

IMPROVING OUTCOMES FOR NEW MOTHERS IN THE UNITED STATES

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I.	INTRODUCTION	187
II.	BACKGROUND.....	189
III.	THRESHOLD NECESSITY	190
IV.	WHY BORROW FROM FINLAND, GERMANY AND CALIFORNIA	193
V.	LAWS AND PRACTICES TO BORROW	194
	A. <i>Home Healthcare from a Trained Professional:</i>	194
	B. <i>“Motherpass:”</i>	195
	C. <i>Maternity Package</i>	196
	D. <i>California Practices</i>	196
VI.	LAWS THE U.S. SHOULD IMPLEMENT.....	198
	A. <i>Earlier Postpartum Care</i>	198
	B. <i>Midwife Care:</i>	200
	C. <i>Motherpass:</i>	202
	D. <i>Maternity Package:</i>	203
VII.	SAVING MONEY THROUGH THE IMPLEMENTATION OF NEW LAWS	204
VI.	CONCLUSION.....	205

I. INTRODUCTION

The United States has a shockingly high maternal mortality rate. Conservative estimates put the maternal death rate between 700-900 deaths

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per year,¹ which is more than double since 1987.² Research shows that it is more dangerous to give birth in 2020 than it was 40 years ago. What is even more shocking is that research also shows that at least 60% of these deaths are preventable.³

The maternal mortality rate, also called the pregnancy-related mortality ratio, is the number of pregnancy-related deaths for every 100,000 live births.⁴ The Centers for Disease Control and Prevention (CDC) defines pregnancy-related deaths as the “death of a woman while pregnant or within 1 year of the end of a pregnancy – regardless of the outcome, duration or site of the pregnancy – from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.”⁵ This definition is taken from the World Health Organization (WHO)⁶ and is used by all countries, allowing for comparisons of maternal mortality rates between countries.

The maternal mortality rate has more than doubled in the U.S. from 7.2 deaths per 100,000 in 1987 to 18 deaths per 100,000 live births in 2014, according to the U.S. Dept. of Health and Human Services (HHS).⁷ The CDC released a report in January 2020 listing the U.S. maternal mortality rate for 2018 at 17.4.⁸ This ranks the U.S. 55th worldwide, according to WHO, just behind Russia. The U.S. is ranked tenth out of ten when compared to similarly wealthy countries.⁹ This number could be a drastic undercount since the CDC number does not count births for women over forty-four nor do they

1. Robin Fields & Joe Sexton, *How Many American Women Die From Causes Related to Pregnancy or Childbirth? No One Knows.*, PROPUBLICA (Oct. 23, 2017, 8 AM), <https://www.propublica.org/article/how-many-american-women-die-from-causes-related-to-pregnancy-or-childbirth>.

2. U.S. DEP’T OF HEALTH AND HUM. SERV., HRSA MATERNAL MORTALITY SUMMIT: PROMISING GLOBAL PRACTICES TO IMPROVE MATERNAL HEALTH OUTCOMES 5 (2019).

3. Emily E. Petersen et al., *Vital Signs: Pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013–2017*, 68 MORBIDITY AND MORTALITY WKLY. REP. 423, 423 (2019), <https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6818e1-H.pdf>.

4. PREGNANCY MORTALITY SURVEILLANCE SYSTEM, CDC, <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> (last visited Oct. 10, 2019).

5. *Id.*

6. WORLD HEALTH ORGANIZATION, INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS 156 (2010 ED., 10TH REV. VOL. 2).

7. U.S. DEP’T OF HEALTH AND HUM. SERV., *supra* note 2, at 5.

8. Press Release, CDC, First Data Released on Maternal Mortality in Over a Decade (Jan. 30, 2020), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2020/202001_MMR.htm.

