Feminist Health Antitrust

Theodosia Stavroulaki[*]

ABSTRACT: America is suffering from a maternal mortality crisis that disproportionately harms lower-income individuals and communities of color. Although access to comprehensive insurance coverage, quality housing, and healthy food reduces the risk of maternal mortality, the most vulnerable among us are often uninsured, live in neighborhoods that are unsafe, or are deprived of access to healthy food. The structural racism that pervades the U.S. health care system also contributes to the poor maternal health minority populations experience, leading to alarming increases in maternal death rates.

This Article adds an additional and routinely overlooked layer to this story. It argues that the maternal mortality crisis that is plaguing America is also the result of a wave of hospital mergers that has increased consolidation in the hospital industry, which has left vulnerable populations with no access to quality maternal care. The reason is twofold. First, post-merger, the acquiring hospital often moves to close essential health care services, especially obstetric care. Second, mergers help hospitals increase their market power in the labor market, which allows them to suppress the wages of their employees and offer employment under adverse working conditions. Because jobs in the hospital industry are primarily occupied by female workers, mergers end up indirectly harming women the most. In addition, public health research demonstrates a correlation among income, working conditions, and maternal health. As a result, the anticompetitive effects of hospital mergers are more likely to hurt the maternal health of lower-income individuals and communities of color who already struggle to improve their socioeconomic status and well-being.

But despite these obvious harms, antitrust enforcers and courts alike have failed to combat the harm hospital mergers pose to women's prosperity and maternal health. This Article makes three proposals. First, antitrust enforcers and courts should object to any merger that reduces access to obstetric services,

[*] Assistant Professor of Law, Saint Louis University School of Law. I am deeply grateful for the comments I received from Sidney Watson, Spencer Waller, Kyle Eash, Chad Flanders, Christopher Leslie, Jamille Fields Allsbrook, Gregory Day, Felix Chang, Kelly Gillespie, Shiloh Deitz, Elettra Bietti, Nikolas Guggenberger, Daniel Francis, Michael Sinha, and Heather Walter-McCabe. A big thank you also to the attendees of the BYU School of Law Future of Antitrust Workshop, the Saint Louis University School of Law Faculty Workshop, the Competition, Antitrust Law, and Innovation Forum at Irvine University School of Law and the 20th Annual ASCOLA meeting in Chicago for helpful discussions.

especially for residents in underserved areas. Second, they should accept mergers only under the condition that the merged entity will not cut obstetric services in rural communities. Third, they should assess the effects of hospital mergers on labor and, more specifically, on the wages and working conditions of workers in the hospital industry.

These proposals come at a critical time. Although the United States spends the most on health care in comparison to all other wealthy nations, it has the worst maternal mortality rates. Following the Supreme Court's decision in Dobbs v. Jackson Women's Health Organization, *which allows states to prohibit or limit access to abortion care, this trend will only worsen. In the wake of* Dobbs, *hospitals in abortion-ban states struggle to retain obstetricians because they fear criminal punishment if they offer women the full range of medical services for which they have received training. Mergers that reduce access to obstetric care can only hasten the further deterioration of maternal health brought on by the* Dobbs *decision. But by implementing the proposals outlined in this Article, antitrust enforcers can help mitigate the adverse effects of* Dobbs *on women's health and alleviate the maternal mortality crisis that is harming the United States.*

INTRODUCTION

America is experiencing a maternal mortality crisis, with a maternal mortality rate that is much higher than that of other wealthy nations.[1] Despite spending nearly two times more per person on health care than any other developed country,[2] maternal mortality rates are disproportionately high: There were 669 maternal deaths in 2023[3] and 688 in 2024.[4] As a result, the United States ranks fifty-fifth in the world for maternal mortality, by far the worst of any higher-income country.[5]

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1. Munira Z. Gunja, Evan D. Gumas, Relebohile Masitha & Laurie C. Zephyrin, *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, COMMONWEALTH FUND (June 4, 2024), https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison [https://perma.cc/995T-RZ5C]; *see also* Michele Goodwin, *Distorting the Reconstruction: A Reflection on* Dobbs, 34 YALE J.L. & FEMINISM 30, 33 (2023).

2. Emma Wagner, Matt McGough, Shameek Rakshit & Cynthia Cox, *How Does Health Spending in the U.S. Compare to Other Countries?*, PETERSON-KFF HEALTH SYS. TRACKER (Apr. 9, 2025), https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries [https://perma.cc/W5ZG-GRRP]; *see also* Anna Bella Korbatov, *What Explains the United States' Dismal Maternal Mortality Rates?*, WILSON CTR. (Nov. 19, 2015), https://www.wilsoncenter.org/event/what-explains-the-united-states-dismal-maternal-mortality-rates [https://perma.cc/U5B9-ZSDF]; Veronique de Rugy, *US Health Care Spending More than Twice the Average for Developed Countries*, MERCATUS CTR. (Sept. 17, 2013), https://www.mercatus.org/research/data-visualizations/us-health-care-spending-more-twice-average-developed-countries [https://perma.cc/9PMZ-Y7RC].

3. DONNA L. HOYERT, NAT'L CTR. FOR HEALTH STAT., U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH E-STAT 100: MATERNAL MORTALITY RATES IN THE UNITED STATES, 2023, at 1 (2025), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/Estat-maternal-mortality.pdf [https://perma.cc/J5TX-JZHM].

4. FB Ahmad, JA Cisewski & DL Hoyert, *Provisional Maternal Mortality Rates*, CDC NAT'L CTR. FOR HEALTH STAT. (July 16, 2025), https://www.cdc.gov/nchs/nvss/vsrr/provisional-maternal-deaths-rates.htm [https://perma.cc/DXN9-LUX2]; Mike Stobbe, *US Maternal Death Rate Rose Slightly Last Year, Health Officials Say*, ASSOCIATED PRESS (Apr. 30, 2025, 1:02 PM), https://apnews.com/article/us-maternal-deaths-2024-statistics-12091a2583016 2cfa005cb5c801a1c1b [https://perma.cc/YMT6-L9NQ].

5. *The US Ranks 55th in the World for Maternal Mortality—So Where Do We Go From Here?*, PERELEL (Feb. 25, 2025), https://perelelhealth.com/blogs/news/maternal-health-crisis [https:/

Unfortunately, Black and Hispanic communities are disproportionately affected by the maternal mortality crisis plaguing the nation, demonstrating that race is an indicator of increased vulnerability in America. Data show that in 2023, the maternal mortality rate for Black women was almost 50.3 deaths per 100,000 live births, 3.5 times the rate for white women.[6]

Several factors contribute to this devastating outcome. For starters, the high rate of maternal mortality among vulnerable women in America is driven by the correlation between maternal health and social determinants of health. For instance, access to health care services reduces the risk of pregnancy-related deaths.[7] However, many Black people, especially in underserved areas, remain uninsured, increasing their risk of adverse health outcomes before, during, and after pregnancy.[8] Although expanding Medicaid in a given state can reduce Black and white disparities in maternal mortality,[9] several states have nonetheless chosen not to do so. Not surprisingly, these states experience higher maternal mortality rates than states that have opted for Medicaid expansion.[10]

Furthermore, while quality housing and healthy food improve maternal health, many lower-income individuals and communities of color are deprived of these essential goods, increasing their risk of maternal mortality. For example, inferior housing conditions have been associated with an increased prevalence of asthma and high blood pressure.[11] Suffering from these health conditions increases the risk of pregnancy-related complications, such as preeclampsia—

/perma.cc/BM59-7ZYR]; *see also* Gunja et al., *supra* note 1 ("The United States continues to have the highest rate of maternal deaths of any high-income nation . . . .").

6. HOYERT, *supra* note 3, at 1; *see also* Ryan S. Huang, Andrea R. Spence & Haim A. Abenhaim, *Racial Disparities in National Maternal Mortality Trends in the United States from 2000 to 2019: A Population-Based Study on 80 Million Live Births*, 309 ARCHIVES GYNECOLOGY & OBSTETRICS 1315, 1319 (2024).

7. *Maternal Mortality*, WORLD HEALTH ORG. (Apr. 7, 2025), https://www.who.int/news-room/fact-sheets/detail/maternal-mortality [https://perma.cc/8ETT-8AKC]; *see also* Latoya Hill, Alisha Rao, Samantha Artiga & Usha Ranji, *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, KFF (Oct. 25, 2024), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them [https://perma.cc/BJ9B-J7EL].

8. Hill et al., *supra* note 7; *see also* Mahika Ahluwalia, *To Reduce Maternal Health Disparities, Expand Medicaid*, HASTINGS CTR. FOR BIOETHICS (Sept. 14, 2023), https://www.thehastingscenter.org/to-reduce-maternal-health-disparities-expand-medicaid [https://perma.cc/H6JS-9U7W].

9. Erica L. Eliason, *Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality*, 30 WOMEN'S HEALTH ISSUES 147, 151 (2020) ("Medicaid expansion could be associated with reducing the stark racial disparities in maternal mortality in the United States.").

10. *Id.* at 149 ("After Medicaid expansion implementation, the maternal mortality ratios in expansion and nonexpansion states diverge as expansion states see a visibly lower total maternal mortality ratio compared with nonexpansion states . . . .").

11. *Quality of Housing*, U.S. DEP'T HEALTH & HUM. SERVS., https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/quality-housing [https://perma.cc/8ZRG-E39U].

a risk factor for maternal death.[12] In addition, lower-income individuals cannot afford healthy food and often live in food deserts.[13] Because people living in these deserts often have no choice than to shop from convenience stores in their neighborhoods where fresh food is unavailable, they face a higher risk of maternal morbidity.[14]

The structural racism embedded within health care delivery also contributes to the poor health outcomes Black women experience in the United States. This disparity exists for at least two reasons. First, due to health care providers' racial bias, they often treat Black women unfairly, offering them inferior maternal care. A report found that discrimination defined as "treating someone less or more favorably based on the group, class, or category they belong to resulting from biases, prejudices, and stereotyping" contributed to thirty percent of pregnancy-related deaths in 2020.[15] Second, Black women often deliver their babies in lower-quality hospitals, which fail to offer the maternal care they so deserve and need,[16] explaining why Black women are at a higher risk of maternal death than their white counterparts.

But there are yet other reasons why the most vulnerable women face the highest mortality rates in the United States. Increasingly, lower-income individuals and communities of color find themselves living in maternal care

12. Daniela C. Bravo-Solarte, Danna P. Garcia-Guaqueta & Sergio E. Chiarella, *Asthma in Pregnancy*, 44 ALLERGY & ASTHMA PROC. 24, 26 (2023) (noting that suffering from asthma increases the risk of complications during pregnancy including preeclampsia); *see also* Z. Ali, A.V. Hansen & C.S. Ulrik, *Exacerbations of Asthma During Pregnancy: Impact on Pregnancy Complications and Outcome*, 36 J. OBSTETRICS & GYNAECOLOGY 455, 459 (2015) (noting that the incidence of asthma exacerbation during pregnancy increases the risk of preeclampsia and gestational diabetes); Elizabeth F. Sutton et al., *Early Pregnancy Blood Pressure Elevations and Risk for Maternal and Neonatal Morbidity*, 136 OBSTETRICS & GYNECOLOGY 129, 129 (2020) (noting that elevated blood pressure during early pregnancy increases the risk of preeclampsia); *see also* Evdokia Dimitriadis et al., *Pre-Eclampsia*, NATURE REVS. DISEASE PRIMERS 1 (Feb. 16, 2023), https://www.nature.com/articles/s41572-023-00417-6 (on file with the *Iowa Law Review*) ("Pre-eclampsia is a life-threatening disease of pregnancy . . . and a leading cause of maternal and neonatal morbidity and mortality.").

13. Food deserts are geographic areas where people are deprived of supermarkets, and hence, deprived of nutritious food. Kelly Brooks, *Research Shows Food Deserts More Abundant in Minority Neighborhoods*, JOHNS HOPKINS MAG. (2014), https://hub.jhu.edu/magazine/2014/spring/racial-food-deserts [https://perma.cc/73JW-C5EM].

14. Matthew J. Tipton et al., *Association of Living in a Food Desert with Pregnancy Morbidity*, 136 J. OBSTETRICS & GYNECOLOGY 140, 140 (2020).

15. *Circumstances Contributing to Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 38 U.S. States, 2020*, CDC (May 28, 2024), https://web.archive.org/web/20250821085002/https://www.cdc.gov/maternal-mortality/php/report/index.html#cdc_report_pub_study_section_5-mental-health-conditions-other-than-substance-use-disorder [https://perma.cc/5XJ4-X57A]. For a broader overview of the literature on the relationship between implicit bias and health outcomes, see generally William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH e60 (2015).

16. Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1265 (2020).

deserts—areas where people lack access to obstetric care.[17] One study measuring the loss of obstetric care units in rural areas between 2004 and 2014 shows that almost nine hundred rural counties did not have any hospital providing obstetric care at any point during the study period.[18] Because hospitals during these years experienced a continuous decrease in obstetric services, in 2014 approximately six hundred thousand women lived in counties with no access to obstetric care.[19] A recent report demonstrates that this trend continues; between 2019 and 2020, twenty-one rural counties lost at least one obstetric unit, further reducing women's access to obstetric services in rural America.[20]

Maternal care deserts increase infant and maternal mortality rates and contribute to rising health inequities in the United States. Indeed, rural counties with no hospital-based obstetric care experience higher rates of emergency department and premature birth—a major cause of infant mortality.[21] Women living in maternal care deserts also face a higher risk of health complications during labor. This is because half of all women living in rural communities must travel more than thirty minutes to receive obstetric care.[22] As a result, women in rural areas face a nine percent higher risk of maternal mortality and morbidity compared to women in urban areas.[23]

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17. *Maternity Care Deserts*, MARCH OF DIMES PERISTATS (Apr. 2025), https://www.marchofdimes.org/peristats/data?top=23 [https://perma.cc/Q392-SQX8] ("[A] maternity care desert is any county without a hospital or birth center offering obstetric care and without any obstetric clinicians."); *see also* John Cullen, *A Worsening Crisis: Obstetric Care in Rural America*, HARV. MED. SCH. CTR. FOR PRIMARY CARE (Mar. 25, 2021), https://info.primarycare.hms.harvard.edu/perspectives/articles/obstetric-care-rural-america [https://perma.cc/LP46-AKZ9] ("These deserts are especially prominent in communities with a higher percentage of minorities. And further, the resources available for obstetric emergencies decline with rising percentages of minorities within respective communities.").

18. Peiyin Hung, Carrie E. Henning-Smith, Michelle M. Casey & Katy B. Kozhimannil, *Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004–14*, 36 HEALTH AFFS. 1663, 1665 (2017) ("Forty-five percent (898) of rural counties did not have any hospitals with obstetric services at any point during the period 2004–14, and 9 percent (179) of the counties experienced the loss of all in-county hospital obstetric services during the study period . . . .").

19. *Id.* ("In 2014, 1.8 million women ages 15–44 lived in counties that never had any hospitals providing obstetric services in the study period, and slightly more than 600,000 women lived in counties that lost those services . . . .").

20. CHRISTINA BRIGANCE ET AL., MARCH OF DIMES, NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE U.S. 11 (2022), https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf [https://perma.cc/3FK3-CKXS].

21. Katy B. Kozhimannil, Julia D. Interrante, Mariana K.S. Tuttle & Carrie Henning-Smith, *Changes in Hospital-Based Obstetric Services in Rural US Counties, 2014-2018*, 324 JAMA 197, 197 (2020).

22. BRIGANCE ET AL., *supra* note 20, at 11. Comparatively, only seven percent of women living in urban areas must travel at least thirty minutes to receive obstetric care. *Id.*

23. Katy Backes Kozhimannil, Julia D. Interrante, Carrie Henning-Smith & Lindsay K. Admon, *Rural-Urban Differences in Severe Maternal Morbidity and Mortality in the US, 2007-15*, 38 HEALTH AFFS. 2077, 2077–78 (2019) ("When we controlled for sociodemographic factors and clinical conditions, we found that rural residents had a 9 percent greater probability of severe

Importantly, data show that counties with higher proportions of non-Hispanic Black and lower-income individuals are more likely to experience a loss of hospital-based obstetric care.[24] These findings reflect the immense challenges that women in vulnerable communities already face in obtaining maternal care. Researchers have found that lower-income individuals and communities of color in rural areas face higher barriers to accessing non-local, high-acuity care than white or privately insured women in rural neighborhoods, even when Black women have high-risk clinical conditions that would receive advanced care in urban hospitals.[25]

Following the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*,[26] which allowed states to either prohibit or limit access to abortion care, abortion restrictions are on the rise.[27] In the wake of *Dobbs*, hospitals in abortion-ban states struggle to retain gynecologists and obstetricians because these doctors fear potential criminal punishment and even life imprisonment if they offer women the full range of medical services for which they have received training.[28] This has reduced rural women's access to maternal care which, in turn, will further deteriorate their disparately poorer health.[29]

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maternal morbidity and mortality, compared with urban residents."); *see also* Katharine A. Harrington, Natalie A. Cameron, Kasen Culler, William A. Grobman & Sadiya S. Khan, *Rural–Urban Disparities in Adverse Maternal Outcomes in the United States, 2016–2019*, 113 AM. J. PUB. HEALTH 224, 226 (2023) ("[P]regnant individuals residing in rural areas experienced maternal mortality rates of up to almost twice the rate of individuals in urban areas, with persistent differences between 2016 and 2019. . . . Although the reasons for the higher rates of adverse maternal outcomes in rural areas are likely multifactorial, substantial declines in hospital-based obstetric services between 2014 and 2018 in rural counties highlight the importance of policy efforts to ensure access to high-quality and high-acuity care.").

24. Hung et al., *supra* note 18, at 1667.

25. *Id.*

26. *See generally* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

27. Eugene Declercq, Ruby Barnard-Mayers, Laurie C. Zephyrin & Kay Johnson, *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*, COMMONWEALTH FUND (Dec. 14, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes [https://perma.cc/UB62-W6RS].

28. *Id.*; *see* Julie Rovner, *Abortion Bans Drive Off Doctors and Close Clinics, Putting Other Health Care at Risk*, NPR (May 23, 2023, 5:00 AM), https://www.npr.org/sections/health-shots/2023/05/23/1177542605/abortion-bans-drive-off-doctors-and-put-other-health-care-at-risk [https://perma.cc/F5DQ-NU6T]; Sophie Novack, "*You Know What? I'm Not Doing This Anymore.*," SLATE (Mar. 21, 2023, 5:45 AM), https://slate.com/news-and-politics/2023/03/texas-abortion-law-doctors-nurses-care-supreme-court.html [https://perma.cc/P8WP-BN2N].

