US maternal mortality rate the highest among high-income countries

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The release of a critical report by The Commonwealth Funds this week only further underscores the decrepit state of healthcare in the United States, the center of world capitalism. The study, titled "Insight into the US Maternal Mortality Crisis: An International Comparison," found that in 2022 maternal mortality for the US at 22.3 maternal deaths for every 100,000 live births continues to be the highest among high-income nations. And as the Centers of Disease Control and Prevention (CDC) has previously noted, more than four in five of these deaths could have been prevented.

By comparison, Chile and New Zealand, the next closest countries in this category, are substantially lower at 14.3 and 13.6 deaths per 100,000, respectively. For many European Union nations, the rates are three-fold lower. In Norway, the maternal mortality rate in 2022 reached zero deaths per 100,000.

Although the US figures are down considerably from their 2021 highs at 32.9 deaths per 100,000 (a 33 percent decline), this has more to do with the decline in rates of COVID deaths among pregnant women. Numerous studies indicated that COVID significantly contributed to preeclampsia, preterm births, stillbirths and other adverse outcomes. Still, when compared to 2020, when the rate was 23.8 maternal deaths, the figures have remained essentially unchanged since the pre-pandemic period.

Perhaps what is most remarkable is that 65 percent of these deaths occur after delivery. Twelve percent occur in the first week after birth. Contributing factors during this early period include severe bleeding, elevated blood pressures and infections. Another 23 percent of deaths take place between days seven and 42, while 30 percent are in the late postpartum period, between days 43 and 365. Causes for these deaths are usually attributable to a condition called cardiomyopathy, when the heart muscles grow weak.

Researchers have been scratching their heads to identify the causes for these alarming outcomes. Certainly, conditions like obesity and other chronic diseases compounded by increasing cesarean sections have contributed to severe maternal comorbidities. However, as Dr. Lindsay Admon, an obstetrician-gynecologist at the University of Michigan Medical School, told *Scientific American*, "Focusing too narrowly on demographics, labor and delivery paints an incomplete picture of maternal health."

As the report observed, "[Over] the past decade, maternal mortality during labor and delivery has decreased in US hospitals across people of all ages, races and ethnicities, which researchers say is a result of improved birthing protocols. This reduction in deaths during childbirth itself implies that other factors are driving the overall rising rates of maternal mortality."

Indeed, while efforts have been placed on ensuring safer deliveries, little has been done to improve outcomes before and after deliveries.

When one reviews maternal mortality by state, there is an obvious correlation between states like Arkansas (43.5 maternal deaths per 100,000), Mississippi (43.0), Tennessee (41.7), Alabama (41.4), and Louisiana (39.0) and high rates of poverty. An eye-opening report from last month published by Lending Tree, an online lending marketplace, found that six of 10 states that offered the worst access to prenatal and maternal care were in the South. Among these were Alabama, Texas, Florida, Georgia, Arkansas and Tennessee. In particular, Alabama ranked lowest in the number of maternal care providers per capita. Mississippi also has the highest infant mortality rate in the country.

In another concerning difference in the international comparison study, Commonwealth Funds found that the number of providers per 1,000 live births in the US was one of the lowest among the high-income countries. Although the number of obstetricians per capita was the same for the US and Sweden, which has almost ten-fold lower maternal mortality, Sweden has 69 midwives per 1,000 live births, compared to the US with only four midwives per 1,000 live births.

These differences have a historical context. Although, as an institution, midwifery survived in Europe, in the US it was displaced in the early 20th century when pregnancies were "medicalized" and births began to take place more and more in hospital settings. A 2014 State of the World's Midwifery Report demonstrated that well-educated midwives operating under international standards could provide more than 80 percent of the essential care for women and their newborns.

In a *Lancet Global Health* report from 2021, the authors noted that "[in] high-income settings, midwife-led continuity of care has been associated with positive outcomes, including fewer preterm births, fewer fetal losses at any gestation, and high rates of positive experiences reported by women."

The authors of the Commonwealth Fund study said, "Midwives are clinicians trained to provide a wide range of services—helping to manage normal pregnancies, assisting with childbirth, and providing care during the postpartum period, among others."

