic and health inequities.** Effectively addressing the Black maternal health crisis will require improving employment opportunities and outcomes for Black women who work in the health sector. Not only do these women provide critical care before, during, and after pregnancy, but they also provide care throughout the lifespan. Their work increases the likelihood that Black women will have fewer underlying health issues going into their pregnancies, that their families' health needs will be met and not fall exclusively on the shoulders of women who are the heads of their households, and that women will be cared for and appreciated as they age. Black women health care workers also deserve all of those things, and we must create the economic conditions to ensure they can have them.

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*This brief was prepared by Andrea Flynn and Dr. Martinique Free. It was made possible with support from the David and Lucile Packard Foundation. The authors would also like to thank Dr. Kate Bahn for providing feedback and Miranda Peterson for fact-checking.*

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

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