29. Adam Gaffney, David U. Himmelstein & Samuel Dickman, *Projected Health Outcomes Associated with 3 US Supreme Court Decisions in 2022 on COVID-19 Workplace Protections, Handgun-Carry Restrictions, and Abortion Rights*, JAMA NETWORK OPEN 6 (June 8, 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805787 [https://perma.cc/PL24-NJ97] ("*Dobbs* nullification of *Roe v Wade* will be associated with 6 to 15 pregnancy-related deaths annually."); Amalia Londoño Tobón et al., *The End of Roe v. Wade: Implications for Women's Mental Health and Care*, FRONTIERS PSYCHIATRY 3 (May 5, 2023), https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2023.1087045/full [https://perma.cc/CUS7-3G5Q]; Elyssa Spitzer, Tracy Weitz & Maggie Jo Buchanan, *Abortion Bans Will Result in More Women Dying*, CTR. FOR AM.

This Article unveils a hidden dimension of this story. By examining the maternal mortality crisis in the United States through an antitrust lens, this Article argues that this crisis is also the result of a wave of hospital mergers that have increased consolidation in the hospital industry and left vulnerable populations with no access to obstetric care.

As noted, lower-income individuals and communities of color suffer from high maternal mortality rates because they are more likely to live in maternal care deserts. The alarming increase in hospital closures that created these deserts can be traced, in large part, to the financial challenges rural hospitals face nationwide. To reduce the risk of closure and improve their profit margins, some rural hospitals choose to be acquired by their competitors. In theory, a merger can provide hospitals with a rapid infusion of capital, help hospitals achieve economies of scale, and even improve their efficiency.[30] By merging, rural hospitals hope to achieve financial stability, ensuring continuity of their services.

However, theory does not always match reality. In fact, such mergers reduce, rather than ensure, access to care for underserved populations. Recent studies demonstrate that, following a merger, acquired rural hospitals experience a reduction in the availability of essential health care services, including obstetric care.[31] Specifically, after the merger takes place, the acquiring hospitals often discontinue vital health care services, especially maternal care.[32] Given that rural residents in the United States have already incurred severe loss of obstetric services, these mergers worsen maternal health in rural communities.

PROGRESS (Nov. 2, 2022), https://www.americanprogress.org/article/abortion-bans-will-result-in-more-women-dying [https://perma.cc/MX79-THWY]; Elizabeth Kukura, *Pregnancy Risk and Coerced Interventions after* Dobbs, 76 SMU L. REV. 105, 108 (2023) (discussing how *Dobbs* negatively affects women's health); Rebecca B. Reingold, Lawrence O. Gostin & Michele Bratcher Goodwin, *Legal Risks and Ethical Dilemmas for Clinicians in the Aftermath of* Dobbs, 328 JAMA 1695, 1695 (2022) (noting that *Dobbs* will increase the risk of pregnancy-related deaths and racial disparities in maternal mortality).

30. Claire E. O'Hanlon et al., *Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation*, 38 HEALTH AFFS. 2095, 2096 (2019).

31. *Id.* at 2100 (noting that post-merger, acquired rural hospitals witnessed a seven to fourteen percent annual reduction in the availability of obstetric services compared to non-affiliated entities as well as a seven to nineteen percent annual reduction in the availability of primary care departments within five to six years following the deal); *see also* Rachel Mosher Henke, Kathryn R. Fingar, H. Joanna Jiang, Lan Liang & Teresa B. Gibson, *Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Hospital Mergers in Rural Areas*, 40 HEALTH AFFS. 1627, 1634 (2021).

32. SARA SIROTA, AM. ECON. LIBERTIES PROJECT, THE HARMS OF HOSPITAL MERGERS AND HOW TO STOP THEM 2, 5 (2023), https://www.economicliberties.us/wp-content/uploads/2023/04/Hospital_QuickTake-0421-002.pdf [https://perma.cc/67M4-NJAX]; *see also* Hoag Levins, *Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality*, LEONARD DAVIS INST. HEALTH ECON. (Jan. 19, 2023), https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality [https://perma.cc/2AEA-EGS6] ("Acquiring systems often move to close services like intensive care, labor and delivery, psychiatric care, and cardiac surgery."); O'Hanlon et al., *supra* note 30, at 2100–01; Henke et al., *supra* note 31, at 1631–33 (noting that mergers led to a reduction of maternal, surgical, and mental health care services in rural areas).

But this is not the only reason why hospital mergers cause harm to women's health. Mergers allow hospitals to increase their market power in the labor market and even attain monopsony power,[33] especially if they operate in underserved areas where competition for labor is limited.[34] As a result, hospitals are able to suppress the wages of their employees and impose adverse working conditions.[35] Because a majority of workers in the hospital sector are women, it is women who disproportionately suffer the consequences of such anticompetitive effects. Considering public health research illustrating a correlation among people's income, working conditions, and health, such mergers can harm women's maternal health, especially in lower-income communities and communities of color.[36] In this way, hospital mergers may widen the racial disparities in maternal health outcomes in the United States.

This Article argues that antitrust enforcers and the courts should combat the threat these mergers pose to maternal health. It also proposes how they might do so. This Article proceeds in three parts: Part I identifies the roots of the problem from a public health perspective. It shows that, due to the sociodemographic characteristics of vulnerable populations in the United States and the structural racism that pervades health care delivery, lower-income individuals and communities of color are at higher risk for maternal death.

Part II sheds light on the antitrust dimension of the maternal mortality crisis in the United States. It explains that mergers among hospitals may lead to worse maternal health outcomes in three ways. First, such mergers often lead to a reduction in the availability of obstetric care, causing maternal care deserts. Second, mergers allow hospitals to increase their market power in labor markets. This enables them to reduce the wages of their employees and the quality of their working conditions. Because the majority of employees working in the hospital sector are women, such mergers may disproportionately affect their wealth and, ultimately, maternal health. Third, mergers increase the already high levels of burnout hospital workers experience. Research also demonstrates a relationship between providers' burnout and lower-quality maternal care. Hence, by deteriorating providers' working conditions, hospital mergers can lead to inferior maternal care. Part II shows that the poorest individuals and communities of color will be among the most affected.

Part III offers three prescriptive proposals. First, the enforcers and the courts should challenge any merger that is likely to reduce access to obstetric services, especially for residents in underserved areas. Second, they should accept mergers only under the condition that the merged entity will not cut obstetric

33. José Azar & Ioana Marinescu, *Monopsony Power in the Labor Market: From Theory to Policy*, 16 ANN. REV. ECON. 491, 492 (2024) (noting that monopsony is defined as the employers' ability to offer workers less than the competitive wage).

34. Theodosia Stavroulaki, *The Healing Power of Antitrust*, 119 NW. U. L. REV. 943, 950, 970 (2025).

35. *Id.*

36. *See infra* Part I.

services in underserved communities. Third, antitrust enforcers should expand their merger analysis by assessing the impact of hospital mergers on the wages and working conditions of employees in the hospital sector.

This Article is the first to demonstrate how hospital mergers harm women's maternal health: namely, by reducing access to obstetric care and worsening health outcomes for vulnerable populations. But by implementing the outlined proposals, the antitrust enforcers and the courts can help alleviate the maternal mortality crisis afflicting the nation, thereby improving the maternal health of millions of women.

I. THE PUBLIC HEALTH DIMENSION OF THE MATERNAL MORTALITY CRISIS IN AMERICA

This Part explores the maternal mortality crisis in the United States, which disproportionately affects lower-income individuals and communities of color, through a public health lens. It first illustrates that vulnerable women suffer from high rates of maternal death, given the correlation between the social determinants of health and maternal health. Research shows that access to comprehensive insurance coverage,[37] quality housing, and healthy food reduces the risk of maternal mortality.[38] Predictably, lower-income individuals are often uninsured and live in neighborhoods that are unsafe, where they are exposed to pollutants or deprived of access to healthy food. After explicating these facts and their consequences, this Part illustrates how pervasive structural racism in the U.S. health care system leaves minority populations with no access to quality maternal care.

A. THE SOCIOECONOMIC CONDITIONS OF VULNERABLE WOMEN IN AMERICA

1. Lack of Health Insurance Coverage

Medicaid is the main form of health insurance coverage for lower-income Americans.[39] The 2010 Affordable Care Act ("ACA") forced states to expand Medicaid so that all citizens with household incomes up to 138% of the

37. JUDITH SOLOMON, CTR. ON BUDGET & POL'Y PRIORITIES, CLOSING THE COVERAGE GAP WOULD IMPROVE BLACK MATERNAL HEALTH (2021), https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health [https://perma.cc/CCN8-N27T].

38. Jodie G. Katon, Daniel A. Enquobahrie, Katie Jacobsen & Laurie C. Zephyrin, *Policies for Reducing Maternal Morbidity and Mortality and Enhancing Equity in Maternal Health*, COMMONWEALTH FUND (Nov. 16, 2021), https://www.commonwealthfund.org/publications/fund-reports/2021/nov/policies-reducing-maternal-morbidity-mortality-enhancing-equity [https://perma.cc/3QMT-5GTL].

39. Lisa Bunch, Halelujha Ketema & Katherine Keisler-Starkey, *How Age and Poverty Level Impact Health Insurance Coverage*, U.S. CENSUS BUREAU (Sept. 10, 2024), https://www.census.gov/library/stories/2024/09/health-insurance-coverage.html [https://perma.cc/8VRG-F3UE] (showing that "over three-quarters of children under 19 and about half of working-age adults in poverty had public coverage," of which Medicaid is the predominant type).

federal poverty level would be covered.[40] However, in *National Federation of Independent Business v. Sebelius*,[41] the Supreme Court ruled that this obligatory expansion of Medicaid was unconstitutional;[42] thus states now merely have *the option* to expand their Medicaid programs. Consequently, to date, ten states have opted not to expand Medicaid.[43] Those states, such as Mississippi, Alabama, and Tennessee, are among those with the highest rates of maternal mortality in the United States.[44] On the other hand, states that opted for Medicaid expansion have experienced reduced mortality rates generally, and have also seen a reduction in racial and health disparities in birth outcomes.[45]

Indeed, data indicate a relationship between Medicaid expansion and lower maternal and infant mortality rates, especially for minority women. According to one study, Medicaid expansion correlates with almost seven fewer maternal deaths per one hundred thousand live births.[46] That same study also found that non-Hispanic Black mothers have benefited the most from expansion.[47]

This should not be surprising. In expansion states, a greater portion of lower-income individuals have coverage; in non-expansion states, many lower-income individuals have no pathway to affordable health insurance because they are ineligible for Medicaid.[48] As a result, lower-income individuals in non-expansion states may leave chronic conditions, such as high blood pressure and diabetes, untreated before pregnancy—which increases the risk of maternal

40. *See Status of State Medicaid Expansion Decisions*, KFF (Aug. 26, 2025), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map [https://perma.cc/BPR3-VX54] [hereinafter *Interactive Map*].

41. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 588 (2012).

42. *See* MARYBETH MUSUMECI, KAISER FAM. FOUND., A GUIDE TO THE SUPREME COURT'S DECISION ON THE ACA'S MEDICAID EXPANSION 4 (2012), https://www.kff.org/wp-content/uploads/2013/01/8347.pdf [https://perma.cc/H3H4-Q2YD].

43. *See Interactive Map*, *supra* note 40.

44. *Which States Have the Highest Maternal Mortality Rates?*, USAFACTS (May 15, 2023), https://usafacts.org/articles/which-states-have-the-highest-maternal-mortality-rates [https://perma.cc/CKD8-B2BR].

45. Eliason, *supra* note 9, at 149.

46. *Id.* ("Medicaid expansion was significantly associated with 7.01 (p = .002) fewer total maternal deaths per 100,000 live births relative to nonexpansion states.").

47. *See id.* ("When stratifying by race/ethnicity, the effect size is greatest among non-Hispanic Black mothers, with Medicaid expansion significantly associated with a lower total maternal rate per 100,000 live births by 16.27 (p = .022) maternal deaths relative to non-expansion states among non-Hispanic Black mothers . . . .").

48. SOLOMON, *supra* note 37, at 1–2 ("[T]he Medicaid 'coverage gap' – in which adults with low incomes have no pathway to affordable coverage because their state is one of 12 that has refused to expand Medicaid – puts continuous health coverage out of reach for over 800,000 women of reproductive age. . . . If people in the coverage gap become pregnant, they become eligible for Medicaid. But necessary preconception care is likely unavailable and being uninsured *before* pregnancy is associated with a higher prevalence of risk factors that contribute to poor pregnancy outcomes, especially for Black women. Moreover, uninsured people may delay prenatal care until they apply for and enroll in Medicaid.").

death.[49] Communities of color are more likely to suffer from these preventable chronic conditions.[50] Moreover, Texas, Florida, and Georgia—the states in the United States with the highest Black populations[51]—have not opted for Medicaid expansion.[52] This explains, at least partially, why Black women in the United States are a higher risk of maternal mortality and morbidity than their white counterparts.

2. Housing Instability, Unsafe Neighborhoods, and the Environment

Housing instability or living in adverse neighborhood conditions can deteriorate pregnant women's health. For one, housing unaffordability can lead to homelessness.[53] Homelessness is associated with depression, anxiety, and substance use disorder—all of which can deter a healthy pregnancy.[54] In addition, women living in an emergency shelter while homeless face high barriers to accessing health care[55] and an increased risk of health complications, including hemorrhage and threatened labor.[56] Eviction actions during

49. *Id.* at 6 (noting that having health coverage before and between pregnancies makes it far more likely that health risks such as diabetes get screened for and treated prior to pregnancy, which reduces the risk of poor outcomes); Eliason, *supra* note 9, at 148 ("Increased access to Medicaid coverage before pregnancy could improve women's health risk factors, such as obesity, diabetes, and heart disease, which can often contribute to maternal mortality . . . .").

50. A.L. Heywood, *11 Conditions that Disproportionately Affect Black People*, HEALTHLINE (Feb. 6, 2023), https://www.healthline.com/health/health-disparities-in-the-black-community (on file with the *Iowa Law Review*); SOLOMON, *supra* note 37, at 6.

51. Gracie Martinez & Jeffrey S. Passel, *Facts About the U.S. Black Population*, PEW RSCH. CTR. (Jan. 23, 2025), https://www.pewresearch.org/social-trends/fact-sheet/facts-about-the-us-black-population [https://perma.cc/3WQY-SJ49].

52. *Interactive Map*, *supra* note 40.

53. Felix M. Muchomba, Julien Teitler & Nancy E. Reichman, *Association Between Housing Affordability and Severe Maternal Morbidity*, JAMA NETWORK OPEN 2 (Nov. 22, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798874 [https://perma.cc/T9TM-8EKP].

54. Robin E. Clark, Linda Weinreb, Julie M. Flahive & Robert W. Seifert, *Homelessness Contributes to Pregnancy Complications*, 38 HEALTH AFFS. 139, 142, 145 (2018) ("Women who used shelter had significantly higher rates of alcohol, opioid, and nonopioid drug use disorders; adjustment, anxiety, and depressive disorders . . . . Higher rates of depressive, anxiety, adjustment, and substance use disorders contribute to pregnancy and birth complications.").

55. *Id.* at 144–45 ("Placements outside of their original community, coupled with transportation problems, may disrupt established relationships with providers and require women to look for new ones, which makes it difficult to maintain continuity of care . . . ."). For a discussion on the barriers homeless pregnant people face in accessing health care, see Madeleine Walsh et al., *Homelessness Is a Form of Structural Violence That Leads to Adverse Obstetrical Outcomes*, 113 AM. J. PUB. HEALTH 1160, 1161 (2023); Christine McGeough, Aisling Walsh & Barbara Clyne, *Barriers and Facilitators Perceived by Women While Homeless and Pregnant in Accessing Antenatal and or Postnatal Healthcare: A Qualitative Evidence Synthesis*, 28 HEALTH & SOC. CARE CMTY. 1380, 1389–91 (2020); and Kathaleen C. Bloom et al., *Barriers to Prenatal Care for Homeless Pregnant Women*, 33 J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 428, 432 (2004).

56. Clark et al., *supra* note 54, at 142–43; *see also* Walsh et al., *supra* note 55, at 1160.

pregnancy also worsen women's health, leading to adverse birth outcomes, and a trend toward infant mortality.[57]

When women spend most of their disposable income on rent due to their financial constraints, they consequently lack the resources to invest in food and health care—factors that positively affect maternal health.[58] A study found that women living in neighborhoods where housing is unaffordable are more likely to suffer from pregnancy-related complications, especially if they lack a quality education.[59] Specifically, the study observed that women with no high school education are more likely to experience severe maternal morbidity—a major risk factor for maternal mortality—compared to women with a college education.[60] Thus, living in neighborhoods with unaffordable housing increases the risk of maternal death, especially for poorer populations in the United States.

Women living in segregated neighborhoods are also at risk for poor maternal health. A study exploring the relationship between residential segregation and maternal health concluded that living in high-segregated Black neighborhoods correlates with a higher risk of maternal morbidity.[61] The researchers observed that the discrimination in employment, housing, health care, and education that racial minority populations in the United States experience increases their risk of adverse birth outcomes.[62]

High-police-contact neighborhoods demonstrate a similar trend. High rates of police contact exacerbate the levels of stress residents experience, increasing their risk for preterm birth.[63] Because "predominantly Black

57. Gracie Himmelstein & Matthew Desmond, *Association of Eviction with Adverse Birth Outcomes Among Women in Georgia, 2000 to 2016*, 175 JAMA PEDIATRICS 494, 494 (2021) ("C]ompared with mothers who experienced eviction actions at other times, eviction during pregnancy was associated with lower infant birth weight . . . increased rates of LBW . . . and prematurity . . . ."); *see also* Emily A. Benfer, *Housing Is Health: Prioritizing Health Justice and Equity in the U.S. Eviction System*, 22 YALE J. HEALTH POL'Y L. & ETHICS 49, 68 (2024) (noting that newborns whose mothers are evicted during pregnancy are more likely to have low birth weight, extended hospitalization, and face increased mortality).

58. Muchomba et al., *supra* note 53, at 9.

59. *Id.* at 5.

60. *Id.* ("[A] higher rental cost burden was associated with significantly higher odds of SMM . . . . The rates of SMM were 260.4 per 10000 persons among those with less than a high school education and 159.9 per 10000 persons among those with a college education . . . .").

61. Peiyin Hung et al., *Analysis of Residential Segregation and Racial and Ethnic Disparities in Severe Maternal Morbidity Before and During the COVID-19 Pandemic*, JAMA NETWORK OPEN 7 (Oct. 20, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797496 [https://perma.cc/T3CC-N7TF] ("[W]e found that living in high-segregated Black communities was associated with greater risk of maternal morbidity, independent of individual demographic, clinical, and economic conditions.").

62. *Id.* at 7–8.

