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OPINION

GUEST ESSAY

More Mothers Are Dying. It Doesn't Have to Be This Way.

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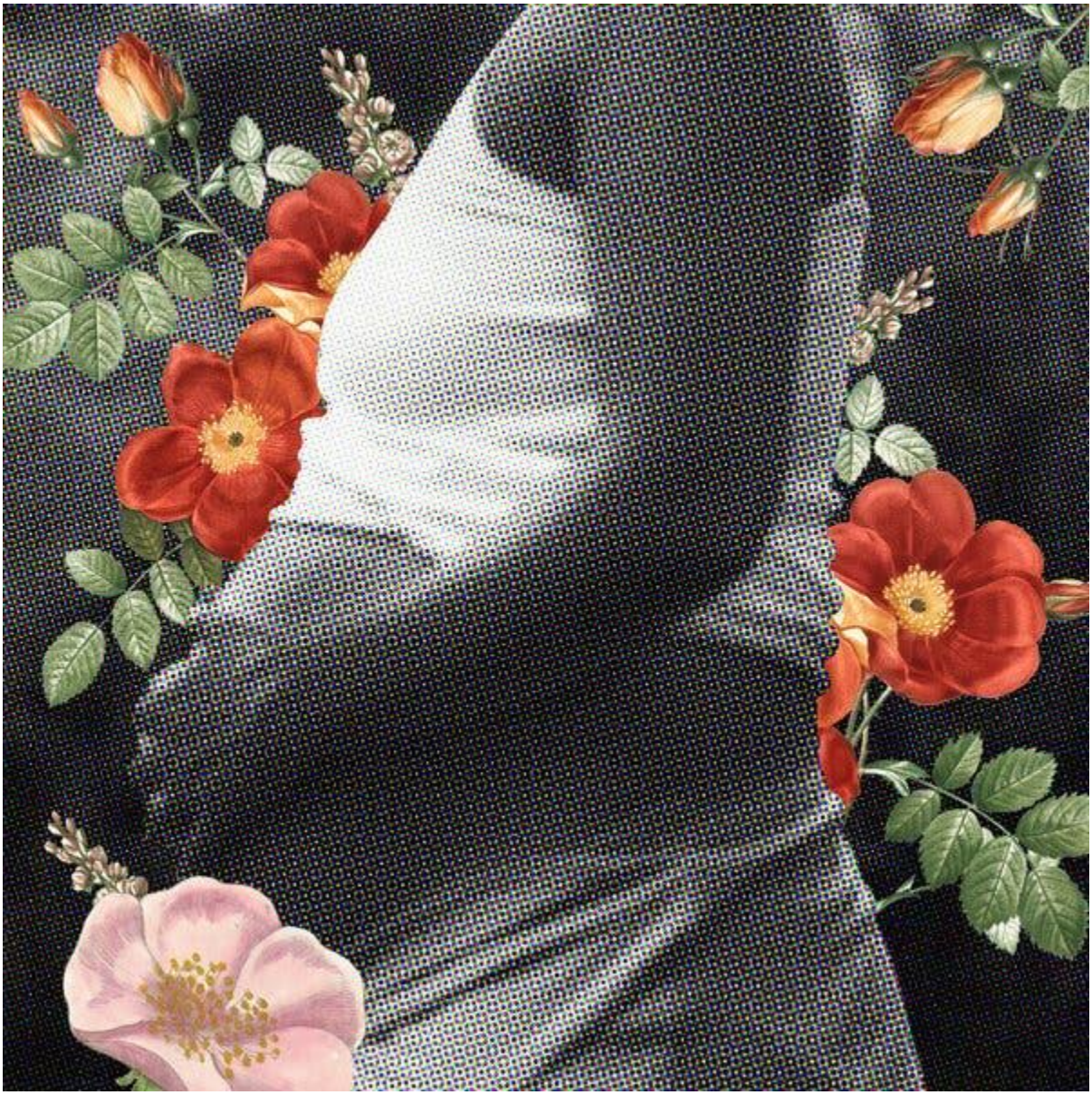

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By Veronica Gillispie-Bell

Dr. Gillispie-Bell is an OB-GYN and an associate professor for Ochsner Health in New Orleans.

After Tori Bowie, an elite athlete, died in May, the reality of the health risks to Black women posed by childbirth was once again in the spotlight. The maternal mortality rate for Black women in America is, according to the Centers for Disease Control and Prevention, 2.6 times that for white women.

Now a recently published study in the medical journal JAMA has revealed that the U.S. maternal mortality rate — already the highest among peer nations — has increased for all racial and ethnic groups. Maternal outcomes in the United States are a public health crisis, and they are only getting worse. We know the data. We need to focus on the solutions.

As a practicing OB-GYN and the medical director of Louisiana's Maternal Mortality Review Committee, I understand not only the problem but also the solutions. To ease the U.S. maternal health crisis, we must improve systems of care, improve clinical quality of care and address social determinants of health. In the United States, we have a health care system that does not serve all populations equitably. Black women are more likely to bear the brunt of structural factors that limit access to care in the form of transportation, child care and economic stability. Even when Black women are able to access health care, we are not always provided the same quality of care as our white counterparts. But there are pathways to improvement.

Some of the increase in the rate of maternal deaths can be attributed to changes in data collection. The addition of a pregnancy check box to the U.S. Standard Certificate of Death in 2003 led to better detection of maternal deaths that otherwise might have been missed, although it may have also introduced some overcounting, according to a C.D.C. report. But this does not account for the disproportionate maternal deaths among Black, American Indian and Alaska Native women.

