Institute for Research on Women, Gender & Sexuality
College of Liberal Arts and Social Sciences

Edited transcript of UH IRWGS Webinar on
Racial Disparities in Maternal Health: The Role of Pre-Existing Conditions,
Friday, July 12, 2024. Recording link.

Presenter: Dr. Annamaria Milazzo
Panelists: Dr. Neema Langa, Dr. Zelma Oyarvide Tuthill
Welcome: Dr. Elizabeth Gregory

00:00:01:11 - 00:00:07:04
Dr. Elizabeth Gregory
Hello. Welcome.
I guess we'll get started, because we have a short period. Welcome everyone to our first institute for Research on Women, Gender, and Sexuality webinar. and thank you for joining us at this new time, in spite of all the complications of Hurricane Beryl. We will record this so that all the people who were intending to make it but couldn't because unfortunately, they don't have electricity, or other access to the internet will be able to find it online.
Also due to the change, we're not sure that all of our panelists will be able to join. But I'm going to introduce everybody, and those who can join will participate. I don't want to not introduce anyone and then have them come on just at the last minute.
So just in quick overview for those not familiar, the IRWGS in Harris County, Texas, partners with community organizations to gather data on those topics -- women, gender and sexuality – in order to share that with the community and to inform policy here. We're based at the University of Houston College of Liberal Arts and Social Sciences. Please check out our reports on our website - on research we've done on domestic violence, reproductive health, economics, LGBT issues, childcare, the pandemic, etc. To find us, search UH IRWGS.

Today IRWGS researcher Professor Annamaria Milazzo will present the findings from her study on “Racial Disparities in Maternal Health: The Role of Pre-Existing Conditions," which is based on Texas hospital discharge data from all delivery hospitalizations from 2016 to 2022. After her presentation, we'll hear from our distinguished panel, who will give us an overview of their work on maternal health and health disparities, and also share questions for and intersections with Milazzo's findings.

Our moderator, Dr. Zelma Tuthill, will then pose questions for the panel and then we'll go to questions from our audience.

And now, brief introductions of our panelists:
Dr. Milazzo is an economist and a research assistant professor in IRWGS. She studies health outcomes for women and children and has worked on projects in Africa, India and elsewhere with the world Bank and now in the US with UH IRWGS.
She is a co-investigator on an NSF-funded grant on maternal morbidity and mortality in Texas, for which Dr Neema Langa is the primary investigator.

Dr Neema Langa, an Assistant Professor of Sociology and African-American Studies. Her research explores the role of institutional forces in determining disparities in the utilization of maternal health care and maternal health outcomes in developing countries and the US. And she is, as noted, the PI on the NSF grant on maternal morbidity and mortality.

Dr. Shreela Sharma, going in alphabetical order, is Professor of Epidemiology and Director of the Center for Health Equity at the UT School of Public Health. Her research focuses on food insecurity, health equity, health disparities, and diet related chronic diseases. She's also the co-founder of Brighter Bites, a nationwide nonprofit dedicated to providing fresh produce and nutrition education to low income children and their families. [unable to join]

Dr Brittany Slatton is a Professor of Sociology at Texas Southern University. Her research focuses on the impact of structural racism and social determinants of health on black women's physical, emotional, and financial well-being, on the effect of social determinants on black women's maternal and child health outcomes, and on gender- and race-based discrimination within the health care industry, illuminating how these forms of bias contribute to health disparities. [unable to join]

Dr. Zelma Tuthill is an Assistant Professor of Sociology and Women's, Gender and Sexuality Studies at UH and a researcher on health and inequality. Her research agenda highlights how racism, sexism, and heterosexism structure and reproduce poorer health outcomes in health environments. So we're very happy to welcome our panel today and our audience. And now I'll hand it over to Dr. Tuthill.

Presentation

Dr. Zelma Oyarvide Tuthill

Thank you so much for being here, literally after a storm. So we're very thankful. And for those of you who are dealing with either minimal or unstable or no power, we really appreciate you being here. And for those who are watching the recording at a later time, we appreciate you also watching. The topic today is very important, something that a lot of us are passionate about, and we are very excited to learn more about Dr. Milazzo's paper.

I'm going to hand it over so that she can provide just with more information about what this report and this paper found. And then my goal is to go deep into some of these questions that she poses in this paper, as well as and the report, into some of the answers that she provides that I think can really shine light into how we can really solve and address some of these issues that we we're very concerned with here, which is maternal morbidity and mortality. So I'll hand it over and once the presentation concludes, we will open up to the panelist to provide some feedback.