63. Rachel R. Hardeman et al., *Association of Residence in High-Police Contact Neighborhoods with Preterm Birth Among Black and White Individuals in Minneapolis*, JAMA NETWORK OPEN 7 (Dec. 8, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786940 [https://perma.cc/229F-LFHH].

neighborhoods" tend to have greater police contact than "predominantly White neighborhoods," Black pregnant women face higher odds of being exposed to police than their white counterparts, which can increase the racial disparity in preterm birth.[64]

Furthermore, lower-income individuals and communities of color suffer disproportionately from worse maternal health because they live in neighborhoods that are highly exposed to environmental pollutants and toxins,[65] which increases their risk for still- and preterm birth.[66] Moreover, although access to clean water is essential for good maternal health, Black communities are more likely to be deprived of this vital resource, given that they access water through lead pipes at higher rates than white communities.[67] These environmental factors widen the racial disparities in maternal health outcomes in the United States.

3. Food Insecurity

Deprivation of nutritious food during pregnancy increases the risk of maternal and infant death as well. For instance, malnutrition is associated with obesity,[68] which itself relates to several pregnancy complications such as macrosomia[69] and preeclampsia.[70] Obesity increases the need for a C-section,[71]

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64. *Id.* at 1–2.

65. Bridges, *supra* note 16, at 1258; *see also* Emily A. Benfer, Seema Mohapatra, Lindsay F. Wiley & Ruqaiijah Yearby, *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL'Y L. & ETHICS 122, 155 (2020) (noting that segregated neighborhoods which are primarily Black have more noise and environmental hazards).

66. Bonaventure S. Dzekem, Briseis Aschebrook-Kilfoy & Christopher O. Olopade, *Air Pollution and Racial Disparities in Pregnancy Outcomes in the United States: A Systematic Review*, 11 J. RACIAL & ETHNIC HEALTH DISPARITIES 535, 540 (2024).

67. Chakena D. Perry, Opinion, *Access to Clean Water Is a Matter of Life and Death for Black Mothers*, HARV. PUB. HEALTH (Aug. 22, 2023), https://harvardpublichealth.org/reproductive-health/clean-water-is-a-must-to-reduce-black-maternal-mortality [https://perma.cc/JB6L-YYGF].

68. Sherry A. Tanumihardjo et al., *Poverty, Obesity, and Malnutrition: An International Perspective Recognizing the Paradox*, 107 J. AM. DIETETIC ASS'N 1966, 1966 (2007) ("*Malnutrition* is usually associated with poverty and food insecurity, and *malnourished* is defined as poorly or wrongly fed and having a poor or inadequate diet. However, a newly appreciated paradox has been described that links poverty, food insecurity, and malnutrition to obesity, or the state of *overnutrition*. This paradoxical condition exists because many of the diets of people living in poverty have adequate kilocalories to meet or exceed their energy requirements, but lack the dietary quality needed to promote optimal health and prevent chronic disease." (footnotes omitted)).

69. Rui-xue Dai, Xiu-Jie He & Chuan-Lai Hu, *Maternal Pre-Pregnancy Obesity and the Risk of Macrosomia: A Meta-Analysis*, 297 ARCHIVES GYNECOLOGY & OBSTETRICS 139, 139 (2018) (noting that pre-pregnancy obesity is a risk factor for macrosomia).

70. AK Mbah et al., *Super-Obesity and Risk for Early and Late Pre-Eclampsia*, 117 BJOG 997, 997 (2010).

71. Jessica A. Ellis, Carolyn M. Brown, Brian Barger & Nicole S. Carlson, *Influence of Maternal Obesity on Labor Induction: A Systematic Review and Meta-Analysis*, 64 J. MIDWIFERY & WOMEN'S HEALTH 55, 63 (2019) ("[W]omen with obesity were nearly 2 times more likely . . . to end labor with caesarean birth . . . ."); *see also* Jenny Bjorklund, Eva Wiberg-Itzel & Tove Wallstrom, *Is There*

and research demonstrates a correlation between cesarean delivery and severe maternal morbidity, including blood transfusion and respiratory syndrome.[72]

What's more, deficiencies in key micronutrients, such as iron and vitamin D, can deteriorate maternal and infant health. For example, iron-deficiency anemia increases the risk of several maternal complications, such as preterm labor, postpartum hemorrhage, and even maternal death.[73] It is also associated with various fetal complications.[74] Similarly, insufficient levels of vitamin D during pregnancy are associated with recurrent miscarriage and low birth weight,[75] which can impair brain development[76] and result in breathing problems and infections following childbirth.[77]

Communities of color and lower-income individuals are more likely to be deprived of the nutritious food necessary for a healthy pregnancy for two primary reasons. First, they often live in neighborhoods offering easier access to fast food chains and convenience stores, where low-quality and high-calorie food is available, rather than grocery stores and supermarkets.[78] Second, due to limited resources, they may have no choice but to purchase cheaper food rich in added sugar and synthetic fats, rather than more costly fresh food and vegetables.[79] Naturally, this deprivation of healthy food during pregnancy can increase the maternal mortality and morbidity vulnerable communities face.

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an Increased Risk of Cesarean Section in Obese Women After Induction of Labor? A Retrospective Cohort Study, PLOS ONE 1–2 (Feb. 25, 2022), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0263685 [https://perma.cc/D5RL-NS38].

72. Elena V. Kuklina et al., *Severe Obstetric Morbidity in the United States: 1998–2005*, 113 OBSTETRICS & GYNECOLOGY 293, 297–98 (2009).

73. Ashley E. Benson, Jamie O. Lo & Aaron B. Caughey, *Iron Deficiency and Iron Deficiency Anemia During Pregnancy—Opportunities to Optimize Perinatal Health and Health Equity*, JAMA NETWORK OPEN 1 (Aug. 20, 2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2822546 [https://perma.cc/N74P-NZEN] ("Iron deficiency anemia is associated with an increased risk of maternal complications, including preterm labor, cesarean delivery, postpartum hemorrhage, and maternal death . . . ."); *see also WHO Global Anaemia Estimates*, WORLD HEALTH ORG. (2025), https://www.who.int/data/gho/data/themes/topics/anaemia_in_women_and_children [https://perma.cc/K9YC-KPG2].

74. *WHO Global Anaemia Estimates*, *supra* note 73.

75. Mei-Chun Chien, Chueh-Yi Huang, Jie-Huei Wang, Chia-Lung Shih & Pensee Wu, *Effects of Vitamin D in Pregnancy on Maternal and Offspring Health-Related Outcomes: An Umbrella Review of Systematic Review and Meta-Analyses*, NUTRITION & DIABETES 6 (May 30, 2024), https://www.nature.com/articles/s41387-024-00296-0 [https://perma.cc/9PDZ-NZ5Q].

76. K. Sripada et al., *Trajectories of Brain Development in School-Age Children Born Preterm with Very Low Birth Weight*, SCI. REPS. 1 (Oct. 22, 2018), https://www.nature.com/articles/s41598-018-33530-8.pdf [https://perma.cc/GW5N-6RWN].

77. *Low Birthweight*, MARCH OF DIMES (June 2021), https://www.marchofdimes.org/find-support/topics/birth/low-birthweight [https://perma.cc/6XK7-JYST].

78. Angela Hilmers, David C. Hilmers & Jayna Dave, *Neighborhood Disparities in Access to Healthy Foods and Their Effects on Environmental Justice*, 102 AM. J. PUB. HEALTH 1644, 1650–51 (2012).

79. Maya Feller, *Healthy Food Is a Right for Black People, Not a Privilege*, HEALTHLINE (Oct. 13, 2020), https://www.healthline.com/health/nutrition/black-communities-need-access-to-healthy-food [https://perma.cc/853W-CEJR].

B. Structural Racism in Health Care Delivery

The previous Section illustrated the correlation between women's socio-economic conditions and maternal health outcomes. This Section shows that the structural racism that pervades health care delivery in the U.S. health care system aggravates the maternal mortality crisis nationwide. First, providers often discriminate against communities of color due to implicit or explicit racial bias. As a result, communities of color receive inferior care compared to their white counterparts.[80] Second, Black populations primarily receive maternal care in so-called "high [B]lack-serving hospitals," which offer low-quality obstetric services.[81] These factors all contribute to racial disparities in maternal mortality and morbidity in the United States.

1. Racial Bias

Implicit or explicit bias in the provision of health care can increase maternal deaths. Influenced by their racial bias, providers often rely on a false belief that due to Black populations' "biological makeup," Black people have stronger bones, thicker skin, and higher pain tolerance than white people.[82] As a result, providers tend to make an incorrect assessment as to how much pain Black patients can tolerate.[83] Additionally, providers often disregard Black patients' symptoms and complaints[84] or decide not to refer them to specialty care.[85]

Empirical studies shed light on those concerns. One study shows that Black patients receiving care in hospitals' emergency departments are less likely to be given analgesia compared to white patients.[86] Black women suffering from

80. Bridges, *supra* note 16, at 1262–63.

81. *Id.* at 1265.

82. Joli Hunt, *Maternal Mortality Among Black Women in the United States*, BALLARD BRIEF (2021), https://ballardbrief.byu.edu/issue-briefs/maternal-mortality-among-black-women-in-the-united-states [https://perma.cc/K74B-NPSM].

83. *Id.*; *see also* Peter Mende-Siedlecki, Jennie Qu-Lee, Robert Backer & Jay J. Van Bavel, *Perceptual Contributions to Racial Bias in Pain Recognition*, 148 J. EXPERIMENTAL PSYCH. 863, 864 (2019) ("[R]egistered nurses and nursing students attribute higher thresholds for pain to Blacks, compared to Whites . . . .").

84. Martha Hostetter & Sarah Klein, *Understanding and Ameliorating Medical Mistrust Among Black Americans*, COMMONWEALTH FUND (Jan. 14, 2021), https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans [https://perma.cc/245G-4VAR].

85. Bruce E. Landon, Jukka-Pekka Onnela, Laurie Meneades, A. James O'Malley & Nancy L. Keating, *Assessment of Racial Disparities in Primary Care Physician Specialty Referrals*, JAMA NETWORK OPEN 9 (Jan. 25, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775603 [https://perma.cc/QJL9-ZL8J] ("[R]eferrals for Black patients come from fewer PCPs in general for any particular specialist physician."); Ruqaiijah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1284–85, 1297 (2012).

86. Elizabeth N. Chapman, Anna Kaatz & Molly Carnes, *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504, 1507 (2013).

fibroids are more likely to be subject to hysterectomy compared to white women, who are often subject to minor procedures before resorting to hysterectomy for curing fibroids.[87] Black patients suffering from myocardial infarction are less likely to receive thrombolysis, the most appropriate type of treatment for curing this ailment, as compared to white patients.[88] Black and Hispanic populations receive a migraine diagnosis at significantly lower rates than white populations, although the overall prevalence of migraine is similar across races.[89]

Evidence of racial bias is also evident in the obstetric care provided to Black communities.[90] Black women in the United States are more likely to receive general anesthesia at the time of cesarean delivery compared to white women despite research highlighting that general anesthesia for cesarean delivery increases maternal mortality and morbidity.[91] Black and Hispanic women are less likely to receive an opioid prescription in the postpartum period than white women even though Black and Hispanic women are more likely to experience acute pain.[92] When Black women visit the hospital emergency department due to a pregnancy complication they must wait forty-six percent longer than white women to obtain care.[93]

The story of superstar tennis player Serena Williams, who developed pulmonary embolism after she gave birth to her daughter Olympia, illustrates the devaluation of Black women in maternal health care.[94] Soon after childbirth, Williams experienced complications.[95] Because Williams had suffered from a life-threatening embolism in the past, she immediately informed the medical staff about her feelings of discomfort. Fearing that, once again, she was experiencing pulmonary embolism, Williams requested a CT scan with contrast

87. Heba M. Eltoukhi, Monica N. Modi, Meredith Weston, Alicia Y. Armstrong & Elizabeth A. Stewart, *The Health Disparities of Uterine Fibroid Tumors for African American Women: A Public Health Issue*, 210 AM. J. OBSTETRICS & GYNECOLOGY 194, 195 (2014); *see also Addressing Implicit Bias in Women's Health*, GEO. U. BERKLEY SCH. NURSING (Apr. 1, 2021), https://online.nursing.georgetown.edu/blog/addressing-implicit-bias-in-womens-health [https://perma.cc/F6VV-EEHP].

88. Alexander R. Green et al., *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231, 1235 (2007).

89. Jessica Kiarashi et al., *Factors Associated with, and Mitigation Strategies for, Health Care Disparities Faced by Patients with Headache Disorders*, 97 NEUROLOGY 280, 281 (2021).

90. Gillian Clouser, *Blackness, Maternal Mortality, and Prenatal Birth: The Legacy of Slavery*, YALE SCH. MED. (May 16, 2022), https://medicine.yale.edu/news-article/blackness-maternal-mortality-and-prenatal-birth-the-legacy-of-slavery [https://perma.cc/8TZA-3CK8].

91. Caroline Leigh Thomas et al., *Racial and Ethnic Disparities in Receipt of General Anesthesia for Cesarean Delivery*, 79 OBSTETRICAL & GYNECOLOGICAL SURV. 387, 388 (2024).

92. Nevert Badreldin, William A. Grobman & Lynn M. Yee, *Racial Disparities in Postpartum Pain Management*, 134 OBSTETRICS & GYNECOLOGY 1147, 1151 (2020).

93. Megan E. Deichen Hansen et al., *Racial Inequities in Emergency Department Wait Times for Pregnancy-Related Concerns*, WOMEN'S HEALTH 4 (Oct. 27, 2022), https://journals.sagepub.com/doi/reader/10.1177/17455057221129388 [https://perma.cc/3TCJ-YRTB].

94. P.R. Lockhart, *What Serena Williams's Scary Childbirth Story Says About Medical Treatment of Black Women*, VOX (Jan. 11, 2018, 9:40 PM), https://www.vox.com/identities/2018/1/11/16879984/serena-williams-childbirth-scare-black-women (on file with the *Iowa Law Review*).

95. *Id.*

and a blood thinner.[96] Even though pulmonary embolism can be the root cause of lung damage or even death, the medical staff dismissed William's request.[97] Instead, they ordered an ultrasound of her legs, which revealed nothing.[98] After insisting, Williams eventually had a CT scan which showed that "several small blood clots had settled in her lungs."[99] Had Williams not advocated for herself, she may not have survived the day.

Serena Williams is not alone. A 2018 survey, *Listening to Mothers*, explored the quality of maternity care women receive in California. The survey participants were asked whether they had been discriminated against during their hospital stay for childbirth due to their language, ethnicity, or type of health insurance.[100] The survey illustrated that English language speakers and those with access to private health insurance were more likely to be treated fairly.[101] Several women reported that the medical staff treated them disrespectfully and used a harsh language when communicating with them.[102] Researchers found that this was especially the case for Black patients.[103]

When women's voices are not heard, or when they feel discriminated against due to their race, their maternal health deteriorates at alarming rates. First, when providers discriminate against Black women, they experience trauma and a feeling of unworthiness.[104] As a result, they may avoid necessary care.[105] Second, because of providers' racial bias, Black communities often receive inferior health care services.

2. Segregated Hospitals

Black women suffer from higher mortality rates than white women for yet another reason: They are more likely to give birth in lower-quality hospitals

96. *Id.*

97. Ashley Pattain, *Black Maternal Mortality Rate: Improving Outcomes for Black Mothers Using Legislation that Reverses the Effects of Structural Racism in Medicine*, 45 MITCHELL HAMLINE L.J. PUB. POL'Y & PRAC. 141, 143 (2024).

98. Lockhart, *supra* note 94.

99. *Id.*

100. Jamila K. Taylor, *Structural Racism and Maternal Health Among Black Women*, 48 J.L. MED. & ETHICS 506, 511 (2020).

101. *Id.*

102. CAROL SAKALA, EUGENE R. DECLERCQ, JESSICA M. TURON & MAUREEN P. CORRY, LISTENING TO MOTHERS IN CALIFORNIA: A POPULATION-BASED SURVEY OF WOMEN'S CHILDBEARING EXPERIENCES 66 (2018), https://www.chcf.org/wp-content/uploads/2018/09/ListeningMothersCAFullSurveyReport2018.pdf [https://perma.cc/G2EX-DWU5].

103. *Id.*

104. Bridges, *supra* note 16, at 1264.

105. *Id.* at 1265; Ruqaiijah Yearby & Seema Mohapatra, *Systemic Racism, the Government's Pandemic Response, and Racial Inequities in COVID-19*, 70 EMORY L.J. 1419, 1469 (2021) (noting that Black people may avoid care due to providers' racial bias); Elizabeth Tobin Tyler, *Black Mothers Matter: The Social, Political and Legal Determinants of Black Maternal Health Across the Lifespan*, 25 J. HEALTH CARE L. & POL'Y 49, 63–64 (2022) (noting that Black Americans miss care due to their fear that they will be discriminated against).

that fail to offer patients the care they so deserve and need.[106] Empirical data indicate that seventy-five percent of Black women give birth in only a quarter of all hospitals in the United States.[107] Comparatively, only eighteen percent of white women obtain maternal care in those high Black-serving hospitals.[108] Researchers warn that high Black-serving hospitals are characterized by higher pregnancy delivery complications, including obstetric embolism and blood transfusion[109] and higher adjusted maternal morbidity rates.[110] With these factors showing suboptimal care for Black women in America, the question must be asked: *Why is this the case?*

The answer is not straightforward. For example, one could argue that high Black-serving hospitals serve marginalized communities who suffer from diabetes, hypertension, and other chronic and complex health conditions at higher rates. People suffering from these health conditions are more likely to face complications during pregnancy and may not even survive childbirth. This could at least partially explain why high Black-serving hospitals appear to fail in providing optimal care.

Research, however, shows that this is not the case. A study found that both Black and white patients who received obstetric care in high Black-serving hospitals faced higher rates of maternal morbidity compared to white patients who obtained care at low Black-serving hospitals.[111] In this way, the study illustrates that the lower-quality care offered by high Black-serving hospitals contributes to the higher morbidity and mortality rates Black women face nationwide.

The heartbreaking story of Tanesia Walker, a young flight attendant who gave birth at a low-quality, high Black-serving hospital in New York City sheds

106. MARCH OF DIMES, NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE U.S. 2020 REPORT 10 (2020), https://www.marchofdimes.org/sites/default/files/2022-10/2020-Maternity-Care-Report.pdf [https://perma.cc/E9R8-U56X].

107. Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 CLINICAL OBSTETRICS & GYNECOLOGY 387, 391 (2018).

108. *Id.* ("[H]ospitals that disproportionately cared for black deliveries had higher risk-adjusted severe maternal morbidity rates for both black and white women in those hospitals.").

