Information Suppression in Idaho: Maternal Mortality Data in the Shadow of Recent US Supreme Court Judgements.

Frank Houghton[1], Margo Hill[2], Daisy Houghton[3] and Mary Ann Keogh Hoss[4].

> *There are three things that cannot long be hidden: the sun, the moon and the truth*
> The Lord Buddha, Siddhartha Gautama

Legal Background

On June 4th 2022 the United States Supreme Court overruled both Roe vs. Wade (1973) and Planned Parenthood of Southeastern Pennsylvania vs. Casey (1992) and returned the legality of abortion to the states. The issue examined was whether the Constitution confers the right to obtain an abortion. The Court held that *"The Constitution does not confer a right to abortion; Roe and Casey are overruled; and the authority to regulate abortion is returned to the people and their elected representatives."* In Dobbs vs. Jackson Women's Health Organization, the U.S. Supreme Court considered the standard that is used to decide whether the Fourteenth Amendment's reference to "liberty" protects a particular right. The Constitution has no direct reference to abortion, but a number of Constitutional provisions are utilized to validate the constitutional right to abortion. Roe vs. Wade held that a woman's right to abortion is a right to privacy that comes from the First, Fourth, Fifth, Ninth, and Fourteenth Amendments. The dissenting opinion in the Dobbs Judgement points out that if sex was non-consensual, or a planned pregnancy takes a tragic turn due to a serious foetal abnormality or maternal health complications, treatments may now be denied or delayed due to potential prosecution.

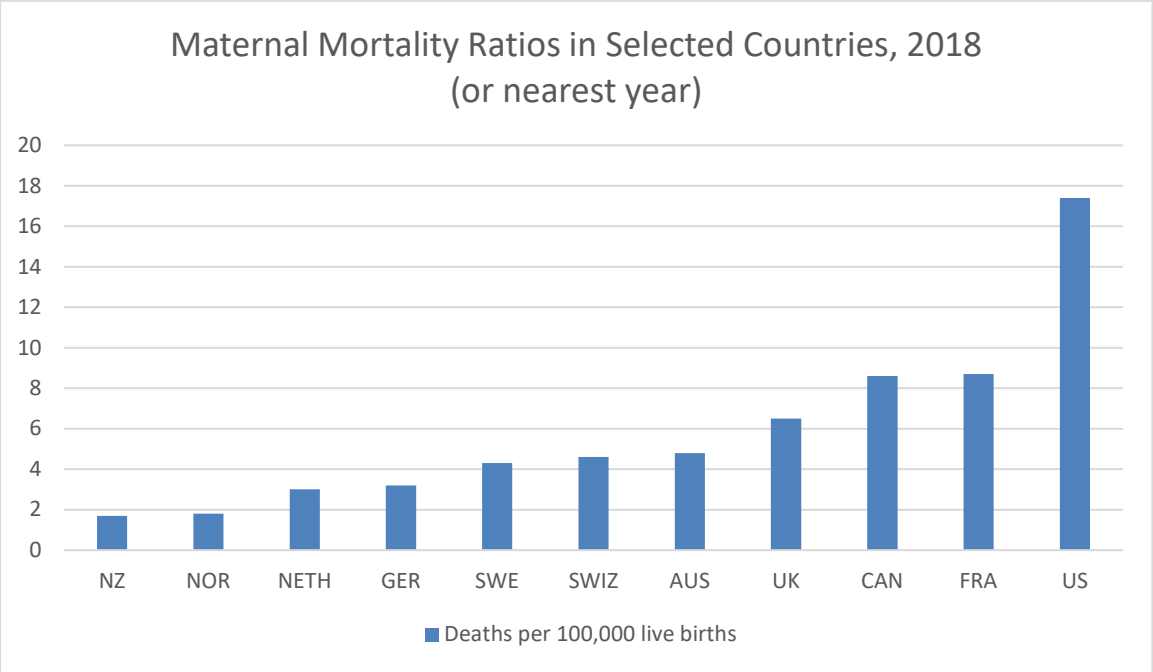
During the Supreme Court process thirteen States in the US prepared so-called 'trigger laws' in expectation, ready to be implemented immediately if the challenge was successful (Jiménez, 2022). Since the abortion protections of Roe vs. Wade have been overturned, an increasing number of States have severely restricted access to abortion, even in cases of rape and incest (New York Times, 2023; Nash & Guarnieri, 2023). This legislation clearly represents an assault on women, denying them bodily autonomy (Hill et al., 2023).

