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# America's Maternal Mortality Crisis: Policy Proposal

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Kira Eidson

## **Issue:**

The United States of America spends the most money on healthcare per capita of any nation in the world, however the country's maternal mortality rate is the highest of any developed country and has been rising (Reducing US Maternal Mortality as a Human Right). Maternal death is defined by three separate categories. A maternal death can occur during pregnancy, during labor or within forty-two days of giving birth, or between forty-three days and one-year after giving birth (Sofer). If a woman dies during any of these time periods from a condition in connection with the development and birth of a child, her death is considered a maternal mortality. The United States bears the shameful statistic of 26.4 maternal deaths per 100,000 live births; the United Kingdom bears the next highest death rate of a developed country at 9.2 deaths per 100,000 live births (Martin and Montagne). America's maternal death rate spiked in 2000 and has been on the rise while other developed countries' rates have gradually declined. Mothers are dying in America because of flaws in the American healthcare system that must be addressed. Maternal mortality is more likely to strike black mothers, the poor, and women in rural areas than other women. This problem is abetted by inadequacies in the healthcare system, systemic racism, misogyny, and a lack of resources and education regarding maternal health. Each year between 700 and 900 women in the United States die of a maternal-related cause and leave behind children who will grow up without mothers, and families who must adapt their lifestyles to manage without their loved one (Martin and Montagne). Since 2000, California is the only state to have decreased its maternal death rate; the state implemented life-saving policies in response to the nationwide crisis (Sofer). Meanwhile, Texas's rates skyrocketed just as the state made major budget cuts to healthcare and family planning and reproductive clinics (Rowe-Finkbeiner). This demonstrates that the scope of the maternal mortality issue is nationwide but can be improved at the state level. It is imperative that the United States act on the maternal mortality crisis and implement policy to fall in line with the downward trends set by California and other developed nations.

## **Evidence:**

The United States is one of only thirteen countries where the maternal mortality rate is worse today than it was fifteen years ago (When the State Fails: Maternal Mortality and Racial Disparity in Georgia). America experienced a 26.6% increase in the number of maternal deaths from 2000-2014 (The Editorial Board USA Today). Poverty, race, education, geographical location, previous medical conditions, access to healthcare, and choices regarding maternal care each contribute to high maternal mortality rates. Many of these factors intertwine and create major discrepancies between the rates of death of women of different groups. For example, a black woman living in New York City is twelve times as likely to die from a maternal cause as her white New York City counterpart (Turlington Burns). The scope of the maternal mortality race problem has not improved with time. In 1935 the maternal mortality rate of black women was only 1.8 times as high as that of white women (Reducing US Maternal Mortality as a Human Right). Today, the death rate is over four times as high (The Editorial Board USA Today). Maternal mortality is an issue intertwined with racism in America. The shamefully high rates of maternal deaths of black mothers is a driving force reason that America's maternal death rate is higher than other developed countries. America's white maternal death rate is just 12.5 deaths

per 100,000 live births, comparable to the rate in other developed countries. However, there are 42.8 deaths of black mothers in America per 100,000 live births (The American College of Obstetricians and Gynecologists). In general, American women are more than three times as likely to die from a maternal cause than Canadian women, and six times as likely to die as women from Scandinavia (Martin and Montagne).

Maternal death rates in counties with high rates of poverty are nearly two times as high as counties with average poverty levels (Turlington Burns). In addition, over sixty-five million people live in areas unequipped with enough healthcare providers to fulfill the county's healthcare needs; nearly half of all United States counties do not have an obstetrician who specializes in maternity care (Turlington Burns). Consequently, the scope of maternal mortality's impact expands to rural and impoverished areas and hits hard.

The scope of maternal mortality expands past pregnancy and birth. Deaths of mothers that occur up to a year after childbirth and are related to maternity are included within the definition of maternal death. Approximately one-third of maternal deaths occur during pregnancy, about forty-four percent occur within forty-two days of birth, and just over twenty-two percent occur between forty-three days and a year after giving birth (Report from Maternal Mortality Review Committees: A View Into Their Critical Role).