109. Andreea A. Creanga et al., *Performance of Racial and Ethnic Minority-Serving Hospitals on Delivery-Related Indicators*, 211 AM. J. OBSTETRICS & GYNECOLOGY 647.e1, 647.e5 (2014).

110. Howell, *supra* note 107, at 391; *see also* Annie Waldman, *How Hospitals Are Failing Black Mothers*, PROPUBLICA (Dec. 27, 2017, 8:00 AM), https://www.propublica.org/article/how-hospitals-are-failing-black-mothers [https://perma.cc/6LKK-XJD6] ("[W]omen who hemorrhage at disproportionately black-serving hospitals are far more likely to wind up with severe complications, from hysterectomies, which are more directly related to hemorrhage, to pulmonary embolisms, which can be indirectly related. When we looked at data for only the most healthy women, and for white women at black-serving hospitals, the pattern persisted.").

111. Elizabeth A. Howell, Natalia Egorova, Amy Balbierz, Jennifer Zeitlin & Paul L. Hebert, *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OBSTETRICS & GYNECOLOGY 122.e1, 122.e5 (2016) ("As compared with white women who delivered at low black-serving hospitals, black and white women who delivered at high black-serving hospitals had 66.9% ($P = .002$) and 56.9% ($P = .006$), respectively, higher adjusted rates of severe maternal morbidity.").

some light on those concerns.[112] Initially, Tanesia was scheduled to have a cesarean section at Brooklyn Methodist Hospital.[113] However, shortly after her scheduled cesarean, her doctor changed the delivery to another hospital where he had privileges, SUNY Downstate.[114] Given the hospital's negative reviews, this change caused Walker severe stress.[115] Her fear was not unreasonable. SUNY Downstate, which primarily offers care to Black patients, has one of the highest complication rates for hemorrhage across three states: New York, Illinois, and Florida.[116] A survey revealed that sixty-two percent of women at SUNY Downstate who experienced hemorrhage while giving birth suffered from severe complications, a rate almost double that of other hospitals in New York.[117]

Walker gave birth at SUNY Downstate and began feeling pain shortly after childbirth.[118] Unfortunately, she died later that same day.[119] Walker was educated, financially stable, and lived a healthy lifestyle.[120] Thus, she had no risk factors for death after her cesarean section. A blood clot was the only explanation doctors gave.[121] To prevent blood clots, other hospitals provide blood thinners to all women undergoing cesarean section.[122] SUNY Downstate, a lower-quality, high Black-serving hospital, does not ensure access to this essential service.[123] If Walker had given birth at a higher-quality hospital, she might still be alive.

II. CONNECTING THE DOTS: THE ANTITRUST DIMENSION OF THE MATERNAL MORTALITY CRISIS IN AMERICA

The previous Part examined the maternal mortality crisis in the United States from a public health perspective. It identified the relationship between the social determinants of health and the high rates of maternal mortality and morbidity disproportionately impacting lower-income individuals and communities of color. It also showed that, due to the structural racism which pervades the U.S. health care system, Black populations receive lower-quality

112. Waldman, *supra* note 110.

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.* ("Three miles away from Downstate, at a Brooklyn hospital that has a smaller concentration of black patients, and a lower complication rate related to hemorrhages, Maimonides Medical Center gives blood thinners to nearly all . . . mothers who undergo cesarean sections or have other risk factors.").

123. *Id.*

obstetric services. As a result, the most vulnerable among us suffer from poor maternal health.

Part II illustrates that the public health perspective of the maternal mortality crisis is only part of the story. Here, Part II shows that mergers among hospitals, especially in underserved areas, contribute to the high rates of maternal death. By doing so, this Part demonstrates that the maternal mortality crisis plaguing the nation is also a failure of antitrust law.

This is true for at least three reasons. First, hospital mergers, especially in rural communities, lead to the elimination of vital health care services including obstetric care, causing maternal care deserts. Second, they increase the market power of hospitals in the labor market, which allows hospitals to suppress the wages of workers in the hospital sector. Because jobs in the hospital industry are primarily occupied by female workers, these mergers harm women the most. The less disposable income female workers have, the less likely it is that they can afford quality housing, healthy food, and good insurance coverage—factors that contribute to a healthy pregnancy. Third, mergers among hospitals exacerbate the burnout that providers of maternal care experience, and research indicates that higher levels of burnout lead to higher rates of medical error and ultimately death.

A. *HOW DO HOSPITAL MERGERS WORSEN THE MATERNAL MORTALITY CRISIS IN THE UNITED STATES?*

1. Impact on Output Markets: Reduced Access to Obstetric Care

Childbirth is the leading cause of hospitalization in the United States.[124] Despite that, since 2005, two hundred rural hospitals have closed their doors, leaving more than fifty percent of rural counties with no access to hospital obstetric care.[125] Consequently, eighteen million women of reproductive age in rural communities face high barriers to receiving obstetric services.[126] This especially affects residents in Mississippi, Arkansas, and Ohio: Residents of certain counties in these states are often forced to travel to more populous counties to receive maternal care and deliver their babies.[127] This raises the question of what is causing this closure epidemic.

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124. Hung et al., *supra* note 18, at 1663.

125. Lexa Giragosian, *Addressing the Impact of Rural Hospital Closures on Maternal and Infant Health*, ASS'N STATE & TERRITORIAL HEALTH OFFS. (June 20, 2023), https://www.astho.org/communications/blog/addressing-impact-rural-hospital-closures-on-maternal-infant-health [https://perma.cc/87ZD-RR46].

126. Hung et al., *supra* note 18, at 1663.

127. Amir Masoud Forati et al., *The Economic Case for Investing in Maternal Health*, HEARTLAND FORWARD (May 1, 2024), https://heartlandforward.org/case-study/the-economic-case-for-investing-in-maternal-health [https://perma.cc/FK3C-99JC] ("The out-of-county rate for Mississippi is 51%, meaning one of every two pregnant women deliver their baby in a county different from the one in which they live. Arkansas and Louisiana are slightly better off, with rates around 40%, while Ohio is better off with only 34% of women experiencing an out-of-county childbirth.").

Rural communities in the United States are suffering from a severe shortage of physicians.[128] Although rural populations account for twenty percent of the U.S. population, only ten percent of physicians in the nation provide services in underserved areas.[129] Because physicians are a key input for the provision of health care services, this uneven distribution of health care professionals undermines hospitals' ability to remain in their communities, with devastating outcomes for the health and well-being of rural residents.[130]

In addition, because rural communities are characterized by low population density, rural hospitals serve fewer patients than their urban counterparts.[131] As a result, they are unable to achieve the scale necessary to cover fixed costs and improve profit margins, which undermines their financial stability and heightens their risk of closure.[132] This is especially the case for obstetric care hospitals.[133] An empirical study explored the primary reasons why hospitals in rural America discontinue obstetric care.[134] The study found that rural hospitals treat lower birth volumes, which contributes to their financial distress and, ultimately, their closure.[135]

But low population density is not the only reason why rural hospitals treat a lower volume of patients as compared to urban hospitals. Higher-income rural patients who have private health insurance often bypass their local hospitals to receive obstetric care from higher-quality hospitals.[136] Because rural hospitals have fewer resources than urban hospitals, they invest less in

128. Elaine K. Howley, *The U.S. Physician Shortage Is Only Going to Get Worse. Here Are Potential Solutions*, TIME (July 25, 2022, 4:07 PM), https://time.com/6199666/physician-shortage-challenges-solutions [https://perma.cc/8WD9-BSRQ]; *see also* Scott A. Shipman et al., *The Decline in Rural Medical Students: A Growing Gap in Geographic Diversity Threatens the Rural Physician Workforce*, 38 HEALTH AFFS. 2011, 2011–12 (2019).

129. *See* AM. HOSP. ASS'N, RURAL REPORT: CHALLENGES FACING RURAL COMMUNITIES AND THE ROADMAP TO ENSURE LOCAL ACCESS TO HIGH-QUALITY, AFFORDABLE CARE 5 (2019), https://www.aha.org/system/files/2019-02/rural-report-2019.pdf [https://perma.cc/ABS3-YTDQ].

130. *Id.* at 7.

131. *Id.* at 3–4.

132. *Id.* at 3.

133. Alexandra Schumm, *Maternal Care Deserts Expand Amid Persistent Wave of OB, Maternity Service Closures*, CHARTIS (Feb. 2, 2024), https://www.chartis.com/insights/maternal-care-deserts-expand-amid-persistent-wave-ob-maternity-service-closures [https://perma.cc/9XT6-MQ22]; Claire Rush & Laura Ungar, *Rural Hospitals Are Closing Maternity Wards. People Are Seeking Options to Give Birth Closer to Home*, ASSOCIATED PRESS (Sept. 17, 2023, 9:08 AM), https://apnews.com/article/birthing-rural-hospitals-maternity-care-births [https://perma.cc/674H-W5D3]; *see also* Alexander Willis, *'It's Going to Be a Catastrophe;' Concerns Grow over Maternity Unit Closures*, ALA. DAILY NEWS (Oct. 26, 2023), https://aldailynews.com/its-going-to-be-a-catastrophe-concerns-grow-over-maternity-unit-closures [https://perma.cc/C8JW-TXFJ].

134. Hung et al., *supra* note 18, at 1666–67.

135. *Id.*

136. *See Patterns of Hospital Bypass and Inpatient Care-Seeking by Rural Residents*, CECIL G. SHEPS CTR. FOR HEALTH SERVS. RSCH., https://www.shepscenter.unc.edu/product/patterns-of-hospital-bypass-and-inpatient-care-seeking-by-rural-residents [https://perma.cc/UKP3-ZYSN]; Willis, *supra* note 133.

medical technologies and infrastructure improvements.[137] This motivates higher-income rural residents with better coverage to obtain obstetric services at urban hospitals.[138] Deprived of this privately insured patient base, rural hospitals primarily rely on Medicaid patients to remain financially viable.[139] Since Medicaid pays significantly lower reimbursement rates than private health insurers, rural hospitals face heightened financial challenges relative to their urban counterparts, thereby accelerating their risk of closure.[140]

To avoid this fate and stay afloat, some hospitals in underserved communities choose to be acquired by their closest competitors.[141] By merging, these hospitals hope to receive an infusion of capital, improve their profit margins, and continue treating their patients.[142] Nonetheless, hospital mergers, especially in rural areas, restrict rather than expand access to obstetric care. This is because following the merger, acquired rural hospitals often experience a reduction in the already low availability of health care services, including obstetric care.[143] A study examining the relationship between hospital mergers in rural areas and access to maternal care reveals that, although almost 75% of hospitals in rural America offered maternal care in the pre-merger period, only 61.1% offered maternal care services post-merger.[144] The rural hospitals who chose to merge were more likely than hospitals that remained independent to eliminate maternal care, especially in the first and second year following the merger.[145] Another study also points to similar conclusions, illustrating that after the merger was complete, the affiliating rural hospitals experienced a 7% to 14% reduction in the availability of obstetric care.[146]

When hospitals eliminate access to health care services, vulnerable populations no longer receive much-needed care.[147] When a hospital in a rural town closes its obstetric unit, residents are forced to travel as far as

137. *See* JANE WISHNER, PATRICIA SOLLEVELD, ROBIN RUDOWITZ, JULIA PARADISE & LARISA ANTONISSE, A LOOK AT RURAL HOSPITAL CLOSURES AND IMPLICATIONS FOR ACCESS TO CARE: THREE CASE STUDIES 5 (2016), https://files.kff.org/attachment/issue-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care [https://perma.cc/U8K9-DF73].

138. *Id.*

139. *Id.*

140. *Id.* For a thorough discussion on the causes of the hospital closure crisis in the United States, see also Stavroulaki, *supra* note 34, at 950–56.

141. Amy Phillips, *The Consequences of U.S. Hospital Consolidation on Local Economies, Healthcare Providers, and Patients*, WASH. CTR. FOR EQUITABLE GROWTH (Nov. 15, 2023), https://equitablegrowth.org/research-paper/the-consequences-of-u-s-hospital-consolidation-on-local-economies-healthcare-providers-and-patients [https://perma.cc/7D4C-6PMV].

142. *See* O'Hanlon et al., *supra* note 30, at 2096.

143. *Id.* at 2100–01; *see also* Henke et al., *supra* note 31, at 1634.

144. Henke et al., *supra* note 31, at 1632.

145. *Id.* at 1634.

146. O'Hanlon et al., *supra* note 30, at 2100.

147. *See* WISHNER ET AL., *supra* note 137, at 8.

seventy miles from their homes to receive maternal care.[148] This can be nearly impossible for some rural residents, as many do not even have access to a vehicle.[149] For others, taking time off from work or arranging childcare to drive vast distances to receive obstetric services is simply not an option.[150] Due to these barriers, rural residents often skip doctor visits and forego necessary care.[151]

These risks are not merely hypothetical. One study explored the impact of increased travel time on the utilization of prenatal care in rural Kansas, and found that when women must travel more than twenty miles to receive prenatal care, they make fewer prenatal visits, which may lead to inadequate care.[152] Another study examined the structural barriers rural residents in Arizona face in accessing postpartum care.[153] The long distances rural residents must travel to obtain health care services, combined with the lack of a robust transportation system and childcare support, deter them from utilizing postpartum care.[154]

Moreover, traveling long distances to obtain time-sensitive care increases both the risk of health complications and the stress that rural women and their families face when it is time to give birth.[155] Many obstetric emergencies require a medical response within minutes, yet rural residents often must drive for hours to reach a hospital.[156] When people are forced to travel great distances for care and delivery, mortality rates increase at alarming rates.[157] One 2022 report illustrates this risk, showing that rural women face a nine percent greater probability of maternal morbidity and mortality compared to women in urban areas with easier access to obstetric care.[158] Women living in

148. Amy Yurkanin, *Some Pregnant Alabama Women Travel as Far as 70 Miles for Care, Report Finds*, AL.COM (Aug. 01, 2023, 6:00 AM), https://www.al.com/news/2023/08/some-pregnant-alabama-women-travel-as-far-as-70-miles-for-care-report-finds.html [https://perma.cc/4BZD-4KMV].

149. CARRIE HENNING-SMITH, ALEX EVENSON, AMANDA CORBETT, KATY KOZHIMANNIL & IRA MOSCOVICE, UNIV. MINN. RURAL HEALTH RSCH. CTR., RURAL TRANSPORTATION: CHALLENGES AND OPPORTUNITIES 1–2 (2017), https://rhrc.umn.edu/wp-content/uploads/2019/01/1518734252UMRHRCTransportationChallenges.pdf [https://perma.cc/WPL6-PPFQ].

150. Abidemi Okechukwu et al., *Optimizing Postpartum Care in Rural Communities: Insights from Women in Arizona and Implications for Policy*, 28 MATERNAL & CHILD HEALTH J. 1148, 1150 (2024).

151. *Id.*

152. Michael Kennedy, Kelsie Kelly & Corinna Lemke, *The Adequacy of Prenatal Care in Rural Kansas Related to Distance Traveled*, 15 KAN. J. MED. 437, 440 (2022) ("Women traveling ≥ 20 miles to receive prenatal care had statistically significantly lower number of prenatal visits during their second trimester of pregnancy and overall. Women also self-reported less prenatal care services, indicating a possible decrease in the adequacy of prenatal care.").

153. Okechukwu et al., *supra* note 150, at 1150.

154. *Id.*

155. Dina Fine Maron, *Maternal Health Care Is Disappearing in Rural America*, SCI. AM. (Feb. 15, 2017), http://www.scientificamerican.com/article/maternal-health-care-is-disappearing-in-rural-america [https://perma.cc/K43H-9KMC]; *see* Stavroulaki, *supra* note 34, at 948.

156. *See* Cullen, *supra* note 17.

157. *See id.*

158. BRIGANCE ET AL., *supra* note 20, at 11.

underserved areas also face an increased risk of preterm birth compared to women in urban areas.[159] Loss of obstetric services correlates with low birth weight, which increases the risk of morbidity, mortality, and negatively impacts the quality of life in the long term.[160] These health complications and deaths could be prevented if women in rural areas had timely access to obstetric care.[161]

Loss of obstetric care worsens not only gendered health inequities, but also racial disparities nationwide.[162] A study assessing how loss of obstetric units affected women's health in New Jersey between 2006 and 2015 reveals that "Black women had the highest severe maternal morbidity rates, increasing from 1.2% in 2006 to 2.3% in 2015."[163] Additionally, counties with higher percentages of non-Hispanic Black women and lower-income individuals are at a higher risk of losing access to hospital-based obstetric services.[164] Hence, any reduction in the availability of obstetric services can exacerbate the disproportionate barriers lower-income individuals and communities of color face in obtaining maternal care and increase their already higher rates of maternal mortality and morbidity.

Data speak volumes: The U.S. Centers for Disease Control and Prevention ("CDC") reported that the rate of pregnancy-related deaths for Black women in the most rural areas was 59.3 deaths per 100,000 live births.[165] This rate was 19.7 deaths per 100,000 live births for white women living in the same

159. Katy B. Kozhimannil, Peiyin Hung, Carrie Henning-Smith, Michelle M. Casey & Shailendra Prasad, *Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States*, 319 JAMA 1239, 1240–41 (2018).

160. Dan Sontheimer, Larry W. Halverson, Laird Bell, Mark Ellis & Pamela Wilbanks Bunting, *Impact of Discontinued Obstetrical Services in Rural Missouri: 1990-2002*, 24 J. RURAL HEALTH 96, 97 (2008) ("Rates of low birth-weight neonates originating from service areas of hospitals that had ceased birthing services were significantly increased compared to data before hospital OB closure. Low birth weight infants may be at increased risk for morbidity, mortality, increased hospital services and negative impact on long-term quality of life.").

161. MADELINE GOCHEE, KIARA ORTIZ, HALLE TROADEC & FIONA SLEIGH, MATERNITY CARE DESERTS IN RURAL NEW HAMPSHIRE 8–9 (2022), https://rockefeller.dartmouth.edu/sites/rockefeller.prod/files/2122-06_maternity_care_deserts_report.pdf [https://perma.cc/6VA4-L4TT].

162. Pinka Chatterji, Chun-Yu Ho & Xue Wu, *Obstetric Unit Closures and Racial/Ethnic Disparity in Health* 4–6 (Nat'l Bureau of Econ. Rsch., Working Paper No. 30986, 2023), https://www.nber.org/system/files/working_papers/w30986/w30986.pdf [https://perma.cc/38L3-HXFT]; *see* GOCHEE ET AL., *supra* note 161, at 8.

