Left Without Care: Provider Shortages and the Global Reproduction of Women's Health Inequities

A Thematic Integrative Literature Review *(Meta-research / Evidence-based Synthesis)*

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Abstract

Healthcare provider shortages in underserved communities represent a persistent structural barrier to achieving equitable women's health outcomes. While the United States faces well-documented shortages of primary care clinicians, OB/GYNs, midwives, and specialists, similar challenges are emerging across Europe, particularly in rural regions and migrant-dense urban districts. This comparative study examines how provider shortages in both regions contribute to inequitable women's health outcomes through reduced access to preventive and reproductive services, delayed diagnoses, fragmented continuity of care, and increased reliance on emergency or episodic care. Guided by a conceptual framework integrating structural shortages, mediating pathways, women's health outcomes, and moderating equity factors, the analysis synthesizes literature published between 2019 and 2025. Findings reveal that shortages disproportionately affect marginalized women, including racial and ethnic minorities in the United States and migrant, Roma, and low-income women in Europe, intensifying disparities in maternal morbidity, chronic disease management, reproductive health, and preventive screening. Despite differing health system structures, both regions exhibit inequities driven by socioeconomic constraints, insurance or coverage gaps, transportation barriers, and historical mistrust of healthcare institutions. The study underscores the need for equity-centered workforce policies, community-based care models, and targeted resource allocation to mitigate the disproportionate burden borne by women in underserved communities. Addressing provider shortages are essential to advancing women's health equity globally.

Keywords: provider shortages, women's health, underserved communities, health equity, maternal health, structural determinants

Introduction

Persistent shortages of healthcare providers in underserved communities represent a critical structural barrier to achieving equitable women's health outcomes in the United States. Women in marginalized racial, ethnic, and socioeconomic groups experience disproportionate challenges in accessing timely, high-quality care, particularly in communities with limited primary care clinicians, OB/GYNs, midwives, and specialists (Michaeli et al., 2024). These shortages intersect with broader social determinants of health, including poverty, transportation barriers, and insurance inequities, compounding the risks faced by women who already experience systemic disadvantage (Williams et al., 2019).

Healthcare provider shortages have become a defining structural barrier to equitable women's health outcomes across both the United States and Europe. In the United States, shortages of primary care physicians, OB/GYNs, midwives, and behavioral health providers disproportionately affect rural communities, low-income urban neighborhoods, and racially marginalized populations (Michaeli et al., 2024). Europe, despite its universal health coverage frameworks, faces parallel challenges: rural depopulation, aging workforces, and uneven distribution of specialists have created widening gaps in women's access to timely and comprehensive care (Orzechowski et al., 2020; OECD, 2023).

Women in underserved communities experience higher rates of maternal morbidity, delayed diagnoses of chronic conditions, reduced access to reproductive services, and lower preventive screening rates. These disparities are intensified by structural inequities, including socioeconomic disadvantage, insurance or coverage gaps, transportation barriers, and cultural or linguistic mismatches between providers and patients (Hardeman et al., 2020; Orzechowski, 2020).

Prior research demonstrates that women in underserved communities face higher rates of

maternal morbidity and mortality, delayed diagnoses of chronic conditions, and reduced access to reproductive and preventive services (Howell et al., 2020). Despite growing national attention to maternal health disparities, gaps remain in understanding how provider shortages function as a structural determinant that shapes inequitable outcomes. This study addresses that gap by examining the mechanisms through which provider shortages contribute to inequitable women's health outcomes and identifying the moderating factors that intensify these disparities.

Although the United States and Europe differ in health system design, both regions exhibit inequities rooted in structural determinants of health. This study addresses a critical gap in the literature by comparing how provider shortages contribute to inequitable women's health outcomes across these two global contexts. The purpose of this article is to analyze how provider shortages in underserved communities in the United States and Europe contribute to inequitable women's health outcomes and identify policy and practice implications for advancing health equity.

Theme 1: Access Barriers and Delayed Care

United States- Women in rural and low-income communities face long travel distances, appointment scarcity, and limited OB/GYN availability, contributing to delayed prenatal and chronic disease care (Howell et al., 2020).

Europe- Rural regions in Eastern Europe and migrant-dense urban areas experience long wait times and limited specialist access, delaying reproductive and preventive services (OECD, 2023).