Dr. Annamaria Milazzo

[SLIDE 1] Thank you so much. Elizabeth and thank you Zelma, for the introduction. And thank everyone for being here today. It's a difficult time, so I'm really thankful you were able to find time to join the discussion today. So I'm really excited about presenting this work, and to have this discussion that brings together researchers from different backgrounds and different disciplines, and to join efforts in trying to understand the factors behind the racial disparities in maternal health and how, we can make, things better for women here in Texas.

[SLIDE 2] So, the motivation: I'm a development economist and one of the topics I've worked on was the effect of strong preferences for male children on maternal health in developing countries and, I found

that increased fertility and reduced spacing between births led to worse, maternal health and higher maternal mortality.

So when I came to IRWGS about two years ago, it was an obvious choice for me to study the U.S maternal mortality crisis. Considering that the US is the country that spends the most on maternal in health care worldwide, and at the same time it's ranked as last among all comparable high-income countries in terms of maternal mortality.

So this poses a real puzzle: what happened? So I wanted to do research on this. So I put together these small graphs just to show how the US compares to other comparable countries in terms of maternal health, and things have been worsening pretty fast. as you see in the past two, ten, 15 years. So if we had a similar graph about plotting life expectancy or the prevalence of chronic conditions in the US, we would also see,a similar pattern.

So the US does worse compared to other countries. And things have been worsening pretty fast over the past few years. I will be trying to talk about some of the reasons behind this, but the idea of the paper is, to understand, the role of worsening health in understanding racial disparities, in maternal health and mortality.

00:09:08:01 - 00:09:40:07
[SLIDE 3] So we know that the US is facing a maternal mortality crisis, but we also know that this is an alarming phenomenon that is especially experienced by black women, who are about three times more likely to die from pregnancy-related causes compared to white women. So while there are issues in terms of how to measure maternal mortality, the racial disparities are not under dispute—these are huge and visible and, they really need, attention. So you see this graph here -- you see these huge, disparities, especially between non-Hispanic black women and white women. So severe maternal morbidity (SMM) is an alternative indicator of maternal health, that is, more frequent.

[SLIDE 4] So, for every maternal death there are about 50 to 100 women who suffer from severe maternal morbidity, with an average of about 1 to 2% of women who give birth who are affected by it. So these are events that can be considered near misses for maternal death because, if these conditions are not properly identified and treated, timely, they can lead to death.

And these conditions include hemorrhage, eclampsia, which is a very high blood pressure that can lead to seizures and coma. Sepsis, which is a generalized infection [that can lead to ___] and organ failure, among other causes.

[SLIDE 5] So this paper - so we know that, as I have shown before, that maternal mortality has been worsening in the US and also that also comorbidities in general, underlying health has been worsening in the US. At the same time, you know, there are huge racial disparities in maternal health.
So the idea of the paper is to try to understand how much health comorbidities that are present before women deliver at the hospital—so the underlying health of women, matter for explaining the differenxe in severe maternal morbidity between black and white women. And to try to compare that to other sources of disparity. So to do that, I use Texas hospital discharge data from 2016 to 2022 that has information for every hospitalization.

So for each one, I have information about the diagnosis and procedure code that they went through during their hospitalization that are coded using standard [gap]. The dataset also has important

information on the hospital and the physician. So there is a unique identifier in the dataset that enables the inclusion of hospital fixed effects, which, to make it very simple, enables me to understand what is the disparity within the same hospital and physician? So for women who go to the same hospital and are also using the same physician.

So the idea of the paper is to decompose the influence of multiple factors. One, as I mentioned, is the underlying health, which I can also call "the stock of health capital," which includes many things that can happen prior to the hospitalization for the mother. So the persistent effects of prior health behaviors or prior medical care and other experiences that can impact current health and mortality rates. Individual level observables, meaning like characteristics like the type of insurance that women are using, age and other covariates that are available in the data set.

And other factors include the differential care that women receive during their hospitalization. And these include two factors, one is hospital location. So, the possibility that black women are more likely to give birth in hospitals that provide worse care to all women. So they're using a worse hospital , of poor quality. And other factors are within hospital and, within hospital physician. So that includes implicit biases, racism in the health care system. So black women receiving worse care than white women, delivering at the same hospital and being treated by the same physician.

[SLIDE 6] So how do I calculate severe maternal morbidity?
I use an algorithm that is provided by the CDC using the hospital discharge data and using the ICD-10 codes. And these are the conditions that are included and that define SMM. So hemorrhage, respiratory conditions and all the other conditions that are listed here.