Maternal Mortality in the US

Legislation restricting access to abortion in the US will inevitably increase maternal mortality. A body of research has already emerged that has clearly identified significant increases in maternal mortality rates in US States where abortion services have been restricted (Vilda et al., 2021; Sherburne Hawkins et al, 2020; Gender Equity Policy Institute, 2023). Any increase in US maternal mortality rates is an issue of considerable concern as these are already extremely high. The US has the highest rate of maternal mortality amongst industrialised countries. To give an example, New Zealand, is a country which experienced significant economic difficulties from the early 1970s onwards following not only the oil prices shocks and inflation that marked this decade, but also the loss of its main trading partner as the UK joined the Economic Community (EC) at the start of 1973. However, as can be seen from Figure One, despite only moderate growth since then, New Zealand's maternal mortality rate in 2018 was 1.7 per 100,000 live births. The equivalent rate in the US is ten times higher, at 17.4 (Tikkanen et al., 2020). Information from the Centers for Disease Control & Prevention (CDC, 2023) indicates an ongoing rise in maternal mortality rates in the US from a rate of 7.2 per 100,000 live births in 1987. Recent analysis from the National Centre for Health Statistics suggests the US maternal mortality rate in 2021 was 32.9 deaths per 100,000 live births. This is notably higher than the rate of 23.8 for 2020, which is in turn higher than the figure of 20.1 for 2019 (Hoyert, 2023). It is anticipated that this rate will continue to rise as data for 2022 and 2023 becomes available.

The United Nations' (UN) Millennium Development Goal 5a was to reduce maternal mortality by three-quarters over a 25 year period from 1990. Significant strides internationally were made towards this goal, with decreases observed in 157 out of a total of 183 countries (WHO, 2014). Globally maternal mortality declined by 44% during this period, with a slightly higher rate of decline noted in industrialized countries (WHO, 2015). However during the period from 2000 to the year 2014 it is estimated that maternal mortality rate in 48 US States plus Washington DC actually increased by 27 percent (McDorman et al., 2016). Only California showed a declining trend, while Texas demonstrated a late and sudden increase.

Figure One



Source: Tikkanen et al., 2020

US society is riven by endemic racism. This is reflected in its gross health inequalities. Incontrovertible evidence exists which clearly demonstrates the adverse impact of systemic and structural racism on morbidity and mortality rates in the US. There is a distinct racial element to health inequalities in the US, and maternal mortality is no exception to this pattern. Recent evidence clearly demonstrates higher mortality rates among non-Hispanic minority mothers (CDC, 2023; Yearby et al., 2022; Villarosa, 2018; Villarosa, 2022; Petersen et al., 2019; Crear-Perry et al., 2021). African-American mothers have

particularly high maternal mortality rates. Inevitably those experiencing the intersection of multiple aspects of disadvantage, such as race, education, class and rurality, will suffer most from abortion restrictions (Hoang and Wong, 2022; Commonwealth Fund, 2022).

Maternity health care in the US will further decline into the future. Like many countries the US is suffering from a shortage of trained healthcare staff. Historically, a predominantly white workforce has been tempered, at least in part, by affirmative action in hiring and training. Although minority groups remain under-represented throughout the healthcare workforce, particularly in higher status and higher pay disciplines and specialities, affirmative action helped much needed diversification of the workforce. However, another recent Supreme Court judgment (Students for Fair Admissions [SFFA] v. Harvard and SFFA v. UNC) has removed the last legal protections for affirmative action, which had already been severely curtailed in recent years (Rios & Stein, 2023; Bero, 2023; Garces et al., 2015). The result of this judgement will undoubtedly be a further decline in minority participation in the US healthcare workforce. This is highly problematic as diversity is important for promoting both patient outcomes and health equity (Phillips & Malone, 2014; Aguwa et al., 2022).