### **Contributing Factors:**

There are multiple factors that contribute to maternal death that are split into two distinct categories. First, it is imperative to identify what it is that is killing mothers. The major causes of maternal death differ amongst mothers of different stages of pregnancy and birth and different races. Overall, approximately thirteen percent of mothers die from hemorrhage, 8.9 percent die of suicide due to mental health conditions, and 7.6 percent die of preeclampsia and eclampsia, or pregnancy-related high blood pressure (Report from Maternal Mortality Review Committees: A View Into Their Critical Role). A racial breakdown of maternal deaths uncovers that the leading causes of maternal death for non-Hispanic white women are hemorrhage and mental health conditions, and the leading causes for black women are cardiomyopathy, embolism, and eclampsia (Report from Maternal Mortality Review Committees: A View Into Their Critical Role). Black women run a higher risk for high blood pressure than white women and it is imperative that healthcare providers recognize the increased attention that women prone to eclampsia and preeclampsia require. Mothers who die between forty-three days and one-year of giving birth often die from a mental health condition that led to suicide (Report from Maternal Mortality Review Committees: A View Into Their Critical Role). The lack of attention and regard for maternal mental health and education is a major contributing factor to the maternal mortality crisis.

In addition to the literal physical conditions that are contributing to maternal death there are numerous environmental and social factors that contribute to the proliferation of this crisis. In recent years there has been a rise in the number of caesarian-section births and early elective deliveries that take place. In 2009, nearly one-third of all United States births were C-sections (In Focus: Targeting Maternal Care). These procedures often pose greater risks to both the mother and baby. Post-operation complications, not the procedure itself, often lead to conditions that result in maternal death (Moaddab et.al.). Studies have shown that certain factors correlate with higher risk for maternal mortality. Caesarian sections, unintended births and pregnancies, unmarried status, race, and completing less than four medical visits for prenatal care are often indicators of higher risk. Black women have a greater association with C-sections and unmarried

status, as well as high blood pressure which each contribute to the racial disparity in maternal deaths (Moaddab et. al.).

Difficulties in accessing medical care and appropriate and affordable insurance also contribute to high maternal mortality rates. Approximately eleven percent of women between the ages of nineteen and sixty-four are uninsured. This means that 10.5 million women are not covered by health insurance (Women's Health Insurance Coverage). In the past, women could be charged more for or denied insurance due to pregnancy. The Affordable Care Act requires that essential health requirements be covered under insurance plans, hence covering maternity and newborn care and closing insurance discrimination loopholes left open from the Pregnancy Discrimination Act of 1978 (Sonfield). However, high costs of insurance, divorces, dependent status, and gaps in private sector and publicly funded healthcare programs still leave many women uninsured and lacking the opportunity for wholesome care through every stage of motherhood (Women's Health Insurance Coverage). According to UNICEF, nearly eight out of ten maternal deaths could be prevented if women were provided with essential care and basic healthcare services (Office of the United Nations High Commissioner for Human Rights). President Trump's administration is considering cutting the ACA's protections of essential health requirements. Consequently, the inconsistency of healthcare protection threatens the wellbeing of women across the country.

Hospitals and maternal caregivers are ill-equipped with information and resources to fight against maternal mortality, and women are not provided with sufficient information to recognize their own health concerns. Each state now has a checkbox on death certificates to mark whether a death was a maternal death; however, many of these boxes are checked in error (Flynn). This leads to inaccurate information about who is dying of maternal causes, what is causing these deaths, and what can be done to fix the issue. The Centers for Medicare and Medicaid services do not require the public disclosure of information regarding complications with childbirth, and even though Medicaid pays for approximately half of births in the United States, the agencies have not taken steps to acquire information or expand healthcare protections (Kuznar). Hospitals are also not utilizing the information and knowledge that they do have to save lives. For example, the Center for Disease Control has outlined more than twenty "critical factors" that are associated to pregnancy related deaths and determined that the average maternal mortality had 3.7 of these factors (Martin and Montagne). It is estimated that more than sixty percent of maternal deaths are preventable if these critical factors were properly looked for and addressed (Martin and Montagne). In the recent news there have been multiple heartbreaking stories of women who have lost their lives because hospitals did not have enough donor blood available to respond to hemorrhage, ignored signs of rising blood pressure that signified preeclampsia or eclampsia, or were short on staff, water, or other supplies (Office of the United Nations High Commissioner for Human Rights).