[SLIDE 7] In terms of prevalence, so this is just showing the prevalence across the different racial and ethnic groups. You see that, overall, black women are twice as likely to suffer from SMM compared to non-Hispanic white women. And the prevalence is higher for each of the SMM groupings, for all of them. So black women are more likely – the disparities can be larger or smaller, depending on the type. But the disparities are generally much larger, for every group, among black women compared to white.

[SLIDE 8] How do I measure the health status? That's the underlying health of women when they go to the hospital to deliver their child. I use the obstetrical comorbidity score, which was developed by a gynecologist to summarize health at the time of delivery. So it considers 26 comorbidities that predict SMM and basically assigns weights or scores that are based on the importance of each comorbidity in predicting severe maternal morbidity. And this has been validated in different settings and different racial and ethnic and economic groups to assess SMM disparities.

[SLIDE 9] So here is another table to show you the prevalence of the different conditions that are included in the comorbidity score by racial and ethnic group. So there are medical conditions and obstetrical conditions which are specifically related to the current pregnancy.

00:16:23:11 - 00:16:51:22
So among medical conditions we have: asthma, chronic hypertension, cardiac disease, diabetes, obesity and other conditions. And prevalence is much higher among black women for almost all of the preexistent medical conditions and similarly also for the obstetrical/pregnancy conditions. So this is just a summary of the health of the women at the time they go to the hospital. We see that black women are more likely than white women to suffer from many conditions. So their overall health is worse, at that point.

[SLIDE 10] So this sample: the sample includes about 2.5 million delivery hospitalizations over that time frame that occurred in 276 hospitals. The racial composition of the sample is about 35% non-Hispanic white and 11.9% in non-Hispanic black and other racial and ethnic groups. In terms of the payment method that was used to pay for the hospitalization, so about half use private insurance and the rest mostly use Medicaid, which is available to all women when they become pregnant.

[SLIDE 11] So this is the first graph that shows the trends in SMM by racial and ethnic group, in the time period from 2016 to 2022.

00:18:04:02 - 00:18:39:08
So the first striking thing is the huge disparity, again, non-Hispanic black women are twice as likely to experience SMM compared to white women. And we see that the trend has been increasing over time. The overall increase is about 18%. So there has been a spike, especially during Covid. And then, we see it declines in 2022, but to a level that is still higher compared to pre-COVID time.

[SLIDE 12] In terms of the disparity, taking just the ratio to SMM, we see that things have been pretty stable over time. So the disparity has remained more or less the same during this period.

[SLIDE 13] In terms of comorbidities, so the first graph shows the comorbidity score and the second, the graph to the right, shows the prevalence of two or more comorbidities.

00:19:04:16 - 00:19:33:10
So we see huge increases, again, reflecting the worsening of overall health in the US. And we see huge disparities as well. The increases are even stronger than the increases in SMM**,** in the order of about 40% over a six-year period, which are really large increases in a short period of time.

[SLIDE 14] The gap has remained pretty stable over time, as for SMM. Also the gap in terms of comorbidities has remained more or less the same during this time.

[SLIDE 15] So as I mentioned before, these are all alarming trends that basically reflect what's happening in the US, in terms of overall health.
So, one is the decline in life expectancy among adults in the US compared to similar countries. But also overall burden of disease that includes both increased death, but also the number of years that are lost due to diseases that cause disability.

[SLIDE 16] So I will be very quick in terms of the empirical methodology, but the idea is to predict SMM, controlling for race, which is the main coefficient I'm interested in -- to estimate the disparities. And also controlling for many other things that are available in the data dataset, including individual level characteristics like: age, payment method, obviously the comorbidity score, and then other area level variables and I also include hospital and hospital physician fixed effects.

[SLIDE 17] So the idea of the empirical methodology is, you know, after controlling for the factors that I have mentioned, is to compare SMM outcomes for women who are observationally similar, that have the same comorbidity score and who are going to the same hospital or the same hospital physician. And, you know, the only thing that distinguishes them is their race/ethnicity.

00:21:21:11 - 00:21:44:22

[SLIDE 18] So this is the first set of results, and I merged the main results in this table, which is basically showing—so the first column is saying that black women are twice as likely to experience SMM compared to white women. And after we control for the factors I mentioned before - so first I control for age, I control for payment methods. So even though black women are more likely to use Medicaid compared to white women, we see that the type of insurance that they are using does not really matter in terms of SMM. And controlling for area-level factors, the disparities more or less stayed the same. But as soon as we control for the comorbidity score, we see that the disparity drops. So this is basically *saying that preexisting health really matters* in explaining SMM disparities.
Also the other factors and fixed effects don't appear to matter very much.