Theme 2: Quality of Care and Continuity Disruptions

United States- High turnover and clinician burnout reduce continuity, increasing medical errors and fragmented care (Michaeli et al., 2024).

Europe- Aging workforces and reliance on temporary or foreign-trained providers disrupt continuity, particularly in maternal and reproductive care (Orzechowski et al., 2020).

Theme 3: Structural Inequities and Disproportionate Burden

United States- Black, Indigenous, and Latina women experience disproportionate maternal morbidity due to structural racism, insurance disparities, and mistrust (Hardeman et al., 2020).

Europe- Roma women, migrants, and refugees face discrimination, language barriers, and exclusion from some health services, intensifying inequities (Orzechowski et al., 2020).

Theme 4: Reproductive and Maternal Health Vulnerabilities

United States- Limited OB/GYN availability contributes to higher maternal mortality, especially in rural and Southern states (Howell et al., 2020).

Europe- Maternal outcomes vary widely: Nordic countries maintain strong midwifery models, while Eastern Europe faces rising maternal morbidity due to shortages and outdated infrastructure (OECD, 2023).

Theme 5: Community-Level and System-Level Factors

United States- Market-driven provider distribution, insurance fragmentation, and underfunded safety-net systems exacerbate shortages (Michaeli et al., 2024).

Europe- Universal coverage mitigates some barriers, but austerity policies, rural depopulation, and workforce aging create systemic shortages (Orzechowski et al., 2020).

Conceptual Framework

The conceptual framework guiding this study integrates four core constructs: structural provider shortages, mediating pathways, women's health outcomes, and moderating equity factors. Structural shortages—including limited clinician availability, high turnover, and geographic maldistribution—serve as the independent variable influencing downstream health outcomes. Mediating pathways such as reduced access to preventive services, delayed diagnoses, and fragmented continuity of care explain how shortages translate into adverse outcomes (Hatch et al., 2021). Women's health outcomes, including maternal morbidity, chronic disease management, reproductive health, and preventive screening rates, represent the dependent variables. Moderating factors such as race, socioeconomic status, insurance coverage, and historical mistrust shape the degree to which shortages produce inequitable outcomes (Hardeman et al., 2020). This framework illustrates how structural shortages create cascading barriers that disproportionately affect women in marginalized communities, ultimately widening health disparities.

Structural Provider Shortages (Independent Variable)

- Limited numbers of physicians, OB/GYNs, midwives, nurses, and specialists
- High provider turnover
- Long wait times and appointment scarcity
- Geographic maldistribution of clinicians

In the United States, shortages are most severe in rural counties and low-income urban districts. In Europe, shortages are concentrated in rural regions of Eastern and Southern Europe and in migrant-dense urban areas.

Mediating Pathways (Mechanisms of Impact)

- Reduced access to preventive and reproductive services
- Delayed diagnosis and treatment
- Lower continuity of care
- Increased reliance on emergency or episodic care
- Provider burnout and reduced quality of care

These pathways operate similarly across both regions, though the United States experiences

more pronounced insurance-related delays, while Europe experiences more pronounced geographic and workforce aging challenges.