163. Alecia J. McGregor, Peiyin Hung, David Garman, Ndidiamaka Amutah-Onukagha & Joy A. Cooper, *Obstetrical Unit Closures and Racial and Ethnic Differences in Severe Maternal Morbidity in the State of New Jersey*, AM. J. OBSTETRICS & GYNECOLOGY MATERNAL-FETAL MED. 1 (Nov. 2021), https://www.sciencedirect.com/science/article/pii/S2589933321001750/pdfft?md5=b26573f680aof7c1cf51f9ef44a9c684&pid=1-s2.0-S2589933321001750-main.pdf [https://perma.cc/BK2T-MQ3Y].

164. Hung et al., *supra* note 18, at 1667 ("We found that counties with higher proportions of non-Hispanic black women and lower median household incomes had higher odds of losing all hospital obstetric services.").

165. U.S. GOV'T ACCOUNTABILITY OFF., GAO-21-283, MATERNAL MORTALITY AND MORBIDITY 19 (2021).

areas.[166] Black women are three times more likely to suffer a pregnancy-related death in America than white women.

In brief, mergers among hospitals in underserved areas aggravate the maternal care desert problem that harms rural populations. After a merger is complete, the acquiring hospital frequently cuts the essential health care services offered by the acquired rural hospital, especially obstetric care. As a result, millions of women in rural communities are left with no access to obstetric services, which deteriorates their maternal health.

2. Impact on Labor Markets: Lower Wages and Bad Working Conditions

Hospital mergers (especially in underserved areas) allow hospitals to increase their market power in the labor market. This leads to inferior working conditions and lower wages for employees in the hospital sector. The reason is simple: When employers do not rigorously compete to attract labor, their incentives to improve the salaries and the working conditions of their employees are undermined.

Studies validate those concerns. One study examined the effect of eighty-four hospital mergers on the wages of nurses between 2000 and 2010.[167] It found that those mergers, which led to a significant increase in concentration in the hospital industry, also slowed wage growth for nurses.[168] "Following such mergers, the annual increase in nurses' wages in these highly concentrated markets was 1.7 percent slower than in markets characterized by lower concentration levels."[169] A recent study drew similar conclusions, showing that the rising consolidation in the hospital sector has led to a significant cut in the wages of nurses in localized labor markets.[170] For every 0.1 point increase in the levels of concentration in the industry, the "real nurse wage growth was $0.56 less per hour."[171]

This should not be surprising, given that nurses constitute a specialized labor force. For this reason, their specialized knowledge and skills are not easily transferable to employers in other sectors of the economy.[172] Thus, if following a hospital merger there is only one hospital–employer in a small

166. *Id.*

167. Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, 111 AM. ECON. REV. 397, 398, 406 (2021).

168. *Id.*

169. *Id.* For a similar discussion, see also Stavroulaki, *supra* note 34, at 971.

170. Sylvia A. Allegretto & Dave Graham-Squire, *Monopsony in Professional Labor Markets: Hospital System Concentration and Nurse Wages* 17 (Inst. for New Econ. Thinking, Working Paper No. 197, 2023), https://www.ineteconomics.org/uploads/papers/WP_197-Allegretto-HospCons.pdf [https://perma.cc/C2VY-Q8JT].

171. *Id.* Market concentration levels are measured by the Herfindahl–Hirschman Index, with a higher value indicating more concentration. *See* notes 268–69 and accompanying text; *see also* Charles R. Link & John H. Landon, *Monopsony and Union Power in the Market for Nurses*, 41 S. ECON. J. 649, 657–58 (1975) (for the effects of monopsony power on the wages of nurses).

172. *See* Link & Landon, *supra* note 171, at 649.

town, nurses have no choice than to sell their specialized labor to this one employer. This reduces nurses' negotiation power and undermines their ability to obtain higher pay.[173]

Additionally, as noted, mergers affect not only the salaries but also the working conditions of employees in the hospital sector.[174] A 2005 study examining the impact of hospital mergers on nurses' working conditions nationwide concluded that, in the post-merger era, nurses are consistently required to work harder and face significantly greater demands.[175] Another study points to similar conclusions, showing that after a merger is complete, nurses often experience higher levels of burnout, increased responsibilities, and greater job dissatisfaction.[176]

Mergers among hospitals are also associated with a reduction in clinical staff, including nurses.[177] Understaffed hospitals exacerbate the already high levels of fatigue and stress nurses experience. In turn, this encourages them

173. Philips, *supra* note 141 ("This power to suppress wages is the result of a combination of three characteristics: nurse skills are healthcare industry-specific; hospitals are the dominant employer in the healthcare industry for their skills; and hospital consolidation can lead to increased market concentration. This all means that nurses, of whom more than half are employed by hospitals, are left in labor markets with one or only a few hospital employers who can then exploit that labor market power to suppress wages.").

174. ANDREA FLYNN, RAKEEN MABUD & EMMA CHESSEN, THE PLIGHT OF HEALTH CARE IN RURAL AMERICA: HOW HOSPITAL MERGERS AND CLOSURES HARM WOMEN 8–9 (2019), https://rooseveltinstitute.org/wp-content/uploads/2020/07/RI_Hospital-Mergers_Issue-brief_201905.pdf [https://perma.cc/4QVE-7FTJ].

175. Janet Currie, Mehdi Farsi & W. Bentley MacLeod, *Cut to the Bone? Hospital Takeovers and Nurse Employment Contracts*, 58 INDUS. & LAB. RELS. REV. 471, 490–91 (2005); *see also* Sarah Nogues & Diane-Gabrielle Tremblay, *Nurses' Work Experiences 5 Years After Hospital Merger in the Province of Quebec/Canada—An Exploratory Qualitative Study*, 38 INT'L J. HEALTH PLAN. & MGMT. 1851, 1859–60 (2023).

176. Bonnie M. Jennings, *Restructuring and Mergers*, *in* PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES 2-93, 2-98 (Rhonda G. Hughes ed., 2008) ("[R]estructuring efforts and mergers can be related to lower job satisfaction among nurses and increased burnout."); Press Release, Nat'l Nurses United, Nurses Call on Federal Trade Commission and Department of Justice to Strengthen Guidelines to Limit Negative Effects of Mergers, Acquisitions on Patients and Healthcare Workers (Apr. 21, 2022), https://www.nationalnursesunited.org/press/nurses-call-on-ftc-and-doj-to-strengthen-merger-guidelines [https://perma.cc/3GJE-BN9Z] ("[M]ergers and acquisitions 'dilute[] the bargaining power of workers over terms and conditions of employment' with negative effects on wages and working conditions like safe staffing levels. In addition to harming patient safety, 'intentional understaffing, lack of health and safety precautions, and other poor working conditions have driven nurses away from bedside nursing.'" (quoting the union's lead regulatory policy specialist)); *see also* Georgia D. Harrison & Kathleen E. Zavotsky, *Are Critical Care Nurses More Likely to Leave After a Merger?*, J. NURSING MGMT., Sept. 2018, at 34–35; Stavroulaki, *supra* note 34, at 972.

177. Elena Andreyeva, Atul Gupta, Catherine Ishitani, Malgorzata Sylwestrzak & Benjamin Ukert, *The Corporatization of Independent Hospitals*, 2 J. POL. ECON. MICROECON. 602, 607 n.6 (2024) ("The decline in personnel spend is explained mostly by a reduction in employment. . . . We detect a 14% reduction in licensed practical nurses (LPNs), as well as a decline in a composite group that includes social workers, technicians, and aides."); *see also Impact of Hospital Mergers*, HEALTH PROS. & ALLIED EMPS., https://www.hpae.org/issues/merge-monitor/impact-hospital-mergers [https://perma.cc/J6QQ-4A96].

to leave their profession en masse.[178] As a result, the workload for the nurses left behind continues to increase,[179] which contributes to higher rates of burnout. Increased levels of burnout correlate with a higher risk of suicide,[180] which is particularly concerning given the elevated suicide rates in the nursing industry.[181] Between 2007 and 2018, the suicide rates among nurses were significantly higher than among the general population in the United States.[182]

Given these concerns, National Nurses United ("NNU"), the largest union of registered nurses in the nation, urged the Federal Trade Commission ("FTC") and the Department of Justice ("DOJ") to increase antitrust enforcement in the hospital sector so as to combat hospitals' exercise of market power in labor markets.[183] In her comments, Carmen Comsti, NNU's lead regulatory policy specialist, thoroughly explained the ways hospitals exploit their market power in the labor market, which in turn severely harms the well-being of nurses as well as population health.[184] Hospitals' monopsony power, Comsti said, has limited patients' access to care, and has "depresse[d] wages and dilute[d]

178. GRACE DUNN, LARISSA PETRUCCI, FRANK MANZO IV & ROBERT BRUNO, REGISTERED NURSING IN CRISIS: NATIONAL SURVEY REVEALS INSUFFICIENT STAFFING, SEVERE MORAL DISTRESS, AND HIGH TURNOVER 3 (2022), https://illinoisupdate.com/wp-content/uploads/2022/06/pmcr-ilepi-registered-nurses-in-crisis-final.pdf [https://perma.cc/F8C5-E5YQ]; *see The Crisis of Nurse Burnout: Understanding and Addressing the Challenges*, EMBODIED LABS NEWS (Oct. 17, 2024), https://www.embodiedlabs.com/news/the-crisis-of-nurse-burnout-understanding-and-addressing-the-challenges [https://perma.cc/77NM-PFAL]; Linda H. Aiken, Sean P. Clarke, Douglas M. Sloane, Julie Sochalski & Jeffrey H. Silber, *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction*, 288 JAMA 1987, 1987 (2002) ("Job dissatisfaction among hospital nurses is 4 times greater than the average for all US workers, and 1 in 5 hospital nurses report that they intend to leave their current jobs within a year."); K. Jane Muir, Joshua Porat-Dahlerbruch, Jacqueline Nikpour, Kathryn Leep-Lazar & Karen B. Lasater, *Top Factors in Nurses Ending Health Care Employment Between 2018 and 2021*, JAMA NETWORK OPEN 3–6 (Apr. 9, 2024), https://doi.org/10.1001/jamanetworkopen.2024.4121 [https://perma.cc/6QNB-XUQX].

179. DUNN ET AL., *supra* note 178, at 3, 19.

180. Elizabeth A. Kelsey et al., *Suicidal Ideation and Attitudes Toward Help Seeking in U.S. Nurses Relative to the General Working Population*, 121 AM. J. NURSING 24, 25 (2021).

181. Matthew A. Davis, Benjamin A.Y. Cher, Christopher R. Friese & Julie P.W. Bynum, *Association of US Nurse and Physician Occupation with Risk of Suicide*, 78 JAMA PSYCHIATRY 651, 652 (2021); *see* Mark Olfson, Candace M. Cosgrove, Melanie M. Wall & Carlos Blanco, *Suicide Risks of Health Care Workers in the US*, 330 JAMA 1161, 1165 (2023) ("Health care workers overall, including registered nurses, health technicians, and health care support workers, were at increased risk of suicide compared with non-health care workers."); Tim Cunningham & Rosa M. Gonzalez-Guarda, *Burned Out on Burnout—The Urgency of Equity-Minded Structural Approaches to Support Nurses*, JAMA HEALTH F. 1 (Dec. 14, 2023), https://doi.org/10.1001/jamahealthforum.2023.5249 [https://perma.cc/R5E6-UR7T].

182. Davis et al., *supra* note 181, at 652 ("[T]he suicide incidence rates per [100,000 people] in 2017–2018 among women were 17.1 for nurses, 10.1 for physicians, and 8.6 for the general population . . . .").

183. Press Release, Nat'l Nurses United, *supra* note 176.

184. *Id.*

the power of workers to advocate for better working conditions and patient safety."[185]

Because hospital consolidation leads to poorer wages and inferior working conditions for employees in the hospital industry, it can also harm workers' health. Importantly, the majority of workers in the hospital industry, such as nurses, care workers, and medical technicians, are women. Indeed, 89.9% of registered nurses, 83.7% of personal care workers and 53.8% of food-service workers are female workers.[186] For this reason, hospital consolidation, especially in underserved communities, can disproportionately affect the wealth and health of female workers in the hospital sector.[187] Additionally, it can worsen their maternal health and thus contribute to the high mortality rates lower-income individuals and communities of color face. *How?*

There are several interrelated answers to this question. For one, suppressed wages and bad working conditions can lead to worse health outcomes for workers in the hospital industry, due to the strong link between a person's socioeconomic status and health. Lower-income workers have less disposable income to invest in quality housing and nutritious food—factors that improve an individual's well-being but also maternal health. As explained, bad housing conditions correlate with higher asthma prevalence and high blood pressure,[188] conditions that can deteriorate a person's maternal health.[189] Similarly, housing insecurity has been associated with poor health[190] and increased risk of severe maternal morbidity.[191]

185. *Id.* For a similar discussion of how monopsony power enables hospitals to suppress wages and impose adverse working conditions, see generally Stavroulaki, *supra* note 34.

186. RAKEEN MABUD & JESS FORDEN, LEFT BEHIND: SNAPSHOTS FROM THE 21ST CENTURY LABOR MARKET 49–52 (2018), https://rooseveltinstitute.org/wp-content/uploads/2020/07/RI-Left-Behind-201810.pdf [https://perma.cc/M3QE-U32M].

187. FLYNN ET AL., *supra* note 174, at 6 ("[H]ealth care jobs comprise six major occupational groups: health care professionals, social service workers, medical technicians, health aides and assistants, food service workers, and cleaning service workers. Jobs in these occupational groups are dominated by women, many of who[m] are immigrant women and women of color.").

188. *Quality of Housing*, *supra* note 11.

189. Donald K. Hayes, David W. Feigal, Ruben A. Smith & Loretta J. Fuddy, *Maternal Asthma, Diabetes, and High Blood Pressure Are Associated with Low Birth Weight and Increased Hospital Birth and Delivery Charges; Hawai'i Hospital Discharge Data 2003-2008*, 73 HAW. J. MED. & PUB. HEALTH 49, 49 (2014) ("Chronic conditions such as high blood pressure, diabetes, and asthma are also related to adverse reproductive health outcomes including the morbidity associated with Cesarean delivery, eclampsia, perinatal infections, preterm delivery, low birth weight, macrosomia, infant death, and increased health care utilization.").

190. LAUREN A. TAYLOR, HOUSING AND HEALTH: AN OVERVIEW OF THE LITERATURE 1–2 (2018), https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/hpb_2018_rwjf_01_w.pdf [https://perma.cc/KAW9-FXBC].

191. Muchomba et al., *supra* note 53, at 6–9 (highlighting the relationship between housing unaffordability and worse maternal health).

Moreover, lower-income individuals often live in food deserts.[192] People living in food deserts may be deprived of the quality food vital for a healthy pregnancy,[193] which can harm their maternal health. As Part I indicated, malnutrition correlates with obesity,[194] which increases the risk of several pregnancy complications and can negatively impact newborns' long-term health.[195]

What's more, as noted, hospital mergers increase the levels of burnout health care workers experience, and high levels of anxiety and stress increase the risk of pregnancy complications and can negatively affect infants' development and health as well.[196] Work-related burnout and stress, as well as lack of workplace support, are associated with depressive symptoms during pregnancy and even miscarriage.[197]

There are also less obvious, but equally insidious correlations. When essential workers in the hospital industry, such as nurses, suffer from worse health outcomes and higher levels of stress, the quality of care they provide suffers as well. Because health care workers are essential inputs for the provision

192. Brooks, *supra* note 13.

193. U.S. AGENCY FOR INT'L DEV., ROLE OF NUTRITION IN PREVENTING CHILD AND MATERNAL DEATHS: MULTI-SECTORAL NUTRITION STRATEGY 2014–2025 TECHNICAL GUIDANCE BRIEF 4 (2017), https://content.sph.harvard.edu/wwwhsph/sites/2413/2017/10/role-of-nutrition-preventing-child-maternal-deaths.pdf [https://perma.cc/AFT6-7Q2P] ("Optimal maternal nutrition is an important contributor to the survival of both the mother and child and promotes women's overall health, productivity, and well-being.").

194. Tanumihardjo et al., *supra* note 68, at 1966.

195. Kate J. Fitzsimons, Jo Modder & Ian A. Greer, *Obesity in Pregnancy: Risks and Management*, 2 OBSTETRIC MED. 52, 52 (2009) ("[W]omen with obesity are at increased risk of miscarriage, gestational diabetes, preeclampsia, venous thromboembolism, induced labour, caesarean section, anaesthetic complications and wound infections . . . ."); *see also* Darah Dilmaghani, Karl A. Nath & Vesna D. Garovic, *Increasing Maternal Mortality in the United States: Looking Beneath and Beyond the Numbers*, 99 MAYO CLINIC PROC. 873, 874 (2024) (explaining that obesity contributes significantly to cardiovascular risk factors in pregnancy); Lois Kankowski et al., *The Impact of Maternal Obesity on Offspring Cardiovascular Health: A Systematic Literature Review*, FRONTIERS ENDOCRINOLOGY 2 (May 20, 2022), https://doaj.org/article/b3fd514b873b49c6876oc2fb38e162a6 [https://perma.cc/JMX9-F73B] ("Maternal obesity is a risk factor for numerous pregnancy complications, including miscarriage, pre-eclampsia, and gestational diabetes mellitus . . . .").

196. Mary E. Coussons-Read, *Effects of Prenatal Stress on Pregnancy and Human Development: Mechanisms and Pathways*, 6 OBSTETRIC MED. 52, 52 (2013) ("Prenatal stress can have significant effects on pregnancy, maternal health and human development across the lifespan. These effects may occur directly through the influence of prenatal stress-related physiological changes on the developing fetus, or indirectly through the effects of prenatal stress on maternal health and pregnancy outcome which, in turn, affect infant health and development."); *see also Stress and Pregnancy*, MARCH OF DIMES (Feb. 2023), https://www.marchofdimes.org/find-support/topics/pregnancy/stress-and-pregnancy [https://perma.cc/RNM3-62TQ].