So at the end, there is still an unexplained gap that is significant.
So even among black and white women who are going to the same hospital and seeing the same physician, we still see that there is a significant gap. *So black women are 17% more likely to experience SMM, even within the same hospital and within the same physician*. So this is still a large disparity that, again, needs more investigation.
[SLIDE 19] So when I try to decompose the gap in SMM between black and white women, I see the main result here, coming from the decomposition is that they comorbidity score is the main explainer of the differential in SMM.

*So about 78% of the black and white gap in SMM can be explained by differences in underlying health, w*hen women go to the hospital to deliver their child. While the other factors, as you see, don't seem to matter very much.

[SLIDE 20] When we separate the conditions between conditions that are medical, more chronic conditions, versus those that are only related to the pregnancy, we see that medical conditions explain about 58% of the gap, while obstetrical conditions explain about 30% of the gap. This is to say that conditions that appear only during pregnancy, like pre-eclampsia, or placental issues or gestational diabetes, that can be treated during a pregnancy through better prenatal care, for example, are very important.
So, prenatal care: We know black women are less likely to see a doctor in the prenatal time period. And, you know, they start prenatal care later than white women. [And this may be due to when they get access to prenatal care – if they only have access when they become pregnant, through Medicaid, it may take a while to do the paperwork.] So this is to say that, also focusing on the time while women are pregnant is very important and can help in reducing the disparities.

[SLIDE 21] So, to conclude, what are the main takeaways of this study? So we have seen that differences in comorbidities explain a large portion of the gap—about 78%. The differences in hospital and physicians that are used during childbirth don't appear to matter very much.
And the unexplained gap is about 17 to 20%.
So this can be explained by:
Provider bias -- like implicit bias in the health care system.
But *also the severity of each a condition [may be a factor* – if black women have more severe versions of the given comorbidity than white women], which is not available in the dataset.
So these could also explain some of the remaining disparity.

So, I think the main message is that there is a critical need for a major focus on the health of women, well before they conceive and well before they give birth. So starting from very, very early ages. And this is very relevant to for the state of Texas, which is the US state that is the second largest in terms of the

number of births and has the highest share of women in their reproductive ages who don't have insurance and who don't have access to health care.

00:26:17:18 - 00:27:06:08
And that is a 25%. So *one out of four women don't have health insurance here in Texas*. And Texas is also one of the few states that has not expanded Medicaid to low-income adults under the Affordable Care Act. So, again, this is just one policy implication. So going back to what I mentioned at the beginning, while the US is the country that spends the most on health care compared to similar countries, but it is very obvious that, you know, the benefits of these expanded very large expenditures don't benefit the most disadvantaged. And, that *there is a need for expanding attention to the health of women [from birth onward], a more holistic approach*. And it really requires a more inclusive access to health care. Among other things, including *better nutrition*, which can lead to better health, so that women are in better health when they go to give birth to their child. And so that has implications. The food industry should make food that is more nutritious, with more diverse [options] for people.
And also dealing with the opioid and substance-abuse crisis.
So there is a wide range of policy options that and I'm happy to open the discussion about what can be done, and how these results can be used to inform policy and to start discussion about supporting maternal health.

So thank you so much, everyone, for listening to my results. And I'm happy to,listen to any questions you might have. And open the discussion.

00:28:27:13 - 00:28:51:05
Dr. Zelma Oyarvide
Thank you so much for that presentation. There's so much that you -- like for each slide I just had so much that I wanted to ask and talk about. So before we get into some of these questions from the audience – and if you do have questions that you would like to pose, you can start putting them in the chat.
But first I wanted to take some time to get some feedback from some of the people who are doing ongoing work on maternal mortality, including people from our panel. And so, we do have people at this university and on this panel that we've asked to be here who are doing work on maternal mortality and morbidity.

00:29:10:06 - 00:29:44:11
And, I wanted to first give them the opportunity to talk a little bit about their work, to contextualize the type of work that they're doing in this area, and then provide some of their impressions of your findings so that they can either relate that to your findings or to some of the findings in their own work, or just talk more and expand a little bit about some of the things that you've brought up that are striking and really significant and meaningful for us to really understand.

And so I want to, to highlight Dr. Langa, who is an expert in maternal mortality, particularly within black women, both here and internationally. So if you could, Dr. Langa, provide us a little bit of an overview of your work, some of the work that you're doing, and then what are your impressions of some of the results that we just saw, relating to your own work or that you would like to just kind of expand on and talk a little bit more about?