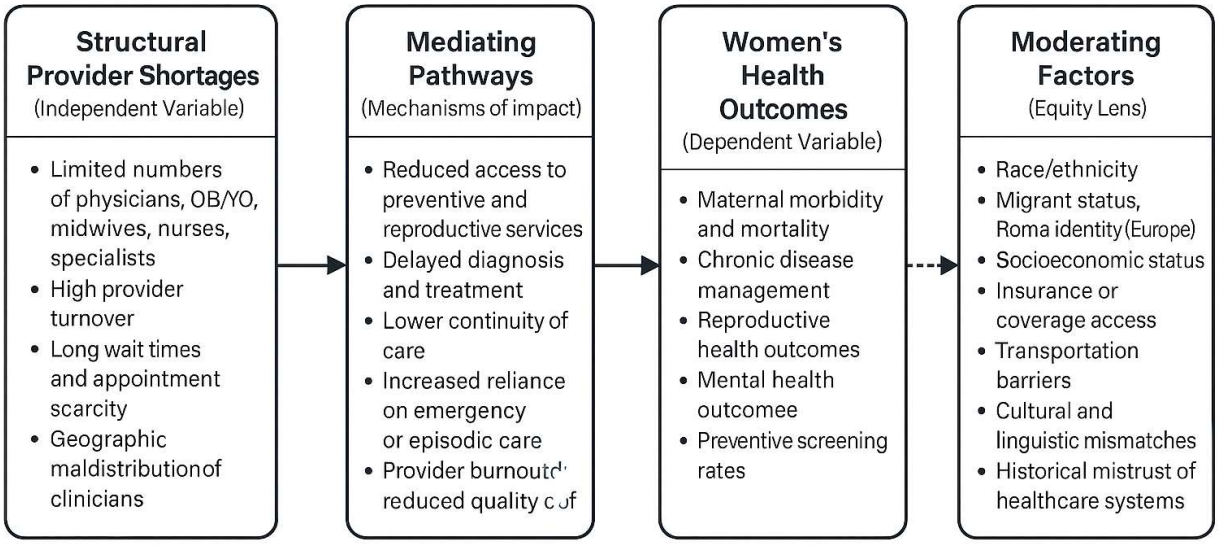
Women's Health Outcomes (Dependent Variable)

1. Maternal morbidity and mortality
2. Chronic disease management
3. Reproductive health outcomes
4. Mental health outcomes
5. Preventive screening rates

Moderating Factors (Equity Lens)

1. Race/ethnicity (U.S.)
2. Migrant status and Roma identity (Europe)
3. Socioeconomic status
4. Insurance or coverage access
5. Transportation barriers
6. Cultural and linguistic mismatches
7. Historical mistrust of healthcare systems

Figure 1: *Core Constructs of the Conceptual Framework*



Research Question

How do shortages of healthcare providers in underserved communities contribute to inequitable women's health outcomes?

Methods

Study Design

This study employs a thematic integrative literature review design to synthesize peer-reviewed evidence on provider shortages and women's health disparities.

Sample

Sources include empirical studies published in peer-reviewed journals between 2019 and 2025, focusing on women's health, provider workforce distribution, maternal health disparities, and structural determinants of health.

Measures

Key variables include provider availability, access to preventive and reproductive services, maternal health outcomes, chronic disease indicators, and equity-related moderating factors.

Procedures

Databases searched included PubMed, CINAHL, and Scopus using terms such as *provider shortages*, *women's health disparities*, *maternal outcomes*, and *underserved communities*.

Data Analysis

A thematic synthesis approach was used to identify recurring patterns across studies, organized into five domains: access barriers, quality and continuity, structural inequities, reproductive vulnerabilities, and system-level factors.

Results

Findings throughout the literature consistently demonstrate that provider shortages lead to:

- Delayed access to care, including prenatal, reproductive, and chronic disease services, (Howell et al., 2020).
- Reduced continuity of care, driven by high turnover and limited appointment availability, (Michaeli et al., 2024).
- Increased reliance on emergency departments, particularly for reproductive and maternal Care, (Hatch et al., 2021).
- Higher rates of maternal morbidity and mortality, especially among Black and Indigenous Women, (Hardeman et al., 2020).
- Lower preventive screening rates, including cervical and breast cancer screenings, (Williams et al., 2019).

These outcomes were consistently more severe in communities with high poverty, limited insurance coverage, and transportation barriers. The results also highlight the role of moderating factors. Structural racism, socioeconomic disadvantage, and insurance inequities intensify the effects of provider shortages, widening disparities in maternal and reproductive outcomes. Additionally, these findings underscore the need for targeted interventions that address both workforce distribution and the broader social determinants that shape women's health.

Discussion

The findings align with the conceptual framework, demonstrating that provider shortages function as a structural determinant that shapes women's health outcomes through multiple mediating pathways. Delayed diagnoses and fragmented care contribute to worsening chronic disease management, while limited OB/GYN availability increases risks during pregnancy and postpartum periods. These findings reinforce existing literature documenting the disproportionate burden of maternal morbidity among minority women (Hardeman et al., 2020).

