Working to Reduce Maternal Death and Morbidity in the United States

Women in the United States die from complications related to pregnancy or childbirth more than women in any other developed country. Recent studies have shown that at least 41 percent of maternal deaths were likely preventable. Recognizing the impact on quality of life and health care costs, some states have established maternal mortality review committees, programs, and solutions. For example, after California created its maternal mortality review process and prevention measures, the state’s maternal mortality rate has fallen by nearly 50 percent. Congress has an opportunity to help other states learn from California and other state models to improve the health and safety of pregnant women.

The Problem:
- The rate of pregnancy-related deaths in the U.S. was 14.5 per 100,000 live births from 1998 through 2005. In 2009 and 2011, the rate climbed even higher to 17.8 per 100,000 live births.
- According to the Centers for Disease Control and Prevention (CDC), the rate of major complications in childbirth (severe maternal morbidity) more than doubled between 1998 and 2011, resulting in emergency blood transfusions or women having cardiac arrest, sepsis, or seizures among other serious health care problems.
- African-American women are three to five times more likely to die of pregnancy-related complications. In 2011, the maternal mortality ratio for non-Hispanic white women was 12.5 deaths per 100,000 births compared with 42.8 deaths for non-Hispanic black women. These rates and disparities have not improved in more than 20 years.
- The CDC recommends that maternal deaths should be investigated through state collaboratives. These state collaboratives bring together leaders in obstetric and neonatal health care from private, academic and public health care settings to make recommendations about preventing pregnancy-related deaths and health complications and identify ways to improve quality of care for women and infants.

How Can Legislation Help?
- Recognize state best practices and support other states in:
  - Obtaining data on pregnancy-related deaths to identify the associated problems and causes;
  - Establishing a collaborative process with health care providers and patients to identify and implement prevention strategies; and
  - Disseminating findings and recommendations to improve upon current maternal morbidity and mortality rates in the United States.
- Direct HHS to identify and monitor severe maternal morbidity in the U.S., which has a detrimental effect on health care costs and quality of life.
- Seek to develop interventions to reduce maternal health disparities.

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