00:30:17:04 - 00:30:53:07
Dr. Neema Langa

Thank you so much for the introduction. Yes, I study maternal health disparities in Africa as well as among African Americans in the US. And throughout my research, I have been looking into factors like the social determinants of maternal health characterization as well as maternal health care outcomes. And what Dr. Milazzo has just presented the is consistent with what I have been looking into, what I have seen from my findings and what she did - the document is consistent with the project that that we are working right now on maternal morbidities, maternal mortality and of health care usage that we just received the NSF grant on.
So on top of what she has highlighted, for example, on how non-Hispanic black mothers have higher likelihood of having severe maternal morbidities as compared to white mothers, I see that in the case of Texas, the idea behind everything is the idea that Texas is a maternity care desert. That the state of Texas has not enough maternal health care services to cover everybody in the areas in the rural/urban divide. The state of Texas itself is huge, to the extent that if you are a rural resident, you are less likely to have maternal health care, and lack of maternal health care is one of the flags that highlight difficulties among women and eventually their likelihood of having severe maternal morbidities. So if you are living in an area where you don't have maybe good access, maybe access because you don't have hospitals or access maybe because you don't have money or you don't have health insurance, or you are underinsured or not insured, things like that may intersect together to influence your likelihood of having SMM.

And who are highly affected? Marginalized, underserved communities, particularly non-Hispanic black moms. Yeah. Thank you.

00:32:35:20 - 00:32:59:20
Dr. Zelma Oyarvide
Yes. And, I was really excited with the Texas focus, because I feel that often it's really important for us to look at the national problem, of course, but also to understand more of a local and, especially here in Houston, we talk all the time about how, I mean, even this week we're the energy capital and we can't keep our lights on.
And we're a medical marvel. And we always talk about how people come here to receive care, but we can't seem to care for the people giving birth in our city. So, definitely, I'm looking forward to talking more about that.
I believe that our other panelists were not able to attend [due to hurricane Beryl], so I will jump in because I'm a sociologist and a former case worker. So I'm always interested in two things: One, how things got to where they are. How did the problem happen? And two, as the case worker, I'm always thinking, well then, what is the solution? So what your presentation really reminded me of was in one of my classes, I asked people, we talk about this paper where we say, we don't have a lot of resources, so we have three options.
The first is: should we spend more on preventative services? So screening.
2: Should we spend more on trying to get universal health care?
3: Or should we spend more on teaching people to change their health behaviors?
And it's really interesting when I have students talking about what they think is the solution to really getting us to increase our life expectancy, and then hearing them argue and read articles that talk about what they think the solution is.
And it always reminds me how difficult it is. And one of the main findings that you highlight is just that one of the issues, and one of the problems is that I don't think we often really, really emphasize is that the people that you're looking at are sick and they're getting more -- *we're* getting more sick.

00:34:46:00 - 00:35:23:01

And so when we think about all these issues in terms of access to doctors, and we think about expansion of Medicaid, and we think about resources for mental health and postpartum, and I always think about how, you know, getting sick takes a really long time. And so oftentimes when we're looking at these snapshots of people who are giving birth, we're looking at them at that moment when they are pregnant, but they have these, you know, preexisting conditions that are often then impacted with pregnancy related conditions.
And so one of my thoughts is, of course, as a sociologist is questions. So I'm always just thinking, when it just seems so overwhelming, that there are so many sources that are contributing to these disparities. And then I think specifically about, I mean it's just so overwhelming to think about the difference for black women. And the most meaningful thing that you really showed that, I think can really hit home to people, is that black women and white women who gave birth in the same hospital with the same doctor still have these differences.

00:36:01:09 - 00:36:29:03
And oftentimes we are told that it's the medical care or it's where they're giving birth or it's who they're talking to, and I am just, you know, I was just it really made me think about what are the possible solutions and answers to that? And then drawing on my experience as a caseworker where I think, you know, sometimes I would only see people for 20 minutes. And so in those 20 minutes, I had to get a recap of how their past couple of weeks were; get any needs, like to help them with resources; and then make sure that they saw their doctor. And so I'm always thinking of, even if we have these resources, how are we supposed to address all these source points that really seem to be contributing?

And whose responsibility is it to really make sure that we address what seems to be a significant driver, which is these comorbidities and these preexisting conditions? And I'm wary of putting it on people and saying, because you made these decisions to have these health behaviors or because you are sick, you must have done something to get sick. And so it really isn't a structural issue. It's an issue in terms of, well, you're just not a healthy person.

00:37:23:21 - 00:37:47:16
And so, again, all these questions that I'm like, you know, I think that sometimes we really—especially when I'm in conversations with policymakers or with, you know, directors of human health services, they want like, an answer.