The US suffers not only from a deficit in the number of maternity care providers, but in their disciplinary training profile. In most countries the number of midwives far outnumber medically trained obstetrics-gynaecology personnel. This works, as many births can be managed without expensive medical support that requires extended training (American College of Nurse-Midwives, 2020). However North America stands out as something of an outlier. In the UK the ratio of medically trained obstetrics-gynaecology personnel to midwives is 1:3.9. Whereas the comparative US ratio is 1:0.4 (Tikkanen et al., 2020). In a marketized system based on the primacy of private healthcare this inverse ratio is crucial, especially given severe inequalities in wealth and income which subsequently bar access to such services for many.

The legislation restricting abortion that has now been enacted in many states will result in increased maternal mortality through a variety of mechanisms. At its most basic level life-saving abortions, such as in instances of ectopic pregnancy, may be denied because of confusion over the bans and fear of prosecution in States such as Texas (Huff, 2022), with many other States having severely curtailed maternity care options. It is important to remember that, as the American Medical Association have noted, 'States that end legal abortion will not end abortion—they will end safe abortion' (AMA, 2022).

Women experiencing miscarriage will find it increasingly difficult to access maternity services (Human Rights Watch, 2023). Even in States where life-saving interventions to care for pregnant women are legal, legislation will inevitably result in delayed and inadequate care as hospitals may well delay treatment until the woman's health has declined to such a degree that they do not risk prosecution, fines and potential imprisonment (Abrams, 2023; Glenza, 2022; Ambast et al., 2023). There is a lack of clarity around the legalities of maternity care provision in the evolving legislative landscape in many States. For example, where does terminating pregnancy in order to commence chemotherapy or initiate potentially lifesaving surgery sit legally (Harris, 2022; Giglio et al., 2022)? In emergency situations women may also opt to travel further to cross State lines to access abortion services (Human Rights Watch, 2023). Such delays will inevitably increase the maternal mortality rate. It must be noted that abortion and general maternity care providers in less restrictive States, but adjacent to abortion restrictive States, may find themselves overwhelmed (Kaye & Samaniego, 2023; Donegan, 2023a). Such excess workloads will lead to diminished care for all (Harris, 2022).

Given the penalties involved, it is no surprise that even finding a health provider offering maternity services is increasingly problematic (Schoenfeld Walker, 2023). Many rural areas in the US are known as maternity care deserts. These are defined as administrative areas (usually counties) without either a hospital or birth centre offering obstetric care, and without any obstetric personnel (Brigance et al., 2023; Buller, 2023). However, the ongoing exodus of trained personnel from some abortion restrictive States is increasing the number of areas that are now defined as maternity care deserts

(McLoughlin, 2023, Brigance et al., 2023; Kaye & Samaniego, 2023). These maternity care deserts mean that women seeking even basic pre-natal care are increasingly forced to travel greater distances or forego such healthcare. Even access to basic contraception services is increasingly threatened under restrictions, especially given the growing dearth of maternity care providers in some areas (Human Rights Watch, 2023)

Doctor – patient trust will inevitably also be compromised in abortion restrictive States (Human Rights Watch, 2023; Samuels-Kalow et al., 2022). Professionals may well limit the information they share with patients in order to avoid accusations or prosecutions related to anti-abortion legislation (Human Rights Watch, 2023). Patients will inevitably be aware of this partial sharing of knowledge. In return patients may lie about conception dates in order to potentially keep their options open. It is highly likely that some pregnant individuals will decide not to opt for prenatal care in order to avoid surveillance and potentially prosecution (Human Rights Watch, 2023). Issues of privacy and confidentiality around medical records are very important under normal circumstances. However, in the increasingly polarized US privacy is even more important as attempts at prosecution for 'aiding and abetting' abortions are emerging (Donegan, 2023b). A total of 19 State Attorneys General have already written to US President, Joe Biden, seeking to gain access to medical records of residents of their States in order to track and prosecute those travelling for abortions and those that aid them (Ingles, 2023). These attempts stem from a lack of unitary data protection legislation in the US.

