In 2000, the United States was one of 189 nations to sign the Millenium Development Goals which included an aim to improve maternal health by decreasing the maternal mortality ratio between 1990-2015 and ensuring that all women had access to reproductive health.¹

From 1990 to 2013, the number of women who died during pregnancy dropped by 45 percent globally.² The United States, however, remains one of the only developed nations in the world to have seen an increase in pregnancy-related mortality from 7.2 pregnancy-related deaths per 100,000 live births in 1987 to 17.3 pregnancy-related deaths per 100,000 live births in 2013.³ This equates to more than 700 maternal deaths every year. Nearly 60 percent of these deaths are avoidable.⁴ Furthermore, the rate of nearly fatal experiences during childbirth has risen even faster than mortality with 50,000 women a year having such experiences.⁵

This brief highlights the various causes of the increase in maternal mortality as well as various disparities that contribute to the overall problem in the United States.
Main Causes of Maternal Mortality in the US

The demographics of mothers are changing in the United States. As the mean age of first-time mothers increases, there are far more risks associated with the pregnancy process.6,7

Underlying health conditions
The increasing prevalence of obesity, diabetes, and hypertension in the United States has been a significant factor in the increase in maternal mortality.8 Once the smallest contributors of pregnancy-related deaths (8.5 percent in 1987), cardiovascular conditions and cardiomyopathy are now the leading causes of maternal mortality in the United States (26.5 percent in 2013).4,9

Increase in C-sections
While only one-third of C-sections are medically necessary, close to one in three women in the United States gets one.5 C-sections are associated with a higher risk of mortality than natural births.10,11 Moreover, they increase the chance that a woman will have a C-section for subsequent pregnancies.5

Lack of access to reproductive care
Medicaid covers the entire pregnancy process from prenatal (before birth) care to postpartum (after birth) care for 60 days after delivery for all women who have an income at or below 138 percent of the federal poverty level (FPL) in states that did not expand Medicaid under the Affordable Care Act (ACA).12 Nonetheless, with 18 percent of deaths occurring between 43 days and 365 days postpartum, this coverage may be insufficient.5 Both prenatal and postpartum care are essential to the mother’s well-being and require visits to the doctor’s office. Yet, lack of access to reproductive healthcare is a major barrier. With only six percent of obstetrician-gynecologists working in rural areas, maternal mortality and morbidity (adverse conditions that negatively impact the wellbeing of a woman) rates are higher for women living in rural areas.13,14

The opioid epidemic
Between 2012 to 2015, nearly 17 percent of maternal deaths in Texas were due to drug overdose and 58 percent of those deaths were related to opioids.15 Similarly, in Colorado, close to 15 percent of maternal mortality deaths between 2004 to 2012 were related to accidental overdose.16 Most of the women who died from opioid-related deaths were white.
Significant Sociodemographic Disparities Associated with Maternal Mortality in the US

Race has a substantial impact on maternal mortality rates. Black women are 3-4 times more likely to die from a pregnancy-related complication than white women in the United States; in some cities, there is a 12 times higher chance of dying for black women. These disparities exist despite controlling for socioeconomic status (SES) and other potential confounders. One of the reasons is that black women are more likely than white women to have underlying health conditions such as diabetes (prevalence ratio of 1.8:1) and hypertension (prevalence ratio of 1.4:1). Black women also have a higher chance of being uninsured which can contribute to the lack of access to routine care to manage underlying conditions. It can also contribute to the lack of access to postpartum care 60 days after delivery when Medicaid coverage stops for mothers who are in one of 17 states that did not expand Medicaid.

Racial residential segregation also has a significant impact on the inequities in quality and access to healthcare for pregnant black women. In Anacostia, a neighborhood in Washington D.C. where the population is 97 percent black and where 32 percent of the people live below the poverty line, there have been two hospital closures. Women have to travel more than one hour on public transportation in order to get pregnancy-related care. Some women have cited losing their jobs to attend these visits, and others have passed up care altogether. Furthermore, higher quality hospitals are less likely to be in black neighborhoods. One study found that black women in New York City are more likely to deliver their babies in lower quality hospitals than white women, and if black women gave birth in the same hospitals as white women, the maternal morbidity rate could be decreased by 2 percentage points (1,000 cases). This is compounded by the fact that black women are more likely to perceive racial discrimination in hospital settings which is a stress-inducing factor that can translate to poor maternal health outcomes and deter women from seeking care in hospitals that do not frequently serve minority women.

Finally, lower SES is correlated with worse pregnancy outcomes for all races as women of lower SES have a five times higher risk of poor maternal health outcomes than their counterparts of higher SES. A Health Resources and Services Administration (HRSA) report found that the risk of maternal mortality was significantly higher for both black and white women who were living in high poverty areas (more than 15 percent of families in the county under the FPL) as compared to lower poverty areas (up to 14.99 percent of families in the county under the FPL).

Federal Policies in the Pipeline

A 2017 ProPublica and National Public Radio piece about a neonatal intensive care unit nurse who died from preventable pregnancy complications went viral and sparked outrage. It also brought the issue to the center stage leading to the introduction of dozens of policies pertaining to the matter. One of these is the Preventing Maternal Deaths Act of 2017 (H.R. 1318) which, if passed, will create a program under the Department of Health and Human Services (HHS) committed to improving the maternal mortality rate in the country. This program will provide state grants to study the causes of maternal deaths and develop uniform procedures. The bill also stipulates mandatory state reporting of maternal deaths. Another bill, known as the Ending Maternal Mortality Act of 2018 (H.R. 5761), would require HHS to develop a national procedure to improve maternal mortality rates by focusing on at-risk populations and standardizing the quality of care. Both bills are currently awaiting committee action.
Did you know?

It was speculated that some of the increase in maternal mortality was due to changing the International Classification of Diseases (ICD) code from the 9th edition to the 10th in 1999, as well as a revision of the death certificates in 2003 which allowed for identification of an individual as pregnant at the time of death. Even after accounting for these potential confounders, however, the upward trend in maternal deaths is still present.

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