They want us to say, well, you should do this. And then that will solve the maternal mortality issue in Texas. And oftentimes they're really disappointed when we're like, well, actually, we found another potential thing that may be driving these comorbidities. So, before we switch to me asking more questions from some of our experts and opening it up for the audience, I wanted to selfishly pose my question before I move on and just say, you know, you do a lot of work that really tries to merge research, but also policy.
And what are any direct suggestions that you think that we should really be considering that are realistic for us to really be able to address these findings that you are highlighting here? Which is, you know, that health matters and, so what do we do when we have this one finding of black women and white women and having different outcomes at the same hospital with the same doctor? And where do we go from there?

00:38:55:24 - 00:39:24:03
Dr. Annamaria Milazzo

Thank you. Thank you, Zelma. This is, now a great question and a very, very difficult one to answer for sure. Yeah. As you mentioned, yeah, that it's overwhelming when you think the, the disparities and the different sources. There are there are things that are, you know, more amenable to change that are more proximate causes that are related to care.

But then, that is only part of the issue. You have to look at the history of women, how did they get to that point? So we see that that matters a lot in this work, we see that that contributes a lot. So in terms of policy solutions, it is a very hard question.
But I think what comes out from the paper is that, one factor is – at least one, there are many things that can be done. But I think the fact that, you know, one of out of four women don't have as insurance in **Texas is—m**

I mean, I'm Italian. I come from a country where everybody has access to health care, and, I'm also Canadian, and that is another country where everybody has access to health care. For me it's unthinkable that people cannot see a doctor or, you know, cannot get the care they need when they need it. So, I think that there are things that are easier to do, and, you know, again, it takes a lot of will, of political will and it takes, it takes funding. But I think it's really crucial that, I mean, at least in the short term, incremental changes can be done. So Medicaid can be changed. So one thing is obviously expanding it to low-income people, as other states have done in the US, so that they can have access, not just when they get pregnant or when, you know, when they have children or when they would have disabilities. *All women should have access to it.*

And another option is making access to health care universal [at all income levels]. That is probably something that takes more time, but I think, you know, the three set of things that you mentioned before in terms of consultation are all important. As this study shows, prenatal care is also very important and can help a lot in reducing disparities. Again, access to Medicaid, access to health care -- being more inclusive, you know, so is just giving access to everyone.
And also, yeah, health behaviors. But again, those are—obviously it's really nobody's fault. So we don't want to point the finger to anyone. It's again part of the system. And also in terms of health behaviors, access to food is also important -- access to nutritious food. And part of when we look at the increasing prevalence of chronic conditions, from reading the literature, it seems like really, it's all about access to nutritious food, which is very limited in the US.

So it's really a lot about the food industry that makes unhealthy food available to too many people; food that is [full of] additives, and chemicals and it makes people really, really sick. So there is a lack of diversity [of food options].
And this is one of the main drivers of poor health in the U.S. So it's a wide set of factors that can be addressed. I don't think there is one single policy. But I think the first thing and easier thing is to expand Medicaid to low-income women [for their whole lives], and then go from there. And obviously, think more holistically about the health of women from birth, in different realms.

It's a very complex question, but I try to answer.

00:43:43:18 - 00:44:22:10
Dr. Zelma Oyarvide
Yes, you did, and I, I gave you a very complicated question and I apologize. It's my training to do so, but I, I really appreciate you saying that it is complicated because I think that it's important to remind people it's a very complicated problem. And so I wanted before we open it up to the audience, give the

opportunity for Dr. Langa to see if she had any questions and also her insight as someone who I know, she was recently in Washington DC talking about her research, sharing it with state representatives here in Texas about what needs to be done.
Dr. Langa, I don't know if you, one of the questions I have is “what's missing from the research?” You know, I can think about, these panels that I've been in and these conversations. But what would you say is something that research programs are missing in their focus that we really need to pay attention to, to better understand and provide better solutions?

00:44:50:23 - 00:45:20:09
Dr. Neema Langa
What I think is currently missing is the idea that we always look at people or individuals who give birth as homogeneous beings, or like they're all the same everywhere. Everyone. Because we have to say that non-Hispanic black people who give birth have high severe maternal morbidities. We think that all black people are the same. No. When we look into other things, we look in general view instead of looking into uniqueness and disparities within similar groups. For example, non-Hispanic black mothers who give birth in Texas may have severe maternal mortality or morbidities. But there are differences among black people themselves there. For example, nativity. Foreign born black people are not the same as native born. When we look into maybe socioeconomic status:

socioeconomic status differences may intersect with individuals’ race, their nativity, and hence impact differently different outcomes. So what I think should be done right now is, observing these maternal health outcomes as an intersection of different factors that together may inhibit the likelihood of women having good healthcare outcomes or good maternal health outcomes, or have lower maternal morbidity.