The comparative analysis reveals that provider shortages in both the United States and Europe produce similar mediating pathways, delayed care, reduced continuity, and fragmented services, leading to inequitable women's health outcomes. However, the underlying drivers differ. The United States faces insurance-driven access barriers and racialized inequities, while Europe faces geographic maldistribution, aging workforces, and challenges integrating migrant populations. Despite structural differences, both regions demonstrate that provider shortages disproportionately harm marginalized women, reinforcing the need for equity-centered workforce strategies.

Limitations

This review is limited by its reliance on published literature, which may underrepresent community-based perspectives. Additionally, variations in study design and measurement across sources limit direct comparability such as variability in data quality across countries, limited longitudinal studies on workforce shortages and underrepresentation of migrants and minority women's perspectives in European research.

Implications

- **Practice:** Expand community-based care models, including midwifery and nurse-led

clinics, to increase access in underserved areas.

- **Policy:** Implement workforce incentives, loan repayment programs, and equitable resource allocation to address geographic maldistribution.
- **Research:** Future studies should examine longitudinal impacts of provider shortages and evaluate interventions that integrate structural and community-level solutions.
- **Practice:** Expand midwifery-led and nurse-led models to increase access.
- **Policy:** Implement targeted workforce incentives, rural recruitment programs, and equity-centered resource allocation.
- **Research:** Conduct cross-national longitudinal studies on provider shortages and women's health outcomes.

Conclusion

Healthcare provider shortages in underserved communities significantly contribute to inequitable women's health outcomes. These shortages create structural barriers that delay care, reduce continuity, and exacerbate maternal and reproductive risks, particularly for women in marginalized populations. Addressing provider shortages through equity-centered workforce and policy strategies are essential to improving women's health outcomes and advancing health equity. Provider shortages in underserved communities in both the United States and Europe significantly contribute to inequitable women's health outcomes. Although the structural drivers differ, the consequences, delayed care, fragmented services, and disproportionate maternal and reproductive risks, are strikingly similar. Addressing these shortages through coordinated, equity-centered workforce and policy strategies is essential to improving women's health outcomes globally.

References

Hardeman, R. R., Karbeah, J., & Kozhimannil, K. B. (2020). Applying a critical race lens to relationship-centered care in pregnancy and childbirth: An antidote to structural racism. *Birth, 47*(1), 3–7. https://doi.org/10.1111/birt.12462

Hatch, B., Hoopes, M., Darney, B. G., Marino, M., Templeton, A. R., Schmidt, T., & Cottrell, E. (2021). Impacts of the Affordable Care Act on Receipt of Women's Preventive Services in Community Health Centers in Medicaid Expansion and Nonexpansion States. *Women's health issues : official publication of the Jacobs Institute of Women's Health*, *31*(1), 9–16. https://doi.org/10.1016/j.whi.2020.08.011

Howell, E. A., Brown, H., Brumley, J., Bryant, A. S., Caughey, A. B., Cornell, A. M., Grant, J. H., Gregory, K. D., Gullo, S. M., Kozhimannil, K. B., Mhyre, J. M., Toledo, P., D'Oria, R., Ngoh, M., & Grobman, W. A. (2018). Reduction of Peripartum Racial and Ethnic Disparities: A Conceptual Framework and Maternal Safety Consensus Bundle. *Obstetrics and gynecology*, *131*(5), 770–782. https://doi.org/10.1097/AOG.0000000000002475

Michaeli, D. T., Michaeli, J. C., Albers, S., & Michaeli, T. (2024). The healthcare workforce shortage of nurses and physicians: Practice, theory, evidence, and ways forward. Policy, Politics, & Nursing Practice, 25(4), 216–227. https://doi.org/10.1177/15271544241286083

OECD. (2023). *Health at a Glance: Europe 2023*. Organisation for Economic Co-operation and Development.

Orzechowski, M., Nowak, M., Bielińska, K., Chowaniec, A., Doričić, R., Ramšak, M., Łuków, P., Muzur, A., Zupanič-Slavec, Z., & Steger, F. (2020). Social diversity and access to healthcare in Europe: how does European Union's legislation prevent from discrimination in healthcare?. BMC public health, 20(1), 1399. https://doi.org/10.1186/s12889-020-09494-8

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and health: Evidence and needed research. *Annual Review of Public Health, 40*, 105–125. https://doi.org/10.1146/annurev-publhealth-040218-043750