It is an unfortunate reality that many of the States which have, or are seeking to curtail abortion rights, are the same States that have steadfastly rejected expansion of the Affordable Care Act ('ObamaCare'), which significantly expanded health insurance coverage for many women (Marchi et al., 2021). Abortion restrictive States are also more likely to have high rates of poverty, minimal enforcement of child maintenance payments, few primary care services, and little in the way of safety nets for vulnerable populations (Vilda et al., 2021). As well as being an embarrassingly high outlier among industrialised nations in terms of maternal mortality rates, the US is also the only

industrialised nation that does not have nationally required maternity pay. Some level of maternity pay is given in the UK for 39 weeks, with the period covered being even longer in countries such as Sweden, Norway, Austria, Japan & Estonia (Bryant 2020; Human Rights Watch, 2023). Abortion restrictive States are also much more likely to be States where both the minimum wage is the lowest rate ($7.25 per hour), and where tipped minimum wages are at their lowest ($2.13), as set by the Federal Government. In such environments restricting abortion access leaves women at significantly increased risk of economic insecurity, which negatively impacts health status.

The longer term forecast for maternal mortality in abortion restrictive States is dismal. Approximately half of all medical training programs in the US are in abortion restrictive States (Vinekar et al., 2022). Trainees graduating from these States are unlikely to achieve training in the full spectrum of maternity care services. Although some medical students may be able to travel out of State for such training, the legality of this option is questionable Lambert et al., 2023; Beasley et al., 2023). In addition, given that many States are abortion restrictive the logistics and feasibility, as well as the cost of arranging so enough out of State internships appears prohibitive (Beasley et al., 2023). Applications for Obstetrics-Gynaecology training in abortion restrictive States have also declined significantly , which will have long term implications for provision of even basic services in this field (Hoffman, 2022).

Abortion restrictive States will also inevitably witness a decline in physician competency through atrophy (Samuels-Kalow et al., 2022; Gyuras et al., 2023). In all likelihood medically trained personnel will not be able to perform enough medically required abortions, even in States that do have some exemptions, to retain competency in this field (Beasley et al., 2023). In a short space of time there will not be enough doctors left to either perform life-saving abortions or teach these skills to others (Harris, 2022; Lambert et al., 2023).

Problems with Maternal Mortality Data in the US

The US Government has not released an official maternal mortality rate since 2007. (Schoenfeld Walker, 2023; MacDorman & Declercq, 2018). The National Vital Statistics System (NVSS) is the source of

official US maternal mortality statistics used for State & international comparisons. However, problems with accuracy in US maternal mortality data are long standing (Horon & Cheng, 2001; Mackay et al., 2005; MacDorman & Declercq, 2018). Efforts to improve reporting include a 2003 revision of the United States standard death certificate to include a pregnancy question (Hoyert, 2007). However, many States have been slow to implement this change and as a result both the quality and consistency of maternal mortality data across States is significantly compromised. By 2015 three States had still had not adopted this question, while there is evidence of over-reporting of maternal mortality in some States with the pregnancy question (CDC, 2017). It has been suggested that strict rules in relation to coding the cause of death around maternal mortality may serve to artificially inflate the rates recorded (National Center for Health Statistics 2017a; 2017b; MacDorman & Declercq, 2018). Although the US does have another specific health information system, the Pregnancy Mortality Surveillance System (PMSS), this is not the panacea to health information deficits in this field that one might assume. The NVSS, with all its deficits, is the main source of data for the PMSS. In addition, access to PMSS data is restricted to the Federal Government on confidentiality grounds. Interestingly, the PMSS is also prohibited from releasing data at State level, thus preventing State to State comparisons (MacDorman & Declercq, 2018).