In addition, there has been an increased focus on the health of newborns that has unfortunately caused a diminished focus on maternal health. Infant mortality rates have never been lower, and at least twenty hospitals have developed multidisciplinary fetal care centers for babies with high-risk conditions—only one hospital has done the same for high-risk mothers (Martin and Montagne). Examination of federal and state funding demonstrates that only six percent of block grant funds set aside for maternal and child health are put towards improving maternal health—nearly eighty-percent is reserved specifically for infants (Martin and Montagne). After the baby has been born, mothers are sent home with information about newborn care, but often no information about their own personal care. This leads to delays in

reaching out for health care because women often do not recognize warning signs, are poorly educated on their health, cannot access information, and are not aware of associated costs (Office of the United Nations High Commissioner for Human Rights).

Finally, Mahmoud Fathalla, the former president of the International Federation of Obstetricians and Gynecologists argued that “Women are not dying because of untreatable diseases. They are dying because societies have yet to make the decision that their lives are worth saving” (Reducing US Maternal Mortality as a Human Right). In conjunction with gaps in healthcare and information, women are subject to enduring exposure to sexism and discrimination. Black mothers die at higher rates because racism is laced into misogyny (Vernadakis). Maternal deaths are regarded as private heartbreaks instead of a major public health disaster that require changes in policy and changes in society (Martin and Montagne).

### **Recommendations:**

Specific action should be taken to combat high maternal mortality rates in America. First, grants should be developed at both the federal and state level to be given to hospitals who create and implement care supply kits for maternal emergencies such as hemorrhaging. Second, the essential health services found within the ACA should be protected by statute and made impervious to executive order. Finally, the Department of Health and Human Services should develop expectations for state Maternal Mortality Review Committees, or MMRCs to develop and make accessible research regarding maternal care both before, during, and after birth, including mental health care and warning signs about maternal conditions.

California is the only state to have decreased its maternal mortality rate since 2000; the state only mourns 4.5 deaths per 100,000 live births (The Editorial Board USA Today). The state developed “toolkits” to respond to major maternal crises, particularly hemorrhage. These toolkits included blood that was readily available for transfusions and led to a reduction in major hemorrhages that required a hysterectomy or transfusion by more than twenty-five percent (In Focus: Targeting Maternal Care). In addition, these toolkits decreased the number of near-death hemorrhages by twenty-one percent (Martin and Montagne). California's actions were so impressive that multiple organizations now encourage the California model. The American College of Obstetricians and Gynecologists paired up with the Alliance for Innovation on Maternal Health to develop recommendations for maternal health and instructions for “safety bundles” modeled after California's toolkits that hospitals need to adopt (The Editorial Board USA Today). State and federal government can encourage the adoption of safety bundles and toolkits by offering grants to incentivize hospitals and relieve a cost burden.

The essential health requirements in the Affordable Care Act must be protected to prevent healthcare discrimination based on race, sex, or pregnancy. Health insurance that assures women that their maternal experience is not a pawn for discrimination but rather an important part of the human health experience that deserves coverage should be protected by law and not vulnerable to changing presidential administrations. Covering all women under health insurance that protects the maternal experience is a major part of saving mothers' lives.