197. María del Rocío Corchero-Falcón et al., *Risk Factors for Working Pregnant Women and Potential Adverse Consequences of Exposure: A Systematic Review*, 68 INT'L J. PUB. HEALTH 11–12 (Feb. 16, 2023), https://www.ssph-journal.org/journals/international-journal-of-public-health/articles/10.3389/ijph.2023.1605655/full [https://perma.cc/LE5E-TMUB].

of health care services, workers who experience worse health outcomes and higher levels of burnout may be unable to offer the best possible care.[198]

Several studies demonstrate the relationship between providers' burnout and lower-quality care. One such study examined the correlation between nurse staffing levels and patient outcomes, concluding that hospitals with high patient-to-nurse ratios are associated with higher levels of burnout for nurses and higher mortality rates for surgical patients.[199] Another study reached similar conclusions, highlighting that nurses' burnout and job dissatisfaction are associated with increased levels of missed care.[200] Researchers also examined the relationship between maternal care providers' burnout and patient safety during the COVID-19 pandemic.[201] They found that workers who experienced burnout, especially nurses, reported worse patient safety attributes, such as increased medical errors and reduced ability to focus on work.[202]

Unfortunately, the gender, economic, and health inequities created by hospital consolidation in the United States disproportionately harm communities of color. Although Black female workers are more overrepresented than any other race in the health care industry, they are overwhelmingly concentrated in the lowest-paid and the most physically demanding jobs.[203] Indeed, more

198. Lambert Zixin Li et al., *Nurse Burnout and Patient Safety, Satisfaction, and Quality of Care: A Systematic Review and Meta-Analysis*, 7 JAMA NETWORK OPEN 10–11 (Nov. 5, 2024), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2825639 [https://perma.cc/LS74-GQMV] ("The association of nurse burnout with patient safety was persistent over time, and the association with quality of care was increasingly negative over 3 decades, even after accounting for the COVID-19 pandemic. This finding is concerning considering decades of national and organizational efforts for quality improvement."); *see also* Jin Jun, Melissa M. Ojemeni, Richa Kalamani, Jonathan Tong & Matthew L. Crecelius, *Relationship Between Nurse Burnout, Patient and Organizational Outcomes: Systematic Review*, INT'L J. NURSING STUD. 10–11 (July 2021), https://www.sciencedirect.com/science/article/pii/S0020748921000742 [https://perma.cc/RQ89-TBTM] (explaining that nurse burnout is associated with worsening safety and quality of care, decreased patient satisfaction, and nurses' organizational commitment and productivity).

199. Aiken et al., *supra* note 178, at 1987 (finding that surgical patients in hospitals with high patient-to-nurse ratios experience greater complications and nurses are more likely to experience burnout and job dissatisfaction).

200. Rebecca R.S. Clark & Eileen Lake, *Burnout, Job Dissatisfaction and Missed Care Among Maternity Nurses*, 28 J. NURSING MGMT. 2001, 2001–02 (2020) ("Missed care was measured as leaving any of 14 care activities undone due to lack of time or resources on the most recent shift a nurse worked.").

201. Eman Haidari et al., *Maternal and Neonatal Health Care Worker Well-Being and Patient Safety Climate Amid the COVID-19 Pandemic*, 41 J. PERINATOLOGY 961, 963–64 (2021).

202. *Id.* at 966.

203. Janette Dill & Mignon Duffy, *Structural Racism and Black Women's Employment in the US Health Care Sector*, 41 HEALTH AFFS. 265, 266 (2022); *see* Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J.L. MED. & ETHICS 518, 521–23 (2020) (noting that due to structural racism, home health care workers, who are primarily women of color are underpaid, work under unsafe working conditions and often lack health insurance); Kathryn E.W. Himmelstein & Atheendar S. Venkataramani, *Economic Vulnerability Among US Female Health Care Workers: Potential Impact of a $15-per-Hour Minimum Wage*, 109 AM. J. PUB. HEALTH 198, 199–200 (2019).

than twenty-three percent of Black women in the labor force are employed in the health care industry, and among this group, Black women have a forty-two percent probability of being either a licensed practical nurse or nursing aid.[204] Black women are less likely to be employed in higher-paying jobs in the health care sector, such as registered nurses, as compared to white women.[205]

In addition, Black nurses suffer from higher levels of burnout,[206] job dissatisfaction,[207] and higher suicide rates than white nurses.[208] Non-white nurses experience more racial microaggressions, higher emotional distress, and have a more negative view about the racial climate in their working

204. Dill & Duffy, *supra* note 203, at 269; *see Occupational Outlook Handbook: Nursing Assistants and Orderlies*, U.S. BUREAU LAB. STAT., https://www.bls.gov/ooh/healthcare/nursing-assistants.htm [https://perma.cc/AH74-JFEB] ("Nursing assistants provide basic care and help patients with activities of daily living."); *Occupational Outlook Handbook: Licensed Practical and Licensed Vocational Nurses*, U.S. BUREAU LAB. STAT., https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm [https://perma.cc/2DVX-XBS9] (Aug. 28, 2025) ("Licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) provide basic medical care."); Sarah Jividen, *What Are the Differences Between an RN and an LPN?*, NURSE.ORG (Aug. 9, 2025), https://nurse.org/resources/rn-vs-lpn [https://perma.cc/46JT-NT2A] ("RN and LPN differences lie in their educational requirements, licenses, and scope of practice. In general, LPN education is shorter, lowering the barrier to entry into the career field but restricting the LPN scope of practice. Conversely, RNs have longer education programs, and their resulting licensure offers a broader scope of practice, allowing RNs more independence in the workplace.").

205. Dill & Duffy, *supra* note 203, at 269.

206. Richard Smiley, Michaela Reid & Brendan Martin, *The Registered Nurse Workforce: Examining Nurses' Practice Patterns, Workloads, and Burnout by Race and Ethnicity*, J. NURSING REGUL., April 2024, at 65, 74 ("[T]he profile of BIPOC and Hispanic/Latino RNs was strikingly different from their White/Caucasian counterparts. Both subgroups, but particularly BIPOC RNs . . . were also more likely to report increased workloads during the pandemic and engage in travel nursing, which are both confirmed drivers of nurse burnout and intent to leave."); *see also* Charlotte Thomas-Hawkins, Linda Flynn, Peijia Zha & Sakura Ando, *The Effects of Race and Workplace Racism on Nurses' Intent to Leave the Job: The Mediating Roles of Job Dissatisfaction and Emotional Distress*, 70 NURSING OUTLOOK 590, 591, 594 (2022) [hereinafter *Nurses' Intent to Leave the Job*]; Cunningham & Gonzalez-Guarda, *supra* note 181, at 1; Charlotte Thomas-Hawkins, Peijia Zha, Linda Flynn & Sakura Ando, *Effects of Race, Workplace Racism, and COVID Worry on the Emotional Well-Being of Hospital-Based Nurses: A Dual Pandemic*, 48 BEHAV. MED. 95, 104–05 (2022) [hereinafter *Workplace Racism and COVID Worry*].

207. J. Margo Brooks Carthon, Jasmine L. Travers, Danielle Hounshell, Idorenyin Udoeyo & Jesse Chittams, *Disparities in Nurse Job Dissatisfaction and Intent to Leave: Implications for Retaining a Diverse Workforce*, 51 J. NURSING ADMIN. 310, 313 (2021) ("Black nurses reported higher job dissatisfaction (22.0% vs 14.9%, $P < .001$) and intent to leave their positions within a year (22.5% vs 14.5%, $P < .001$) than White nurses."); *cf.* Megan Doede, *Race as a Predictor of Job Satisfaction and Turnover in US Nurses*, 25 J. NURSING MGMT. 207, 212 (2017) ("[R]ace is a significant predictor of job satisfaction and turnover among the US nurses, with Asians having more favourable job satisfaction than white nurses overall, and black and Hispanic nurses having higher odds of intending to quit than white nurses, even while controlling for job dissatisfaction, a new finding.").

208. Bernadette Mazurek Melnyk, *Clinician Burnout Demands Urgent Action to Improve Population Health and Ensure Healthcare Quality and Safety*, OHIO STATE U. COLL. NURSING (Sept. 16, 2020), https://nursing.osu.edu/news/2021/05/10/clinician-burnout-demands-urgent-action-improve-population-health-and-ensure [https://perma.cc/K2K3-5QQP].

environment than white nurses.[209] Not surprisingly, non-white nurses are looking for the exit at higher rates than white nurses.[210]

Increased consolidation in the hospital industry can only increase those harmful effects for non-white nurses. As noted, mergers lead to lower wages and worse working conditions for nurses in the hospital industry. Thus, because Black nurses work in lower-paid, more hazardous jobs and experience higher levels of burnout and stress than their white counterparts, any merger in the health care sector that leads to worse salaries and more harmful employment conditions would have a disproportionate effect on their well-being and wealth. For the reasons explained above, hospital mergers can disproportionately harm their maternal health as well.

Yet, there are more reasons why hospital consolidation can cause a disproportionate harm on Black women's maternal health. As noted, health care workers' burnout undermines patient care. Studies further indicate that health care workers' burnout leads to lower-quality care, *especially* for communities of color. For example, a study examining the relationship between burnout and racial bias toward Black patients in resident physicians found that physicians' burnout is associated with higher levels of implicit bias against Black patients and more unfavorable attitudes toward them.[211] Another study found that physicians exhibiting higher levels of implicit bias toward Black patients "demonstrate fewer patient-centered behaviors during clinical interactions with [B]lack patients."[212] As a result, Black patients were less likely to trust their doctor, adhere to medical treatment, and have a follow up visit.[213] Given the high levels of burnout obstetric nurses and providers face,[214] this is particularly concerning. Indeed, due to their high rates of burnout, they may offer a lower quality of care to communities of color, which could contribute to the already wide racial disparities in maternal care.[215]

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209. *Workplace Racism and COVID Worry*, *supra* note 206, at 105 ("Compared to White nurses, nonwhite nurses reported higher emotional distress, more negative racial climates, more racial microaggressions, and higher levels of COVID worry.").

210. *Nurses' Intent to Leave the Job*, *supra* note 206, at 594; *see* Carthon et al., *supra* note 207, at 314.

211. Liselotte Dyrbye et al., *Association of Racial Bias with Burnout Among Resident Physicians*, JAMA NETWORK OPEN 10 (July 26, 2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2739043 [https://perma.cc/28G3-M6WA].

212. *Id.*

213. *Id.*

214. Sharifah Mohammed Faleh Al-Saluli et al., *The Role of Nurses in Obstetric Care: Comprehensive Review*, 7 J. INT'L CRISIS & RISK COMMC'N RSCH. 156, 159–60 (2024).

215. For a similar discussion, see Leandra Lacy & Lauren Fung, *Addressing the Black Maternal Health Crisis Requires Better Support for Black Health Care Workers*, URB. INST. (May 17, 2023), https://www.urban.org/urban-wire/addressing-black-maternal-health-crisis-requires-better-support-black-health-care [https://perma.cc/T9HY-XWAH] ("Providers who care for pregnant people and newborns have faced especially high rates of burnout in recent years. This is troubling for Black women, whose maternal mortality rate is three times higher than that of white women.").

In brief, hospital mergers harm people's maternal health in three ways. First, they often lead to the elimination of obstetric services causing maternal care deserts. Second, they lead to the reduction of wages and worsening of working conditions for employees in the hospital sector. Because the majority of employees working in the hospital industry are women, such mergers disproportionately affect their income, working conditions, and thus ultimately, their maternal health. Third, mergers contribute to the already high levels of burnout hospital workers experience. Research demonstrates that providers' burnout leads to lower-quality care, including obstetric services. Hence, by deteriorating providers' working conditions, hospital mergers undermine the quality of maternal care as well. These negative effects disproportionately harm the most vulnerable women: the poorest and communities of color.

III. FEMINIST HEALTH ANTITRUST: CAN ANTITRUST LAW MITIGATE THE MATERNAL MORTALITY CRISIS IN AMERICA?

The previous Part explored the antitrust dimension of the maternal mortality crisis in the United States, identifying the ways in which hospital mergers profoundly harm women's maternal health. This Part argues that the antitrust enforcers and the courts can confront the threat these mergers pose to women's maternal health, presenting three proposals. First, the enforcers and the courts should challenge any hospital merger that is likely to eliminate access to obstetric services. Second, they should accept hospital mergers only under the condition that the merged entity will not cut obstetric care services. Third, the enforcers and the courts should more closely examine the effects of hospital mergers on labor. Specifically, they should challenge any hospital merger that may lead to suppressed wages and harmful working conditions for employees in the hospital industry.

A. SECTION 7 OF THE CLAYTON ACT AND OUTPUT MARKETS

According to section 7 of the Clayton Act, any merger or acquisition that may substantially reduce competition or may create a monopoly "in any line of commerce" should be prohibited.[216] When the FTC, the DOJ ("the Agencies"), and the offices of the states' attorneys general examine a proposed merger, they enjoy some leverage.[217] Under the Hart-Scott-Rodino ("HSR") Act, "parties to certain large mergers and acquisitions" must submit a detailed merger notification to the Agencies and then must wait for the outcome of their

216. 15 U.S.C. § 18 (2018); U.S. DEP'T OF JUST. & FED. TRADE COMM'N, MERGER GUIDELINES § 1 (2023), https://www.justice.gov/d9/2023-12/2023%20Merger%20Guidelines.pdf [https://perma.cc/ZMJ9-PNHH].

217. *See* Christopher R. Leslie, *Food Deserts, Racism, and Antitrust Law*, 110 CALIF. L. REV. 1717, 1771 (2022).

assessment.[218] After their review is complete, the Agencies have three main options. First, if their merger review does not yield any significant anticompetitive concerns, they can allow the merger to move forward. Second, if the merger has the potential to cause harm to competition and consumers, they can challenge the merger. Third, they can negotiate a consent decree with the merging entities, such that the merger is approved only to the extent the merging entities agree to abide by specific merger conditions.[219]

The Agencies apply a two-step test for determining whether an envisaged merger is likely to harm competition and consumers. First, they define the relevant product and geographic market. Second, they assess the merger's anticompetitive effects. In general, mergers can be anticompetitive either because, post-merger, the merging entity will have increased market power, or because it may increase the levels of concentration in the relevant market significantly, which would facilitate collusion among market players.

The Section that follows argues that a hospital merger that may reduce access to maternal care in underserved communities raises important anticompetitive concerns and should therefore be challenged by the enforcers. Alternatively, it proposes that the enforcers could approve such a merger only under certain merger conditions. *What would their line of thinking be?* The following Section delves into this question.

1. Proposal One: Challenge Any Merger Reducing Access to Obstetric Care

Mergers among hospitals in rural areas leave millions of women with no access to obstetric care. This is because, after these mergers are complete, the acquiring hospital eliminates some of the essential health care services offered by the target rural hospital. Obstetric care units are especially common targets for closure, leading to maternal care deserts. The enforcers and the courts can challenge any merger that causes harm to competition and consumers by leading to reduced output, higher prices, lower quality, or reduced availability of products and services. Mergers causing maternal care deserts reduce the availability and output of obstetric services to almost zero for rural residents. The antitrust enforcers can stop such mergers.[220]

Recently, the FTC opposed two hospital mergers that would leave patients without access to vital care. In 2024, the FTC submitted a public comment urging the Indiana Department of Health to prevent the merger between two

218. *Premerger Notification and the Merger Review Process*, FED. TRADE COMM'N, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/mergers/premerger-notification-merger-review-process [https://perma.cc/CRC9-7S8A].

219. *See* Leslie, *supra* note 217, at 1771.

220. For a similar discussion, see Christopher R. Leslie, *Banking Deserts, Structural Racism, and Merger Law*, 108 MINN. L. REV. 695, 762–63 (2023).

hospitals: Union Health and Terre Haute Regional Hospital.[221] The parties pursued the proposed merger "under a proposed certificate of public advantage, also known as a COPA," that would have immunized the deal from antitrust scrutiny.[222] The parties explained that the merger would help improve patient outcomes and quality of care. To attain this goal, the parties would consolidate several clinical services, including outpatient mammography, oncology, mother–baby/NICU/pediatrics, and intensive care units post-merger.[223]

The FTC was not convinced. In its comments, the FTC raised the concern that the merger would cause harm to patients in Indiana by leading to higher prices, lower quality of services, and reduced access to care.[224] Arguing also that the intended consolidation of clinical services could lead to the closure of facilities and hence could deprive the community of crucial health care services, the FTC opposed the merger. Even if the merger could have produced the promised quality benefits, those benefits would only be realized at the expense of access to care. To the FTC, any potential quality improvements should be weighed against the adverse effect of clinical consolidation and future closures on patients' access to health care services.[225]

The FTC also followed a similar line of thinking when it opposed the hospital merger between State University of New York Upstate Medical University and Crouse Health System, Inc.[226] As in the previous case, the FTC was concerned that the merger would harm consumers by leading to increased prices, inferior health care quality, and reduced access to care.[227] The FTC was concerned because, following the merger, the merging parties aimed to reduce duplicative costs by consolidating various health care services, including labor and delivery and emergency care.[228] Such a consolidation of services

221. *FTC Staff Opposes Proposed Indiana Hospital Merger*, FED. TRADE COMM'N (Sept. 5, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-staff-opposes-proposed-indiana-hospital-merger [https://perma.cc/C8AY-DTG3].

222. *Id.*; *see also* FED. TRADE COMM'N, KEY COPA FACTS 1, https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf [https://perma.cc/563U-JNMW] ("Certificate of Public Advantage ('COPA') laws attempt to immunize hospital mergers from antitrust laws by replacing competition with state oversight.").

223. OFF. OF POL'Y PLAN., FED. TRADE COMM'N, FEDERAL TRADE COMMISSION STAFF SUBMISSION TO INDIANA HEALTH DEPARTMENT REGARDING THE CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION OF UNION HEALTH AND TERRE HAUTE REGIONAL HOSPITAL 33, 37 (2024), https://www.ftc.gov/system/files/ftc_gov/pdf/in_copa_comment_9-5-24_public_redacted.pdf [https://perma.cc/FR2A-5N46].

224. *Id.* at 2.

225. *Id.* at 36–38.

226. *See generally* OFF. OF POL'Y PLAN., FED. TRADE COMM'N, FEDERAL TRADE COMMISSION STAFF SUBMISSION TO NEW YORK STATE HEALTH DEPARTMENT REGARDING THE CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION OF STATE UNIVERSITY OF NEW YORK UPSTATE MEDICAL UNIVERSITY AND CROUSE HEALTH SYSTEM, INC. (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2210126NYCOPACommentPublic.pdf [https://perma.cc/7KUD-EH6H].

227. *Id.* at 1.

228. *Id.* at 34.

would require the closure of facilities as well as a reduction in the health care workforce.[229] However, if the merger was allowed, whatever benefits it might bring to consumers would be outweighed by the costs: increased traveling time to obtain care, limited access to health care services, and increased waiting time for receiving emergency care.[230]

Challenging any hospital merger that may reduce access to obstetric care, especially for underserved communities, could not be timelier. Data show that more than two million women of reproductive age in America live in maternal care deserts.[231] For people living in maternal care deserts, the average time to obtain obstetric services is up to thirty-eight minutes, more than double the average time urban residents need to obtain similar care.[232] When pregnant women must travel vast distances to access health care services, they face a higher risk of stillbirth, maternal mortality, and a need for neonatal intensive care.[233] Additionally, traveling several miles during labor increases the risk of out-of-hospital birth, which aggravates the rates of neonatal morbidity.[234]

Importantly, predominantly Black communities face a higher risk of experiencing a rural obstetric unit closure.[235] As a result, any further reduction of obstetric services in the post-merger era will harm disproportionately the maternal health of communities of color, who already suffer from higher maternal mortality rates.[236]

2. Proposal Two: Negotiating Merger Conditions

After the Agencies complete the review of a merger, they can threaten to challenge the deal unless the merging parties conform with specific merger conditions.[237] These conditions can be either structural or behavioral and serve as a key tool in the Agencies' toolkit. Structural merger conditions usually require the merging parties to divest themselves of specific assets, either tangible (e.g., a factory producing a raw material necessary for the production of another good) or intangible (e.g., patents or trademarks).[238] By proposing a

229. *See id.*

230. *Id.* at 33.