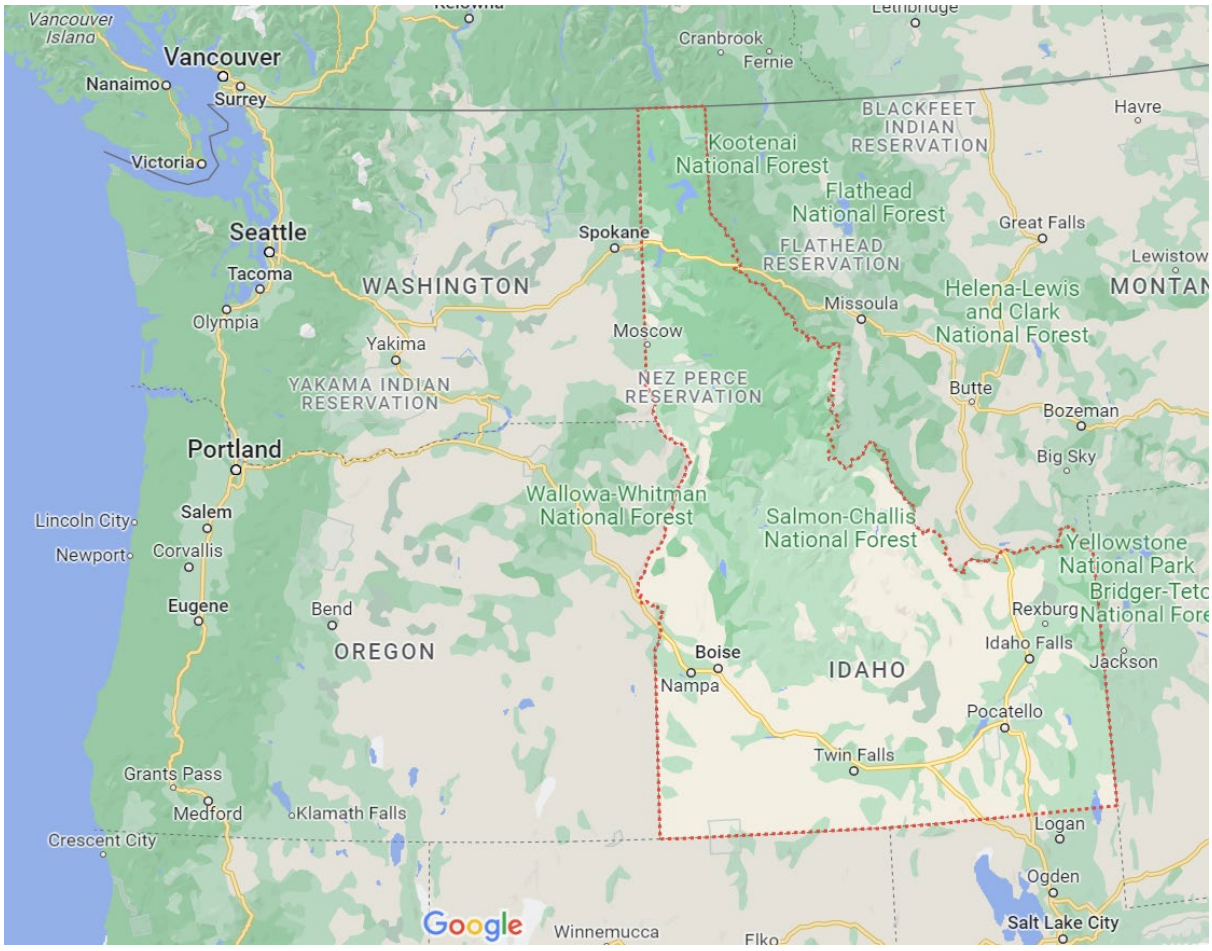
Idaho- An Overview

As can be seen from Figure Two, Idaho is a largely rural State located in the Northwest of the US, which has a population of approximately 1.8 million. Although bordered by the more liberal States of Washington and Oregon, the State is both far more conservative and Republican than its two westerly neighbours.