Maternal Mortality Review Committees play two important roles in fighting the nation's maternal mortality crisis. First, these organizations collect data about maternal mortalities in their states, and second, they make recommendations about what can be done to improve maternal outcomes. These committees are currently active in thirty-three states, but without federal guidelines and participation from the other seventeen states there cannot be a wholistic view of the nation's maternal mortality picture (The American College of Obstetricians and Gynecologists). The Department of Health and Human Services should develop basic guidelines

for MMRCs to be adopted by states so the data gathered can paint a picture of the nation's relationship with maternal mortality. The "Preventing Maternal Deaths Act of 2017" would grant funding to states to develop maternal mortality review panels. If passed by Congress, states without MMRCs would have a better means of adopting them (Martin and Montagne). MMRCs are important tools because they use records and data to identify what is causing the maternal death rate to rise. They use this data to guide policy, inform the healthcare system of care, and shape programs and quality of care so maternal outcomes may be improved (Zaharatos). Additionally, these committees, if guided by the Department of Health and Human Services, would provide data to the Maternal Mortality Review Information Application and support a uniform data system utilized across the country (Zaharatos). MMRCs would fill in the information gaps that burden hospitals performing maternal care procedures and would also be a means of discovering what information mothers lack when it comes to caring for themselves and making decisions about their family planning and care.

**Counter-Arguments:**

Opponents to these policy proposals may disagree with the contributing factors of the maternal mortality crisis. America may have high maternal mortality rates because many American mothers give birth at older ages, many have poor health or conditions of addiction, and many are obese. These factors may lead to greater risk of maternal death instead of social problems and a fractured healthcare system (Declercq).

In addition, the United States ceased the publication of an official maternal mortality ratio per 100,000 live births in 2007 because the accuracy of the death certificate checkbox came into question (Declercq). The problem of maternal mortality in the United States could be heavily inflated by improper use of the checkbox.

Finally, the Affordable Care Act has often been criticized for its cost and is not well supported by President Trump's Administration or Republican-controlled branches of Congress. Including maternal and infant care as a required point of coverage adds a cost on to insurance plans that many do not want to pay for. MMRCs also require costs to implement, review, and enforce their uniformity (Zaharatos). Each policy proposal suggested has an associated cost, and to many, the costs may not be worth the reward if the problem of maternal mortality is inflated or not a result of society and failures of the healthcare system.

**Rebuttal:**

In response to potential counter-arguments it is important to emphasize the validity of the contributing factors related to society and the failures of the healthcare system. California was able to cut its maternal death rate in half by making changes to the healthcare system, not by improving the preexisting health conditions of all mothers. In addition, the concern about whether the maternal mortality issue is inflated could be laid to rest if MMRCs were implemented to research the issue in every state. The argument that there is a lack of information surrounding maternal mortality is better utilized to support MMRCs and research instead of a reason to assume that no issue exists. Review boards can help correct data errors (Flynn). Finally, mothers need healthcare coverage for maternal care. If the ACA were dismantled, then the costs for maternal care would simply be shifted, not eradicated, and more than twenty-three million people would be left without proper insurance. When the choice is between saving lives and saving costs, it is imperative to choose to save lives.

**Limitations and Barriers:**

The current political climate and cost will both be barriers to the implementation of these policy proposals. Bipartisan support would be necessary to authorize setting aside any funds for

maternal care. It would be an uphill battle to secure support for maternal and newborn care in the Affordable Care Act in the Republican-controlled Senate, and the Trump Administration is unlikely to sign off on these protections while President Trump is working to implement healthcare policies of his own design. Additionally, the cost of grants for maternal toolkits and the cost of implementing and enforcing MMRCs would be high. However, block grants that deal with maternal and newborn health already could be reviewed and altered so that more than six-percent addresses maternal care and grants could be awarded to develop toolkits.

Additionally, the power of enforcement will create a barrier when trying to implement MMRCs. Although the Department of Health and Human Services and the CDC play a role in MMRCs already, it will be challenging to implement uniform policies and enforce their uniformity when over thirty states already have MMRCs in place that are well-developed under their state guidelines. These obstacles are worth overcoming to save the lives of mothers and to guarantee accurate information that informs the healthcare system about maternal health.

**Conclusion:**

The United States' grossly high rate of maternal mortality is unacceptable and is a tragic indication of the need to support and care for mothers and their health. California shows that it is possible for the country to make improvements upon maternal care. State implementation and Congressional support for grants supporting maternal emergency toolkits, offering protection and reinforcement of ACA provisions for maternal care, and adopting uniform Maternal Mortality Review Committees are practical steps to take to improve upon the issue.

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