And in that sense, when we look into different or multiple factors and the way they intersect together to influence different levels of health outcomes, we will understand the unique nature of these problems as well as finding a unique solution to our unique problems.

So when I went to Congress this June, I had an opportunity to share my research and propose my policy recommendation that in the state of Texas, if we want to improve maternal health outcomes, if you want to improve access to health care among pregnant people, we have to look into the intersection of various factors that are inhibiting women's likelihood to access care, not just looking at insurance generally among black people. But let's split it - black people's nativity, black people's socioeconomic status, black people area of residences, and how all of these cumulatively impact their likelihood of accessing health care. So having more comprehensive policies, having more comprehensive strategies and solutions that look into multiple lenses to examine problems and have solutions towards them.

00:47:34:06 - 00:48:01:10
Dr. Zelma Oyarvide
Yes, I thank you so much for that. And it's always very important for us to consider those differences. And I always think it's not something that people who make decisions want to hear, right? They want to hear cost effective, one-size-fits-all types of programs and interventions. So I think it's very important, Dr. Langa, to point out, that there's so much diversity and differences even within this one group that we're seeing so much disparity in.

And so I want to make sure that we open up the conversation to anyone who may have a question, you can either type it in the chat or raise your hand or just turn on your camera. If there is anyone that has—and it doesn't have to be a very complicated, deep, provoking question, it can just be a comment as well.

00:48:51:10 - 00:48:52:24
Ailin Flores
Can you hear me? I'm not sure if you can hear me.
Thank you so much for presenting this. This is this was truly informative. And I got to read the report. But yeah, just a little bit about me is, so my name is Ailin. I'm a policy intern for Harris County Precinct One. And so my senior policy advisor, she focuses on health as one of her areas of policies. And so, my question for you is, what actions or steps would you like to see the county take to begin to be a part of the solution?

00:49:33:16 - 00:49:58:11
Dr. Annamaria Milazzo
Thank you for your question. Again, going back to the question about policy, I think, so I thought more about policy at the state level. In terms of Harris County, I think Harris County already has programs like the AIM program, [Alliance for Innovation on Maternal Health] which offers bundles [of health care services for specific ailments, within hospitals].
I think you're probably aware of this program. It tries to address maternal health issues here in the state. So I think Harris County also has this program and that basically offers bundles that standardize care to all women in terms of different bundles: one is hemorrhage, one is hypertension. And there are other bundles - substance abuse. So they basically provide standardized care so that all women receive the same care. It's trying also to address bias. Also given that, again, 17% of the of the gap is still unexplained, so that differential care can be a factor.

So again, this study is only finding that the vast majority of the the racial disparity is due to preexisting health. But definitely, you know, there are other factors that might matter that we are not able to measure with the data we have available. So, in terms of specific action, I think definitely trying also to have a more comprehensive approach, more holistic.
Starting from understanding, as Neema also mentioned before, looking at the different aspects, so, trying to address the social determinants of health, from different point of view. So like *housing*, you know, *unemployment* and other factors that may play a role. So, yeah, it's a difficult question again.
I think, again, providing health care to women very early on, is crucial. And that is something that, you know, we can push for with policymakers.
[Thunder rumbles] I think there is another storm coming!

00:52:18:05 - 00:52:45:14
Dr. Zelma Oyarvide
I know I was like, if I, if I just stop, then just assume I lost power and keep rolling. But hopefully in the last eight or so minutes, we can be okay. You know, thank you so much for that question. And we're again continuing to open it up. I have some questions in the chat, but also want to open it up to anyone who wants to share.

00:52:45:16 - 00:52:48:11
Lucy McLaughlin
Thank you for this very interesting presentation. My background is in pediatric nursing, but I'm a health educator for cancer prevention. And my question regards Texas's position on not wanting to be part of the Affordable Care Act. And some people, I believe, here in Texas do have access to that. But are there state alternatives presently accommodating for the folks who can't really be part of the Affordable Care Act, given the Texas government position?

00:53:41:06 - 00:54:13:08
Dr. Annamaria Milazzo
So yeah, maybe Zelma you are better suited to answer this question. But I think, so it's very much about politics, unfortunately, about not wanting to go on with that. Unfortunately, in terms of other policies, there might be some small programs, that women can access, but they are not really widely accessible, I would say.