The United States spends a larger portion of its gross domestic product on health care than any other high-income country, yet our infant and maternal health outcomes are among the worst. We continue to invest in a system that is broken.

Because the United States is the only wealthy country that does not guarantee health coverage, many patients come into pregnancy with chronic medical conditions that have not been diagnosed or managed before pregnancy, including hypertension, diabetes and heart conditions. Among the leading causes of pregnancy-related deaths from 2017 to 2019 were cardiovascular conditions.

In 2021, 41 percent of births in the United States were financed by Medicaid, with rates ranging from 21 percent in Utah to 61 percent in Louisiana. However, in many states, insurance coverage under Medicaid ends 60 days after birth, leaving mothers uninsured and with no access to care. Fifty-three percent of maternal deaths occur from seven days to one year postpartum, demonstrating that the period to intervene to prevent deaths extends at least a year and maybe longer. Under federal law, states have the option to extend Medicaid to one year postpartum. As of this month, 36 states have enacted the extension. Extension of Medicaid to one year ensures insurance coverage to address those chronic illnesses, such as cardiovascular conditions and diabetes, that increase the risk of maternal death.

Insurance coverage is only one piece of the puzzle. We must also address the physician shortage in the United States, specifically the shortage of OB-GYNs. The Bureau of Health Workforce estimates that by 2030, there will be a demand for 52,660 OB-GYNs but a supply of only 47,490, leaving a deficit of 5,170 physicians, with the impact worst in the West and the South.

Those numbers most likely underestimate the decrease; 40 to 75 percent of OB-GYNs report some form of professional burnout from patient load, malpractice litigation and other demands on time. According to the March of Dimes, 2.2 million women of childbearing age live in a maternity care desert — an area with virtually no access to birth centers or obstetric providers.

To address this shortage, we must incorporate midwives into obstetric care. Midwives are trained health care providers equipped to give prenatal care and deliver infants, allowing obstetricians to focus their care on patients who are at higher risk for morbidity and mortality. When midwives are involved in obstetric care, patients have lower C-section rates and decreased rates of preterm birth. However, among high-income countries, the United States has some of the lowest rates of midwives per 1,000 live births.

As an OB-GYN who has been practicing for 15 years, the way I was trained to treat many conditions, including hypertensive disorders of pregnancy, is no longer recommended. Doctors and other providers are not always aware of these changes. Much like the general population, pregnant women and new mothers need medical care that is evidence based to ensure good health outcomes.

The Alliance for Innovation on Maternal Health, or AIM, is a quality improvement initiative designed to put in place and support best practices to reduce maternal morbidity and mortality. AIM, in combination with state-based perinatal quality collaboratives, or P.Q.C.s, uses patient safety bundles — evidence-based practices to ensure readiness, response and recognition for some of the leading causes of maternal morbidity and mortality — to ensure hospitals and providers are giving quality care. Through P.Q.C.s, states have seen fewer severe complications from hypertension and hemorrhaging and reduced rates of unnecessary C-sections. As of May, at least 27 states had C.D.C.-funded P.Q.C.s, and all states except Wyoming are enrolled in AIM. The Centers for Medicare and Medicaid Services has created the designation "birthing friendly" for hospitals participating in structured quality improvement programs and

establishing patient safety bundles. To improve clinical quality of care, all birthing facilities should work to receive this designation.

Maternal outcomes are not determined by health care alone. What we call social determinants of health — where we live, work and play — also affect health outcomes. Social factors affect about half of health outcomes. When we think about maternal mortality, we should also look to economic stability, education access, health care access, neighborhood and the built environment and community.

Generations of racial residential segregation supported by unfair lending practices for home buying have perpetuated inequities for Black Americans. In minority neighborhoods, there is less access to health care and there are food deserts and environmental factors such as factories that have been linked to various negative health outcomes, including preterm births. Add to this decreased access to transportation, which leaves these mothers and families further removed from care.

Social determinants of health also play a critical role in the year after birth. A report from the Commonwealth Fund comparing maternal care in 11 wealthy countries found that the United States is the only one that does not guarantee home visits in the postpartum period. Ours is also the only high-income country that does not ensure paid maternity leave.

Social determinants of health contribute to the disparities we see, but they are not the only factor. A Black woman with a college degree is 1.6 times as likely to die as a result of pregnancy or childbirth as a white woman with less than a high school diploma. Even when we adjust for socioeconomic factors, Black women still suffer. We know of countless accounts, including my own, of Black women presenting for medical care and being ignored.

Why do we ignore the voices of Black women? Unconsciously, we in the medical field have developed biased beliefs about Black women based on stereotypes. There is a biased belief that Black women are overly loud and demanding and that we can take more pain than our white counterparts. One study showed that some medical residents believe that Black people have thicker skin and therefore do not feel pain in the same way as other racial groups. In the same study, participants who endorsed such false beliefs were less likely to prescribe appropriate pain medicine. Such biases create inequities in health care delivery.

We know the problems driving the maternal health crisis, and we know what we could be doing to improve the situation. No mother should ever go into childbirth fearful that the cost of bringing in a life will be the loss of her own.

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Opinion

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Veronica Gillispie-Bell is an obstetrician and gynecologist and an associate professor for Ochsner Health in New Orleans, as well as the medical director of Louisiana's Maternal Mortality Review Committee.

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