Such services over the months that pass after delivery can greatly facilitate long-term health assessments such as symptoms of heart

overload that may manifest with swelling and fatigue, early signs of thromboembolic events, or even assessment of postpartum depression or domestic violence that could herald tragic consequences. Optimally utilizing midwives could avert 41 percent of maternal deaths, 39 percent of neonatal deaths, and 26 percent of stillbirths.

Furthermore, the Commonwealth study added, "By placing a priority on natural reproduction processes and relationship-building, midwives also can help address the social needs of mother, baby, and family."

Yet, in the US, the trends are diametrically opposed to these conceptions. The cost of delivery continues to climb, and access to obstetric services continues to dwindle. A 2022 March of Dimes report indicated that 5 percent of counties across the country had less access to obstetric services than two years before. "These areas of combined low or no access," they wrote, "affect up to 6.9 million women and almost 500,000 births in the US," or one in eight children born per year.

Another issue that exacerbates maternal mortality rates is the lack of any federally mandated paid leave policy that could help women adjust to the physical and mental demands placed on new mothers while being guaranteed their income and job security. The Bureau of Labor Statistics indicated that in 2023, only 27 percent of civilian workers had access to paid family leave. Even these statistics conceal the fact that access to paid leave is lowest among workers with the greatest needs.

Paid leave has many positive correlations: a decline in infant mortality, decreased risk of preterm birth and low birth weight, lower rates of rehospitalizations, higher rates of attending pediatric and postpartum visits, improved vaccination rates, higher rates of breast feeding, improved parent and child health and interrelationships. There are long-term benefits for the entire family unit, with lowered rates of depression among mothers and better cognitive and coping skills for children.

The study also highlights that while maternal mortality is higher in the US than other high-income countries, it is highest among black women. One can also say that it is highest among all racial categories in the US, or, in other words, no one is spared. Clearly, the disproportion among black women is considerable at 49.5 per 100,000 while among whites it is 19.0 per 100,000 live births—also higher than any other high-income country.

The socioeconomic factors that contribute to these outcomes are multifactorial and regional. The Southern states where access to obstetric care is worst also have a higher proportion of African Americans. Nearly all of the health conditions discussed above are worse in that region of the country. But fundamentally, the issue of maternal mortality is a class issue, and the class differences are pervasive across countries whatever the race or racial divisions in the populations.

A 2021 report by Gopal K. Singh from the US Department of Health and Human Service, published in the *International Journal of Maternal and Child Health and Aids*, looked at trends and social inequalities that contributed to maternal mortality in the US over five decades. Although there had been a notable decline in mortality from 1970s into the 1990s, that trend has ended, along with the broader decline in the global economic standing of the US.

The trends among racial groups have also persisted over the last two decades. The authors found that increasing maternal age increased maternal mortality for all racial groups but was most marked for black women 40 years old and older. Also, higher maternal education was protective of health, while unmarried status increased risk of death. Additionally, those living in small towns and large rural areas had higher mortality rates. But the overriding factor, among women of all races, was poverty.

Singh found that "between 2002 and 2018, both absolute and relative disparities in maternal mortality by deprivation level widened. Higher deprivation levels were generally associated with higher maternal mortality risks among both white and black women in each period. For example, in 2014-2018, black women in the most-deprived area group had a 70 percent higher maternal mortality risk than black women in the most affluent area group. For white women, the corresponding relative risk of mortality was 104 percent higher in the most-deprived group compared to the most-affluent group." Although Singh notes that within each deprivation group racial disparities in maternal mortality existed, these factors are best understood through the perspective of class and the historical development of social life in the United States.

Like many important studies highlighting the enormous inequality that is part and parcel of life under the diktats of capitalism in terminal crisis, these reports stop short of making the correct diagnosis or prescribing solutions. The authors operate under the premise that capitalism can't be altered, let alone done away with, and therefore we must look elsewhere for solutions. So there are no calls for slashing the defense budget and using the resources to eradicate maternal mortality. Such proposals are not impossible or inconceivable, but they require a shift in social consciousness in favor of going to war against social evils, not against working people around the world.