Although achieving suffrage for women relatively early in both State and international terms (1896), Idaho was one of a number of States that enacted trigger laws ready to immediately restrict abortion if Roe was overturned (Kim, 2022; Jiménez, 2022). Idaho has one of the lowest tax regimes in the US, with a concomitant minimal health and social care security net. For example, in the recent legislative session a proposed Bill to expand postpartum Medicaid coverage in Idaho,

did not even receive a hearing (Cohen, 2023). Idaho is also one of the States in which the minimum wage is the federally mandated minimum at just $7.25 per hour, less than half that of its neighbour, Washington State ($15.74), the highest in the country (Washington State Department of Labor & Industries, 2023). Idaho has maintained the Federal minimum rate at just $7.25 per hour since 2009.

Figure Two: The State of Idaho & the Pacific Northwest



Like Texas, Idaho has enacted extremely repressive abortion legislation (Oladipo, 2022). Idaho has also featured heavily in discussions of growing maternity care deserts. A number of news articles have focussed on both the closure of maternity care sites and the relocation of maternity healthcare staff to States with more liberal regimes (Abrams, 2023; Buller, 2023; McLaughlin, 2023; Oladipo, 2023; Tabachnick, 2023).

Maternal Mortality Data in Idaho

Up until recently Idaho was one of 49 States, plus Washington DC, New York City, Philadelphia, and Puerto Rico that had a Maternal Mortality Review Committee (MMRC) (Merelli, 2023). These committees are crucial as they have access to confidential information that can help determine the cause of death accurately. However, even when functioning only 36 of these routinely reported their data (Trost et al., 2022).

However, in the current environment maternal deaths have become a political issue (Merelli, 2023), and Idaho have moved to suppress this information. Idaho has become the first State to stop MMRC tracking of maternity deaths after State lawmakers opted not to extend a 'sunset date' contained in the original MMRC legislation when it was established in 2019 (Schachar, 2023; McLaughlin, 2023). Although addressing different issues the relevance of Chomsky's (2012) work on 'intentional ignorance and its uses' is obvious. In opting not to renew the legal standing of the MMRC, an important issue when dealing with confidential health information, Idaho lawmakers cited the costs of running the committee. However, others have highlighted the Federal funding which fully supports the MMRC (Schachar, 2023; Sullender, 2023).

What makes the decision to shut-down the MMRC in Idaho all the more ominous is that its 2020 Report notes that of the 11 maternal deaths in the State in that year all eleven were preventable and nine were pregnancy related (Liposchak et al., 2022). It is interesting to note that although the MMRC in neighbouring Washington State was also initially established in 2016 with a sunset clause, when the time for renewal came it was legislatively established on a permanent basis (Sullender, 2023).

The closure of Idaho's MMRC will significantly weaken attempts to monitor maternal mortality rates in the State of Idaho. Since 2019 it has been possible for the State to identify and examine maternal mortality rates and causes with a high degree of certainty. However, closing down the MMRC will effectively hide this rate, leaving only estimates, which are more easily ignored or refuted.

Conclusion

The impacts of the Dobbs judgement and the repeal of the protections inherent in Roe vs. Wade represent a blatant right-wing attack on gender equity and bodily autonomy for women. It is unmistakably obvious that the result of abortion restrictive legislation across many States will be to increase maternal mortality. The impacts of this legislation look set to spiral negatively as maternity healthcare providers either relocate or find their skills diminishing. The number of students opting for a specialism in maternal care in abortion restrictive States has already declined. Amidst this backdrop it is an extremely cynical and sinister move for the State of Idaho to purposefully establish what is essentially an information void around this issue. This form of information suppression will no doubt at least partially serve to cloak the increase in maternal mortality which is already becoming visible across the US. However, it represents an affront to gender equity and any vestiges of ideas of an informed democracy.

Notes

1. Frank Houghton. Social Sciences ConneXions, Technological University of the Shannon, Limerick, Ireland; Frank.Houghton@TUS.ie

2. Margo Hill. Department of Political Science and Public Policy Eastern Washington University, Spokane, WA, United States.

3. Daisy Houghton. College of Arts, Social Sciences & Celtic Studies, University of Galway, Galway, Ireland.

4. Mary Ann Keogh Hoss. Department of Political Science and Public Policy Eastern Washington University, Spokane, WA, United States.

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