

Maternal Mortality: A Call for Health Policy Action

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Uzbekistan, Vietnam and the United States—a woman has an almost equal chance of dying from childbirth in each of these three countries despite vast differences in healthcare spending.

The maternal mortality rate in the US is higher than in all other comparable high-income nations. And while the global maternal mortality rate decreased by [44% from 1990 to 2015](#), the US maternal mortality rate has [nearly doubled](#).

As with many US health statistics, there are wide racial disparities in maternal mortality: non-Hispanic black women are [three to four times more likely](#) to die from pregnancy or birth-related complications than white women. The [story](#) of Serena Williams’s near-death experience after the birth of her daughter Olympia recently drew public attention to this startling disparity, which has persisted for decades.

This problem is not intractable. Based on a detailed analysis of maternal deaths in nine states, the [Centers for Disease Control and Prevention](#) found that nearly 60% of maternal deaths are preventable. Indeed, many promising interventions are being pursued at the clinical level including the expanded use of safety protocols known as ‘[bundles](#)’ for pregnancy and childbirth, [programs](#) to lower hospital cesarean section rates, and [implicit bias training](#) initiatives for healthcare providers that aim to reduce pervasive racial stereotyping and unconscious bias throughout the healthcare system.

However, solving this problem also requires broader efforts to reform state- and federal-level policy to support women’s health before, during and after pregnancy.

One important area for health policy intervention is health insurance. In the US, reproductive-age women have long had higher uninsurance rates than their male counterparts due to lower odds of getting insurance through their job. Since the 1980s, Medicaid has been the primary safety net for low-income pregnant women, stepping in to provide coverage from conception to sixty days after delivery. This policy creates high rates of coverage “churn”—moving across different types of insurance or between insurance and uninsurance—surrounding childbirth. [Our research](#) has shown that before the Affordable Care Act, more than half of all women with pregnancy Medicaid were uninsured 12 months prior to delivery and at some point in the six months following birth.

Medicaid policy could be redesigned to acknowledge that a healthy pregnancy and birth requires access to healthcare *before* and *after* pregnancy. This idea is gaining momentum: [federal legislators](#) and [several states](#) have recently proposed bills that would extend Medicaid coverage for pregnant women to one year postpartum.

Beyond insurance, health policy can also shape incentive structures to promote high quality care for women and mothers. Payment reform, within public and private insurance, can hold providers more accountable for poor outcomes and promote the use of evidence-based protocols for preconception, prenatal, and postpartum care. Funding for innovative care delivery models could also be explored, including better coordination between mental and physical healthcare and/or between maternal and

child healthcare. For example, [more states](#) are moving to cover maternal mental health screening in Medicaid well-child visits, which tend to have much higher attendance rates than postpartum visits.

Further, healthcare workforce and training policies that support a more diverse healthcare workforce at all levels (including health system leadership), could play an important role in reducing the [prevalent and persistent racial and ethnic disparities](#) in women's healthcare and health outcomes.

Beyond healthcare policy, public policies that shape the social determinants of health such as employment regulations and family leave, nutrition and food access policy, housing and urban planning, and the criminal justice system, all touch on the lives of women and families and must be considered part of any solution to reduce racial and socioeconomic disparities in maternal mortality and morbidity.

Finally, policy efforts are needed to fund and coordinate systematic and standardized monitoring of maternal health outcomes across jurisdictions. This information will help clinicians, researchers, and policymakers understand the causes and patterns of maternal mortality now and in the future.

However, quantitative data can only get us so far. As solutions are considered on the clinical, community or policy level, we must not forget the importance of elevating the voices of women in the conversation. Developing solutions that can save mothers' lives requires listening to women and learning from their lived experiences both in and out of the healthcare system.

Every maternal death is a tragedy that ought to represent a call to action for all public health professionals. We have a number of policy tools available to stem the rise of maternal deaths. It's time to get to work.