231. ASHLEY STONEBURNER ET AL., MARCH OF DIMES, NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE US 5 (2024), https://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf [https://perma.cc/2PK7-EEGM].

232. *Id.* at 29.

233. *Id.*

234. *Id.*

235. Hung et al., *supra* note 18, at 1667.

236. *2024 March of Dimes Report Card*, MARCH OF DIMES 5 (2024), https://www.marchofdimes.org/peristats/assets/s3/reports/reportcard/MarchofDimesReportCard-UnitedStates.pdf [https://perma.cc/UCF2-WWDB].

237. Christopher R. Leslie, *Pharmacy Deserts and Antitrust Law*, 104 B.U. L. REV. 1593, 1652 (2024).

238. ANTITRUST DIV., U.S. DEP'T OF JUST., MERGER REMEDIES MANUAL 6 (2020), https://www.justice.gov/atr/page/file/1312416/dl [https://perma.cc/P4VV-Q65M].

structural remedy, the Agencies aim to ensure that competition is not eliminated in the market in which the merger may create anticompetitive effects. Behavioral conditions, on the other hand, usually ask the merging parties either to conform with specific conduct or refrain from it. For instance, the Agencies may require the merging parties to license their intellectual property or not to disseminate certain types of information across business units in the merged entity.[239]

Part II argued that hospital mergers in underserved areas often eliminate access to obstetric services, causing maternal care deserts. Given this concern, the Agencies could consider accepting hospital mergers only if the merging entity accepts the burden of conforming with specific merger conditions. Specifically, the Agencies could require the merged entity not to reduce the availability of obstetric services. In this way, the Agencies could mitigate—at least to some extent—the maternal-desert problem that harms the lives of millions of women in the United States.

Recently, two hospital mergers were accepted under the condition that the merged entity would not cut crucial health care services. In November 2024 the California Attorney General approved the merger between two pediatric hospital systems: Rady Children's Hospital San Diego and Children's Hospital of Orange County.[240] In their statement, the merging parties explained that the merger would help them "ensure families have access to the very best practitioners, treatments and technology available in pediatric medicine."[241] Nonetheless, the deal was approved only after the parties agreed to abide by specific merger conditions.[242] Among others, the parties agreed to: (1) preserve pediatric trauma centers, acute hospitals, and specialty and emergency services in Orange County and San Diego County for a minimum of ten years; (2) continue serving Medicaid patients; and (3) provide their respective communities charity care.[243]

Earlier the same year, the California Attorney General approved another deal: UCSF Health's purchase of two San Francisco hospitals, Saint Francis Memorial and St. Mary's Medical Center, after the parties agreed to conform

239. Mark A. Lemley & Christopher R. Leslie, *Antitrust Arbitration and Merger Approval*, 110 NW. U. L. REV. 1, 51 (2015); Leslie, *supra* note 237, at 1652.

240. Ron Southwick, *California Children's Hospitals Complete Merger*, CHIEF HEALTHCARE EXEC. (Jan. 9, 2025), https://www.chiefhealthcareexecutive.com/view/california-children-s-hospitals-complete-merger [https://perma.cc/L5QC-WDLB].

241. *Id.*

242. Press Release, State of Cal. Dep't of Just., Attorney General Bonta: Conditionally Approved Pediatric Hospital Merger to Transform Pediatric Health in Southern California (Nov. 4, 2024), https://oag.ca.gov/news/press-releases/attorney-general-bonta-conditionally-approved-pediatric-hospital-merger [https://perma.cc/ZBF8-3Q25].

243. *Id.*

with specific merger conditions.[244] Again, among other conditions, the hospitals agreed to: (1) maintain both facilities as acute care hospitals without reducing the level of services and staffing for at least ten years; and (2) retain their respective workforces in both hospitals.[245]

Implementing merger remedies as an antitrust tool to prevent acquiring hospitals from eliminating obstetric services offered by target hospitals presents some advantages. First, the proposed condition would reduce hospitals' incentives to acquire close competitors in pursuit of short-term profits and to suppress competition in both output and labor markets. Furthermore, it would enable the Agencies to deter the elimination of obstetric services without undertaking the difficult task of precisely defining the geographic market in which the merger is likely to create anticompetitive effects. Although monitoring whether the merging entities continuously comply with the negotiated merger conditions may impose some costs on the Agencies, such costs would likely be minimal, as any attempt by the acquiring hospital to discontinue obstetric services offered by the target hospital could be readily detected.[246]

Merger conditions are also legally enforceable. This means that when the Agencies negotiate an agreement with merging entities, the latter face significant consequences if they fail to comply. According to the DOJ's Merger Remedies Manual, violations of merger conditions may result in the DOJ filing a civil or criminal contempt action (or both) seeking imprisonment, injunctive relief, or monetary penalties.[247] Similarly, the Federal Trade Commission Act ("FTCA") authorizes the FTC to file enforcement actions seeking severe civil penalties.[248] Because these sanctions are far from trivial, merging parties have strong incentives to comply with the conditions negotiated with the Agencies. To strengthen the deterrent effect of merger conditions, the Biden Administration made it a point to actually pursue their enforcement. Indicatively, in September 2021, the DOJ announced that CenturyLink "had agreed to pay US$275,000 after being found to have violated for a second time the consent decree's requirement that CenturyLink refrain from soliciting the customers of the[ir] divested assets."[249]

244. Ron Southwick, *California Health System Completes Acquisition of Two Hospitals*, CHIEF HEALTHCARE EXEC. (Aug. 14, 2024), https://www.chiefhealthcareexecutive.com/view/california-health-system-completes-acquisition-of-two-hospitals [https://perma.cc/4U7C-YC6Z].

245. *Id.*

246. Stavroulaki, *supra* note 34, at 1004.

247. *See* ANTITRUST DIV., *supra* note 238, at 34–35.

248. 15 U.S.C. § 45(m)(1)(b).

249. Juan A. Arteaga, *DOJ and FTC Push Merger Consent Decree Enforcement to Top of the Agenda*, GLOB. COMPETITION REV. (Oct. 25, 2023), https://globalcompetitionreview.com/guide/the-guide-merger-remedies/fifth-edition/article/doj-and-ftc-push-merger-consent-decree-enforcement-to-p-of-the-agenda (on file with the *Iowa Law Review*).

3. Counterarguments

One could argue that implementing the outlined proposals could deter merging parties from pursuing a merger that may improve the financial performance of the struggling hospitals. Because a merger, the argument goes, would allow the financially fragile hospital to experience a rapid infusion of capital, the merger would help such hospitals improve their financial health. This would allow the rural hospital to continue offering essential health care services, including maternal care.

Theory, however, does not always comport with reality. Studies examining the financial performance of rural hospitals in the post-merger era suggest that mergers do not necessarily help rural hospitals improve their financial stability.[250] A study examining the performance of financially vulnerable rural hospitals after they had been acquired highlights that, although rural hospitals may choose to merge with their competitor in hopes of reducing debt and increasing profits, such outcomes may not necessarily be realized.[251] Hence, the argument that the proposed merger conditions could prevent mergers that would otherwise help rural hospitals avoid closure is not strongly supported by research.

Another empirical study reaches a different conclusion, indicating that in the post-merger era, the rural hospital may improve its financial performance.[252] Specifically, the study concludes that following the affiliation, rural hospitals experienced an increase in their operating margins.[253] This study, however, also highlights that this increase in profitability may be the result of a reduction in unprofitable health care services or increased prices.[254] Further, it illustrates that, although rural hospitals improved their financial health post-merger, at the same time they reduced the availability of several health care services, including obstetric services.[255] In other words, any increase in the profitability of rural hospitals came at the expense of rural residents' access to care. Thus, the argument that a merger may improve the financial condition of rural hospitals and may therefore secure the provision of health care services such as obstetric services is not well-founded. Rather, the opposite is

250. Mark Holmes, *Financially Fragile Rural Hospitals: Mergers and Closures*, 76 N.C. MED. J. 37, 38 (2015) ("[W]hen a hospital is financially challenged, it may sometimes merge with (or be acquired by) a larger hospital system. A recent study during the 2005–2012 period found that hospitals with lower profitability and higher debt—that is, financially fragile hospitals—were more likely to merge. Merging hospitals experienced a decrease in operating margin—meaning they were even less profitable . . . . Thus, even though a challenged hospital may find that a merger is a viable option, its finances generally worsen after a merger . . . ." (footnote omitted)).

251. Marissa J. Noles, Kristin L. Reiter, Jonathan Boortz-Marx & George Pink, *Rural Hospital Mergers and Acquisitions: Which Hospitals Are Being Acquired and How Are They Performing Afterward?*, 60 J. HEALTHCARE MGMT. 395, 396, 403 (2015).

252. O'Hanlon et al., *supra* note 30, at 2100.

253. *Id.* at 2101.

254. *Id.*

255. *Id.*

true. When rural hospitals are acquired by their closest competitors, they often experience a reduction rather than an expansion of care.

Another counterargument may be that the proposed merger conditions might deter hospitals from pursuing mergers that could help them enhance the quality of their services.[256] For instance, a merger increases patient volumes for providers. Medical research identifies a relationship between patient volumes and procedure volumes.[257] This might indicate that the increased patient volumes brought by a merger may improve the overall quality of the services provided.[258]

However, research demonstrates that higher patient volumes do not necessarily correlate with higher-quality care. One study examined how the closure of an obstetric unit in a rural area affected the quality of obstetric services offered by obstetric units that remained open in surrounding hospitals. The study concluded that the quality of obstetric services offered by the operating obstetric units diminished for two primary reasons. First, due to the increased delivery volumes, the obstetric units that continued to serve their communities were "packed to the gills."[259] As a result, some patients in these obstetric units were forced to give birth even in the bathroom or in the hallway.[260] Second, due to the increased volume of patients that these obstetric units experienced, physicians working in these units suffered from higher levels of burnout.[261] Moreover, recruiting additional staff to cover increased demand became a challenge for the remaining obstetric units due to the heavier workloads and the pressure health care workers felt to see more patients with no adequate support.[262]

In brief, hospital mergers in underserved areas do not necessarily save the struggling hospital. In fact, mergers may even undermine the financial stability of the target hospital. Mergers among hospitals may also fail to improve quality of care because higher patient volumes are not necessarily associated with better care. When health care workers are forced to treat a higher volume of patients, they may experience higher levels of burnout and emotional exhaustion. As noted in the previous Part, increased levels of burnout lead to inferior care, especially for communities of color. Accordingly, the claim that

256. *See* Kristin Madison, *Hospital Mergers in an Era of Quality Improvement*, 7 HOUS. J. HEALTH L. & POL'Y 265, 274 (2007).

257. THEODOSIA STAVROULAKI, HEALTHCARE, QUALITY CONCERNS AND COMPETITION LAW: A SYSTEMATIC APPROACH 99–100 (2023).

258. *Id.*

259. Scott A. Lorch, Ashley E. Martin, Richa Ranade, Sindhu K. Srinivas & David Grande, *Lessons for Providers and Hospitals from Philadelphia's Obstetric Services Closures and Consolidations, 1997-2012*, 33 HEALTH AFFS. 2162, 2166 (2014).

260. *Id.*

261. *See id.* at 2165–66.

262. *Id.* at 2166.

hospital mergers—especially those occurring in rural areas—could lead to better care is ill-founded.

B. SECTION 7 OF THE CLAYTON ACT AND LABOR MARKETS

Hospital mergers lead to the reduction of wages of workers and inferior working conditions in the hospital industry. As noted, because the hospital industry is predominantly occupied by female workers, those mergers may disproportionately harm women's wealth and health. Crucially, they can also negatively affect their maternal health due to two factors. First, people's lower socioeconomic conditions can deteriorate their maternal health. Second, hospital mergers further increase the levels of burnout and stress health care workers experience, and provider burnout can lead to lower-quality maternal care. Part II noted that those harmful effects may disproportionately harm lower-income individuals and communities of color. The following Section argues that the enforcers and the courts can mitigate these negative health effects by challenging any hospital merger that is likely to deteriorate the wages and working conditions of employees in the hospital sector.

1. Proposal Three: Challenge Any Merger that Suppresses Wages or Deteriorates Working Conditions

According to the 2023 Merger Guidelines ("the Guidelines"), the Agencies can challenge any merger that may harm labor competition. Specifically, the Guidelines explain that, as mergers among sellers can cause harm to buyers, mergers among buyers can cause harm to sellers. Hence, to the extent mergers among buyers are likely to substantially lessen competition in the relevant market, they can also violate section 7 of the Clayton Act.[263]

Labor markets are just a common type of buyer's market.[264] When the Agencies examine a merger's anticompetitive effects on labor markets, they primarily assess whether the merger may significantly decrease competition among employers for labor.[265] The Guidelines explain that when competition among employers for labor is harmed, the price the employees pay is high: They experience a reduction in their salaries and a deterioration of their working conditions and benefits.[266] The reason is simple: When employers stop rigorously competing to attract labor, their incentives to offer their employees better working conditions and higher pay are undermined. *But how would the enforcers assess whether a hospital merger is likely to harm labor?*

When assessing a merger's potential anticompetitive effects, the antitrust enforcers apply the Herfindahl–Hirschman Index ("HHI"), defined as "the

263. *See* U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 216, § 2.10.
264. *See id.*
265. *Id.*
266. *Id.*

sum of the squares of the market shares."[267] Although HHI is low when competition is robust in the output market, HHI levels increase substantially when just a few firms compete in the relevant market. For instance, an HHI above 1,800 indicates that a market is "highly concentrated."[268] When two firms propose to merge in a market that is already highly concentrated and the merger would significantly increase the HHI, the antitrust enforcers will challenge the envisaged merger on the grounds that it could harm competition and consumers.

To date, the Agencies have applied the HHI framework to assess the impact of a proposed merger on competition and consumers in output rather than input (i.e., labor) markets.[269] This is because, in years past, economic theory supported the notion that product markets are characterized by high levels of concentration, but not necessarily labor markets.[270] Furthermore, the enforcers struggle to effectively analyze the effects of monopsony on labor markets, making them reticent to employ the same analysis to these markets as to product markets.[271] This, however, does not mean that the Agencies cannot apply the same framework to evaluate a hospital merger's impact on labor competition.[272] As the Guidelines explain, "*[t]he same—or analogous—tools used to assess the effects of a merger of sellers can be used to analyze the effects of a merger of buyers, including employers as buyers of labor.*"[273]

Applying a similar framework, the Agencies could take the following steps to detect any potential harm to competition and consumers resulting from a hospital merger. First, the Agencies would define the relevant market in which the anticompetitive effects—notably, lower salaries and inferior working conditions—are likely to occur. Second, they would assess how the proposed hospital merger may affect the labor market concentration. If the merger significantly increased concentration in the labor market, the Agencies could decide to stop it. Additionally, if the merging parties claimed that the merger would generate efficiencies—whether cost-related or qualitative—the Agencies would evaluate whether these efficiencies outweigh any potential anticompetitive effects. *But how would the Agencies define health care labor markets?*

In general, when defining the relevant market in the context of a merger analysis, the enforcers apply the Hypothetical Monopolist Test ("SSNIP").[274] By applying the SSNIP test, the enforcers examine "whether a hypothetical

267. *Id.* § 2.1.

268. *Id.*

269. *See* Ioana Marinescu & Eric A. Posner, *Why Has Antitrust Law Failed Workers?*, 105 CORNELL L. REV. 1343, 1351 (2020); *see also* Hiba Hafiz, *Interagency Merger Review in Labor Markets*, 95 CHI.-KENT L. REV. 37, 46 (2020) (indicating that the Agencies have continued to ignore the effects mergers have on labor markets).

270. Marinescu & Posner, *supra* note 269, at 1376.

271. *Id.* at 1376–77.

272. *See id.* at 1352.

