Elsewhere in JAMA Network Open, Yamamoto and colleagues present “Comparison of Childbirth Delivery Outcomes and Costs of Care Between Women Experiencing vs Not Experiencing Homelessness.” The authors found that unstable housing status among pregnant patients was associated with increased risk of preterm delivery and greater delivery-related costs within hospitals. This work is unique given the within-hospital findings, which challenge the idea that previously observed disparities in birth outcomes were explained by differences in the quality of hospitals where patients with unstable housing receive care. Instead, it is possible that the findings at least partially reflect differences in the quality of care provided to patients within the same hospital or the health effects of experiencing homelessness and associated factors.

One potential source of differential quality of care may be implicit or explicit bias. Unhoused pregnant people in this study likely experienced discrimination based not only on their housing status but on other characteristics as well. For instance, Yamamoto and colleagues highlight health conditions associated with unstable housing, including depression, serious mental illness, and substance use disorders. These conditions are not only associated with preterm delivery, but they are conditions commonly judged and devalued, even in health care settings. Stigmatizing attitudes toward substance use in pregnancy “are widely accepted, culturally endorsed, and enshrined in policy,” according to Livingston and colleagues. Medication for opioid use disorder, the first-line treatment for opioid use disorder, is systemically underused among pregnant people who are unhoused or identify as Black, Indigenous, or another minority racial and ethnic group.

Of note, the reported rates of behavioral health conditions in this study are low compared with prior estimates, suggesting these comorbidities may not have been well accounted for in the administrative data source used. For instance, substance use disorders were identified among approximately 2% of the unhoused birthing population. This is in contrast to other recent work, which has shown that substance use disorders affect up to 30% of the unhoused birthing population. Uncertainty in reported rates of behavioral health diagnoses present challenges in identifying key contributors to the clinical and economic differences identified in this study.

The most striking aspect of the study’s findings is left largely unaddressed. Nearly all patients with unstable housing (approximately 95%) identified as non-Hispanic Black, Hispanic, or another race/ethnicity. Communities of color have been systematically excluded from socioeconomic opportunities in the United States. As such, peoples’ pathways into homelessness and experiences of homelessness vary by race and ethnicity. This discrimination is compounded by racial inequities in education, child welfare, mass incarceration, and health care. Structural racism across these multiple sectors has led to substantial inequities in pregnancy outcomes by race and ethnicity. For example, Black patients are more likely to experience preterm delivery and other adverse gestational outcomes during the delivery hospitalization, such as severe maternal morbidity, after accounting for sociodemographic and clinical characteristics.

Births among pregnant people who identify as belonging to a minority racial/ethnic group are often financed by Medicaid. In this study, nearly 98% of pregnant people with unstable housing were enrolled in Medicaid at the time of delivery. This highlights 2 key issues. First, Medicaid is a critical source of health insurance coverage for the people experiencing the most marginalization in society. Second, failures to address structural inequity result in higher costs paid by Medicaid and, ultimately, taxpayers. Thus, there may be both a moral imperative and an economic incentive to reduce inequity and improve health outcomes among pregnant people with unstable housing.
Yamamoto and colleagues emphasize the importance of screening pregnant patients for unstable housing and referring those who screen positive to social resources that can assist with access to safe, affordable housing. We agree that screening may provide some benefit, particularly in localities with long-term housing options for pregnant people. However, most social service agencies are rarely equipped to provide anything more than temporary housing because of civic failures to invest in affordable housing. While screening for homelessness is an important step at the individual level, it is critical to also undertake structural solutions. Policies and programs to prevent and end homelessness are essential to reducing the inequities identified in this study. These programs should also explicitly consider race and the impact of racial discrimination to break down policies that have created barriers to stable housing for many communities of color.

The pregnant population highlighted in this study is affected by racism, likely high rates of behavioral health conditions, low incomes, and unstable housing. Addressing these issues is critical because, as the authors highlight, families and women represent the fastest growing segment of the homeless population. In addition, millions of families are at risk of losing housing when federal COVID-19 eviction and housing protections expire later this year. These interacting crises are reflective of the public health problems the United States will face in the years ahead. To meet these challenges, collaboration in and across sectors will be critical. An intentional approach to dismantling the structural racism inherent in these sectors is necessary to close health inequities between pregnant people with and without unstable housing.

ARTICLE INFORMATION

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REFERENCES