So, I mean, at least from what I have been reading and what I heard also from other researchers. So, a lot of women are really left out, you know, before they get pregnant, because all women can have access to Medicaid when they get pregnant, but a lot before conception, a lot of women are still left out. So, if anyone wants to add to the specific question, quite commonly, yeah.

00:54:50:10 - 00:55:14:05
Dr. Zelma Oyarvide
I mean, from personal experience, you know, my family, we grew up, I guess you would call us working class or poor. So we didn't have insurance. So I didn't have insurance until I was, until I got a job. And then I got employer based insurance. And our options were, there are some nonprofits that will do sliding scales, so you can go to them and tell them this is how much I make. And they will allow you to pay based on your income. And the only things that I ever got from people when I did try to seek services was, you know, go to Planned Parenthood or go to Legacy Clinic. Or you know, you can take out that care credit card and just like, get in medical debt.

So I think that a lot of the solutions, it's so politicized as we're saying. And you there are a pocket of people that are eligible to buy those insurance plans through the marketplace. But they're high deductible plans. And for people that don't -- my mother was not able to purchase those plans. So she wasn't one of those people that could use the marketplace. Like we're talking about, there are so many subsets of people that are left out of these programs, and the programs that are available, like Medicaid or Chip, do provide services for people while they're pregnant. And they just recently expanded it to the post postpartum period here in Texas.

But, what we're finding is that, well, not what we're finding. I used to help people apply for Medicaid, and it is very difficult. I think it's intentionally difficult. And Texas actually has taken away funding for—there was people in place who were paid to help people apply for Medicaid and Texas defunded that. So that it is now becoming increasingly difficult to even access and apply. And if you do have Medicaid, you have to keep applying. So for people who--for example, if you're a waitress and you don't make the same amount of money every month, if there is one month where you make more than what you did the month before, they unenroll you, and then you have to apply again and show your check stubs.

So it was very difficult as a caseworker to help people apply for Medicaid. So being the person who is pregnant and having to, you know, think about applying for Medicaid is just--it's overwhelming. So that's a great question. And point to bring up. And definitely, I think an avenue for us to address in terms of solutions in this state, to really be able to make sure people are getting—being able to afford to take care of their bodies.

Thank you for that.

And we have a question in the comments. Do you have ideas on why health overall is worsening in the U.S? Is it also due to food and health care access?

00:58:04:22 - 00:58:33:10
Dr. Neema Langa
Yeah, I would try answering that question like comparatively. For example, if we look into health care of the people of the United States, compared to others like Africans, we could say that Africans have poor health care. Oh, they have poor health, and hence we see that they have poor health care. But in the US, we see that the medical technology is higher. We have the best hospitals. For example, in Houston, here we have the best medical center in the world. But health outcomes are not good.

Why are we not having good health care outcomes? So for me, I should look into this fact as the idea that it's not just food, it's that we don't have health care access. In the sense that in the United States, health care is a commodity, something to be sought out, just like how we go buy oil and gas, we buy cars, we have to buy healthcare too.

So if you don't have money to buy health care, you need to have health insurance. But even if you have health insurance, you still have deductibles. You still have so many other fees that make it difficult to access health care. So health care itself is a good that some people may afford purchasing that good, and some may not afford purchasing that good.

So like accessibility itself is what determines whether you have good health or you have bad helps. If I don't see my PCP yearly, if I don't see my ObGyn yearly, for example, if I don't have checkups and if I'm just like at home whenever I'm sick, I'm thinking twice when I should go to the hospital or not.

I'm highly likely to be sicker than somebody who has access to a PCP or who can just call in like, oh, I need to see my doctor tomorrow. Oh yes, come next week because of appointments. So these disparities in access to health care are the one that now determines the health care outcome. That's why if you compare the United States with Africans, I would say United States is better.

But if we compare United States, maybe with Scandinavians, we're going to see huge disparities and differences, mainly because of the way health care is being perceived differently between these different countries. Thank you.

01:00:38:18 - 01:01:02:18
Dr. Zelma Oyarvide
Well, thank you so much, everyone, for being here. It was just in time because at least by my house it's rumbling. So thank you so much. Anyone who's watching this recording and anyone who is here. Thank you to our panelists. Dr. Langa, thank you to our presenter Doctor Lazo. And thank you to Dr. Gregory for allowing us to be able to have opportunities like this to share. We're so, appreciative of everyone really, you know, wanting to be here and have these conversations. So read the report, read the paper if you're interested. Follow the work that's being done at the University. And, we appreciate and hope everyone can stay dry and with power. Thank you.

01:01:23:23 - 01:01:30:00
Dr. Annamaria Milazzo
Thank you, Zelma, for moderating this, and for your great work. Thank you everyone.