273. U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, *supra* note 216, § 2.10 (emphasis added).

274. *Id.* § 4.3.A (SSNIP stands for "small but significant and non-transitory increase in price").

profit-maximizing firm . . . that was the only present and future seller of a group of products ('hypothetical monopolist') likely would undertake at least a small but significant and non-transitory increase in price . . . or other worsening of terms ('SSNIPT') for at least one product in the group."[275] The enforcers can apply a similar test when defining labor markets. In this case, the enforcers would examine whether a hypothetical monopsonist would profitably "undertake at least a SSNIPT, such as a . . . decrease in the wage offered to workers or a worsening of their working conditions or benefits."[276] A firm's ability to profitably reduce wages or degrade the quality of the workplace would be a strong indicator of market power in the relevant product market.[277] When the employer operates in a competitive labor market, any attempt to suppress workers' wages or worsen their working conditions and terms cannot survive the day. In a competitive market where employers strive to attract labor, if the employees saw a cut in their salary or a worsening of their employment terms, the employees could easily switch from one employer to another.[278] However, in a market dominated by just a few employers, employees have a harder time pursuing alternative employment. When labor markets are highly concentrated, even if the employees are unhappy with their salaries and working conditions, they often have no choice than to continue offering their labor in a poor and unsatisfying workplace.[279]

The Guidelines also explain why, due to the unique features labor markets exhibit, they are narrowly defined.[280] For instance, labor markets are characterized by "high switching costs and search frictions due to the process of finding, applying, interviewing for, and acclimating to a new job."[281] Switching costs are especially high when employees have invested in a specific type of job or when they have strong ties with a specific geographic region.[282] Workers also have their own individual needs, which limits the pool of jobs that they realistically see as substitutes.[283] The Guidelines also offer some guidance as to how relevant geographic markets may be defined. They note that "[g]eographic market definition may involve considering workers' willingness or ability to commute, including the availability of public transportation."[284]

Prominent antitrust scholars Professor Marinescu and Professor Posner have delved into the steps the enforcers should take to assess a merger's impact on labor competition. First, the Agencies should "define a labor market

275. *Id.*
276. *Id.* § 4.3.B.
277. *See* Hiba Hafiz, *Toward a Progressive Labor Antitrust*, 125 COLUM. L. REV. 319, 384 (2025).
278. *See id.*
279. *Id.* at 385.
280. *Id.*
281. U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 216, § 2.10.
282. *Id.*
283. *Id.*
284. *Id.* § 4.3.D.8.

by the type of job."[285] To do so, they may rely on the Bureau of Labor Statistics' Standard Occupational Classifications ("SOC"),[286] "and more specifically, an occupation at the six-digit SOC level," which provides a detailed "definition of a job or occupation."[287] For example, under this classification system, "registered nurses" constitute a specific job. Second, the Agencies should "define the geographic scope of the market."[288] This typically corresponds to the region "where most workers both work and live, and more specifically a commuting zone."[289] Commuting zones are "clusters of counties that were developed by the United States Department of Agriculture . . . based on patterns of commuting."[290] Third, the labor market should be bounded in terms of time, since individuals seeking employment "can afford to be unemployed only for a limited period."[291] Marinescu and Posner observe that "[t]he median duration of unemployment was about a quarter of a year in 2016."[292] For this reason, they contend that the Agencies should define the market as "the combination of a six-digit SOC occupation, a commuting zone, and a [fiscal] quarter."[293]

After defining a labor market through the three-step analysis, the Agencies should assess the HHI in that labor market just as they would in output markets. The only distinction is that market share, in this context, refers to "the firm's share of a labor market, rather than its share of a product market."[294] To evaluate labor market concentration, the antitrust enforcers should examine "the number of vacancies in a particular labor market and calculate the HHI based on each firm's share of those vacancies."[295]

Thus far, whenever the enforcers have assessed the impact of a hospital merger on competition and consumers, they have focused primarily on its likely anticompetitive effects on output rather than labor markets. However, recently the Agencies have started paying more attention to hospital mergers' impact on labor. For instance, in the merger between Union Health and Terre Haute Regional Hospital, the FTC urged the Indiana Department of Health to stop the merger on the basis that it may harm competition not only in the hospital services market, but also the labor market. Specifically, the FTC emphasized that because the proposed merger would increase consolidation

285. Marinescu & Posner, *supra* note 269, at 1352.
286. *Id.* at 1352–53.
287. *Id.* at 1353.
288. *Id.* at 1354.
289. *Id.*
290. *Id.*
291. *Id.* at 1355.
292. *Id.*
293. *Id.*
294. *Id.* at 1355–56.
295. *Id.* at 1356.

in the labor industry, it would slow wage growth for registered nurses.[296] The FTC feared that if nurses were to receive poorer benefits and lower pay, they might be discouraged from seeking employment in Terre Haute—a rural community that already suffers from a shortage of health care workers. This would undermine the ability of the hospital–employers to attract adequate labor and keep serving their communities in Terre Haute.[297] To the FTC, the harm the proposed merger would cause to labor would also harm access and quality of care.[298]

In reaching this conclusion, the FTC applied a similar analysis as the one proposed by Professors Marinescu and Posner. First, the FTC assessed "labor concentration in the commuting zone for nursing labor, as developed by the US Department of Agriculture."[299] Second, the FTC identified the commuting zone, which was comprised of seven counties.[300] Then, using American Hospital Association data, the FTC measured "the number and share of employees working at all hospital facilities in this commuting zone" as well as the levels of HHI pre- and post-merger.[301] Conducting this analysis, the FTC concluded that the labor market for registered nurses was characterized by high levels of concentration.[302] Because the merging entities in the affected geographic area were the primary employers for registered nurses pre-merger, the levels of concentration in the labor market would be even higher if the proposed merger moved forward.[303] As a result, the FTC concluded the merger should be prohibited.

In State University of New York Upstate Medical University and Crouse Health System, Inc., the FTC conducted a similar merger analysis, concluding that the proposed merger would substantially reduce competition among employers to attract and retain health care workers, notably registered nurses and respiratory therapists.[304] Post-merger, the level of concentration in those markets would escalate.[305] Again, the FTC warned that this significant harm in health care labor markets would hurt health care workers' wages.[306] Due to

296. OFF. OF POL'Y PLAN., *supra* note 223, at 3.

297. *Id.* at 54–55.

298. *Id.* at 55.

299. *Id.* at 58.

300. *Id.*

301. *Id.*

302. *Id.*

303. *Id.* ("[P]ost-merger HHI is 5,846 and the increase in HHI is 2,652, strongly suggesting that the proposed merger would likely harm competition for registered nurses and that nurse wage growth would likely be suppressed post-merger.").

304. OFF. OF POL'Y PLAN., *supra* note 226, at 28–29.

305. *Id.* at 29 ("The post-merger HHIs are 3,093 and 2,734, respectively, and the increases in HHI are 949 and 874, respectively. The post-merger HHIs and changes in HHIs suggest that the proposed merger may cause harm to competition for registered nurses and respiratory therapists.").

306. *Id.* at 14.

the lower pay, more health care workers would look for the exit, which would exacerbate the shortages of nurses and respiratory therapists in the area and ultimately harm population health.[307]

The fact that the Agencies have started paying closer attention to the effects of mergers on labor markets also became obvious in the FTC's request for a preliminary injunction preventing Kroger from acquiring Albertsons.[308] In its request, the FTC claimed that the proposed acquisition would harm millions of Americans by leading to higher prices for groceries and other essential household goods.[309] But the merger between the two major grocery stores would harm competition for union grocery workers, too.[310] Because, post-merger, the merging firms would enjoy higher leverage during negotiations with union workers, these workers' ability to obtain higher pay and secure improved working conditions and terms would be virtually eliminated.[311] The FTC challenged the merger "alongside a bipartisan group of nine state attorneys general."[312]

The Oregon District Court was convinced by the FTC's analysis and blocked the proposed merger.[313] In her opinion, Judge Nelson found that, if the merger moved forward, the levels of concentration within the market of supermarkets and large format stores would considerably increase.[314] This would hurt American households because they would pay much higher prices for their groceries. Judge Nelson found the FTC's argument that the merger would reduce competition among the merging firms for union grocery workers plausible.[315] Nonetheless, because the FTC did not provide evidence of how the proposed merger would affect the levels of concentration post-merger, Judge Nelson claimed that she lacked the necessary evidence to substantively assess the merger's likely anticompetitive effects in the labor market.[316]

These cases signal that health care workers in the United States should not give up hope. As Part II indicated, increased consolidation in the hospital sector has left health care workers, especially nurses with poorer wages, with adverse working conditions and high levels of job dissatisfaction. In a public workshop organized by the FTC, aimed at evaluating the impact of hospital

307. *Id.* at 28.

308. Press Release, Fed. Trade Comm'n, Statement on FTC Victory Securing Halt to Kroger, Albertsons Grocery Merger (Dec. 10, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/12/statement-ftc-victory-securing-halt-kroger-albertsons-grocery-merger [https://perma.cc/TTZ5-HZY6].

309. Complaint at 2, Kroger Co., No. D-9428 (F.T.C. Feb. 26, 2024).

310. *Id.*

311. *Id.* at 19.

312. Press Release, Fed. Trade Comm'n, *supra* note 308.

313. Fed. Trade Comm'n v. Kroger Co., No. 24-cv-00347, 2024 WL 5053016, at *39 (D. Or. Dec. 10, 2024).

314. *Id.* at *30.

315. *Id.* at *37–38.

316. *Id.* at *38.

mergers in output and labor markets, these harmful effects became clear. At this workshop, several registered nurses explained how their working conditions deteriorated after a hospital merger took place.[317] One nurse stressed that, post-merger, their hospital experienced a radical reduction in staff, which led to a much heavier workload for the remaining nurses.[318] Post-merger the employees' benefits were harmed too.[319] The employees who stayed saw a cut in their sick and pension pay right away.[320] Not surprisingly, several workers chose to leave the hospital and abandon their community to pursue employment opportunities elsewhere.[321]

Other participants also raised similar concerns, illustrating how, post-merger, nurses' healing mission became "more like factory work."[322] One registered nurse, for instance, stressed that, before the merger, the nurse-to-patient ratio was one to three.[323] However, due to the severe cut in staff post-merger, the nurse-to-patient ratio is now one to seven.[324] This increase in the nurse-to-patient ratio increases the volume of patients nurses must treat each day and raises their level of burnout at ever-higher rates. The health care system functions best when workers are fulfilled and rewarded for their work and not treated like factory workers on the assembly line.

Further, as several workshop participants explained, these negative effects reach beyond the individual sphere. When nurses feel squeezed, they are unable to offer their patients the care they deserve and need. One registered nurse explained how, due to the cuts in staff their hospital experienced post-merger, the nurses who stayed were forced to "answer the phones, coordinate communication between departments and perform [several] administrative tasks that [took] precious time" from patient treatment.[325] Another nurse said that, due to the loss in staff, hospital workers are unable to meet patients' requests and needs in a timely manner.[326] Others pointed to the fact that, due to the reductions in nursing staff, hospitals lacked the necessary workforce to treat sick patients during the COVID-19 pandemic.[327] As a result, hospitals

317. *See generally* Fed. Trade Comm'n, FTC and DOJ Host Listening Forum on Effects of Mergers in Health Care Industry (Apr. 14, 2022) [hereinafter Listening Forum Transcript], https://www.ftc.gov/system/files/ftc_gov/pdf/FTC-DOJ-Listening-Forum-%20Health-Care-Transcript.pdf [https://perma.cc/LTU5-25GH] (transcript of an FTC public forum on the effects of mergers and acquisitions in the health care industry).

318. *Id.* at 3.

319. *Id.*

320. *Id.*

321. *Id.*

322. *Id.* at 5.

323. *Id.*

324. *Id.*

325. *Id.* at 3.

326. *Id.* at 4–5.

327. *Id.* at 4.

had no choice but to transfer patients in need of urgent care to hospitals further away.[328]

These stories reveal a hard truth: Increased consolidation in the hospital industry has left nurses with poorer pay and inhuman working conditions. It has also left them feeling crushed. As Part II demonstrated, these anticompetitive effects have important implications for women's maternal health in the United States. Because most workers in the hospital sector are women, the loss of benefits and income they experience post-merger hurts their economic opportunity and hence their ability to invest in the resources that are essential for a healthy pregnancy, such as quality housing and healthy food. Hospital consolidation also leads to a higher level of burnout and stress, which negatively affects workers' maternal health.

Additionally, when hospital workers feel exhausted due to their demanding workload, they offer patients inferior health care services, including maternal care. Increased levels of burnout are associated with higher rates of medical errors and missing care, especially for Black patients. Hence, hospital workers' heavy workloads and severe stress disproportionately affect Black populations' maternal health. Thus, by paying more attention to hospital mergers' effects on labor, and more specifically to the wages and the working conditions of employees in the hospital sector, the enforcers can help vulnerable women improve their maternal health.

2. Counterarguments

Even if the enforcers showed that the proposed hospital merger may substantially increase the levels of concentration in the market for registered nurses, the analysis would not necessarily stop there. The merging parties could try to challenge the enforcers' showings of anticompetitive effects by supporting their own contention that the merger may yield substantial efficiencies that would benefit competition and consumers in the output market.

By way of illustration, consider a merger between two hospitals in an underserved area where competition among hospitals for attracting and retaining nurses is limited. Assume that the enforcers demonstrate that the merger would increase the HHI in the labor market at high rates, and hence would lead to lower wages and inferior working conditions for nurses. In such a case, the hospitals would most likely attempt to rebut the enforcers' findings of anticompetitive effects in the labor market by alleging that the merger may lead to substantial cost savings due to lower labor costs. These cost savings would be passed on to consumers in the form of lower hospital rates and, ultimately, lower health insurance premiums. Relying on Judge Kavanaugh's dissenting opinion in *United States v. Anthem, Inc.*,[329] the merging hospitals

328. *Id.*

329. United States v. Anthem, Inc., 855 F.3d 345, 371 (D.C. Cir. 2017) (Kavanaugh, J., dissenting).

could argue that, although the merger may harm one group of consumers (the workers), it may benefit another (the purchasers of hospital and health insurance services). Thus, the merger should be blessed by the enforcers.

United States v. Anthem, Inc. concerned a merger between Aetna and Anthem, two major health insurers in the United States. The district court stopped the merger because it would have led to high levels of concentration in the market for the sale of health insurance to large-group employers.[330] In response, Anthem argued that the transaction at issue would produce considerable efficiencies that could rebut the enforcers' prima facie case.[331] Because the merged entity would enjoy higher leverage when negotiating with hospitals and physicians post-merger, it would be able to lower the rates paid to them.[332] Consequently, the employer–customers would pay lower prices for the health care services offered to their employees, meaning the proposed merger would create important benefits for them.[333] The district court, however, was not convinced that the claimed efficiencies were cognizable, verifiable, and merger specific. For this reason, it stopped the merger.[334]

In its appeal, Anthem argued that the lower court wrongly rejected the alleged efficiencies.[335] Nonetheless, the D.C. Circuit aligned with the lower court's reasoning and challenged the merger.[336] However, in his dissent, Judge Kavanaugh, told a different story. Kavanaugh argued that, by viewing the envisaged merger as a classic horizontal merger between two major health insurance companies, the court's opinion took for granted that the merger would lead to increased prices for the purchasers of health insurance services—the employer–customers.[337] For this reason, Kavanaugh thought that the district court had failed to examine the merger's broader anticompetitive effects. Specifically, Judge Kavanaugh said:

> Here, these insurance companies act as purchasing agents *on behalf of their employer-customers* in the upstream market where the insurers negotiate provider rates for the employer-customers. . . .
>
> . . . .
>
> The record evidence also overwhelmingly demonstrates that the medical cost savings from the lower provider rates negotiated by Anthem-Cigna would be largely if not entirely passed through to the large employers that contract with Anthem-Cigna. The savings are passed through to employers because, under the contractual

330. *Id.* at 351.
331. *Id.* at 348.
332. *Id.* at 351.
333. *Id.* at 349.
334. *Id.* at 352.
335. *Id.* at 353.
336. *Id.* at 368–69.
337. *Id.* at 372–73.

> arrangements that apply in that market, the employers pay healthcare providers for the healthcare services provided to employees. . . .
>
> . . . .
>
> In short, the record decisively demonstrates that this merger would be *beneficial* to the employer-customers who obtain insurance services from Anthem and Cigna.[338]

In other words, Judge Kavanaugh expressed the view that the cost savings the merger may create in one market, the hospital services market, could outweigh harm to competition in another: the market for health insurance services.

But Judge Kavanaugh's opinion ignored a fundamental tenet of American antitrust law: that "claimed out-of-market procompetitive effects from mergers are not considered cognizable efficiency benefits."[339] The Supreme Court made this clear in *Philadelphia National Bank*, which centered around the merger of the second and third largest commercial banks in the Philadelphia metropolitan area.[340] In that case, if the merger had been allowed to move forward, the merged entity would have been Philadelphia's largest commercial bank.[341] To rebut the government's showing of anticompetitive effects, the merging firms presented an efficiency claim. Specifically, the merging parties contended that, post-merger, "the resulting bank, with its greater prestige and increased lending limit, would be better able to compete with large out-of-state (particularly New York) banks, would attract new business to Philadelphia, and in general would promote the economic development of the metropolitan area."[342]

The Supreme Court rejected this line of thinking. The Supreme Court took the view that, "[i]f anticompetitive effects in one market could be justified by procompetitive consequences in another . . . every firm in an industry could, without violating [the Clayton Act], embark on a series of mergers" that ultimately would make it the leading industry player.[343] For this reason, the Supreme Court challenged the proposed merger.[344] In light of the Supreme Court's ruling in *Philadelphia National Bank*, enforcers could allege

338. *Id.* at 372, 374, 373.

339. Laura Alexander & Steven C. Salop, *Antitrust Worker Protections: The Rule of Reason Does Not Allow Counting of Out-of-Market Benefits*, 90 U. CHI. L. REV. 273, 298 (2023).

340. United States v. Phila. Nat'l Bank, 374 U.S. 321, 330 (1963).

341. *Id.* at 331.

342. *Id.* at 334 (footnote omitted).

343. *Id.* at 370.

344. *Id.* at 371.

that the welfare gains enjoyed by employers cannot outweigh the welfare losses suffered by employees.[345]

The Guidelines also support this view. Specifically, the Guidelines say that:

> If the merger may substantially lessen competition or tend to create a monopoly in upstream markets [including labor markets], that loss of competition is not offset by purported benefits in a separate downstream product market. Because the Clayton Act prohibits mergers that may substantially lessen competition or tend to create a monopoly in *any* line of commerce and in *any* section of the country, a merger's harm to competition among buyers is not saved by benefits to competition among sellers.[346]

Crucially, if the antitrust enforcers accepted the merging parties' counterclaim, they would risk applying antitrust law in a way that implies one segment of consumers deserves more protection than others. This notion, however, would conflict with a fundamental premise of antitrust law: that all consumers equally deserve to enjoy the fruits of antitrust law via lower-priced and higher-quality products and services.[347] Applying this approach would also widen the economic disparities hurting the nation and would further deteriorate women's maternal health. For these reasons, the antitrust enforcers could still stop the merger.

CONCLUSION

The United States is suffering from a maternal mortality crisis that disproportionately affects the most vulnerable populations: the lowest-income individuals and communities of color. This Article demonstrated how this crisis is also the result of mergers among hospitals, especially in underserved areas, for three main reasons.

First, post-merger, the acquiring hospital frequently closes vital health care services such as obstetric care, producing maternal care deserts. Second, hospital mergers help hospitals increase their market power in the labor market, which allows them to suppress the wages of their employees and offer employment under poor working conditions. Because hospital jobs are disproportionately filled by female workers, and given the correlation between socioeconomic status and health, these anticompetitive effects are more likely

345. *See also* Theodosia Stavroulaki, *Mergers that Harm Our Health*, 19 BERKELEY BUS. L.J. 89, 117 (2022) (suggesting application of the same logic to challenge mergers between health insurers and pharmaceutical suppliers).

346. U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 216, § 2.10.

347. Stavroulaki, *supra* note 34, at 988 ("[A]ntitrust law is based on the idea that all individuals deserve the fruits of well-functioning markets: lower prices, increased quality, and wider choice."); *see also* Leslie, *supra* note 217, at 1753 ("Antitrust law is meant to protect all consumers from anticompetitive conduct, collusion, and mergers—including consumers whose income is below average.").

to hurt the wealth and maternal health of lower-income individuals and communities of color. Third, because health care workers—especially nurses—experience higher levels of burnout post-merger, they may offer their patients inferior care, which disproportionately affects maternal health outcomes for people of color.

With this crisis in mind, this Article made three proposals. First, the enforcers and the courts should challenge any merger that is likely to reduce access to obstetric services, especially for rural residents. Second, they should accept hospital mergers in underserved areas only under the condition that the merged entity will not cut obstetric services in these areas. Lastly, the enforcers and the courts should more closely examine the impact of hospital mergers on labor. By implementing the outlined proposals, the enforcers can alleviate the maternal mortality crisis in the United States and improve the maternal health of millions.