9. Julia Belluz, *We Finally Have a New US Maternal Mortality Estimate. It’s Still Terrible.*, VOX (Jan. 30, 2020, 10:40 AM), <https://www.vox.com/2020/1/30/21113782/pregnancy-deaths-us-maternal-mortality-rate>.

count deaths that happen after forty-two days postpartum.¹⁰ By the CDC's own admission, 24% of maternal deaths occur six weeks or more after birth.¹¹

Maternal mortality can vary depending upon a few factors. African American women are three to four times more likely to die from pregnancy-related causes than Caucasian women, and Native American women are three times more likely to die from pregnancy related causes than Caucasian women.¹² The number of maternal deaths also differs depending upon the state where the mother gives birth. California currently has the lowest maternal death rate with a 4.5 out of 100,000¹³ while Louisiana has the highest with 58.1.¹⁴

The U. S. needs to lower its maternal mortality rate. Completely fixing the problem will require addressing many broad aspects of law and society, such as healthcare access, income inequality, and systemic racism within the medical field. This paper will focus on smaller incremental changes that can be made to existing healthcare laws and practices that would immediately help. Drawing from California, Germany, and Finland these changes can be a model for how federal standards should be set and implemented.

II. BACKGROUND

The U.S. spends more on healthcare annually than any other developed nation.¹⁵ The U.S. also spends the most money on pregnancy.¹⁶ Women should not be dying at the rate they are, especially in light of the disproportionate expenditures. The spiraling cost of healthcare in the U.S. is

10. Vanessa Taylor, *The CDC's Updated Maternal Mortality Stats Show How Far the U.S. Has to Go*, MIC (Jan. 31, 2020), <https://www.mic.com/p/the-cdcs-updated-maternal-mortality-stats-show-how-far-the-us-has-to-go-21765288>.

11. *Id.*

12. Belluz, *supra* note 9, at 2; Press Release, CDC, Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths (Sept. 5, 2019, 1:00 PM), <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>.

13. Michael Ollove, *A Shocking Number of U.S. Women Still Die of Childbirth. California Is Doing Something About That.*, WASH. POST (Nov. 4, 2018, 9:00 AM), https://www.washingtonpost.com/national/health-science/a-shocking-number-of-us-women-still-die-from-childbirth-california-is-doing-something-about-that/2018/11/02/11042036-d7af-11e8-a10f-b51546b10756_story.html.

14. *USA Today Investigation Ranks States with the Highest Maternal Death Rates*, CBS NEWS (July 26, 2018, 1:48 PM), <https://www.cbsnews.com/news/best-and-worst-states-to-give-birth-usa-today-investigation/>.

15. Bradley Sawyer & Cynthia Cox, *How Does Health Spending in the U.S. Compare to Other Countries*, PETERSON-KFF HEALTH SYS. TRACKER (Dec. 7, 2018), <https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-start>.

16. *The U.S. Maternal Health Crisis: 14 Numbers You Need to Know*, AMNESTY INT'L (May 3, 2011), <https://www.amnestyusa.org/the-u-s-maternal-health-crisis-14-numbers-you-need-to-know/> [hereinafter AMNESTY INT'L].

a significant problem that should be addressed; however it is beyond the scope of this paper.

Money is not determinative of whether a woman receives good postpartum care.¹⁷ Immensely helpful changes can be implemented that are relatively low cost, such as following the best practices from the Alliance for Innovation on Maternal Health (AIM) and engaging in ongoing education and training.¹⁸ Following these practices makes giving birth safer for women regardless of income.

When people discuss changes to healthcare, the immediate response is to claim the changes are too expensive. Setting aside the real-world consequences, like death, the price argument does not stand up here. If a woman receives comprehensive care during and after pregnancy, then she will be able to avoid many complications that are expensive to treat. About four million women give birth each year in the U.S., making childbirth related care the most common reason for hospital services.¹⁹ Ninety-eight billion dollars is spent each year on hospital bills related to childbirth.²⁰ Healthcare fees for maternal care are twice as high in the U.S. than any other country.²¹ A substantial reason for those costs are that some complications are not caught in a timely fashion, and as a result, costly treatments ensue. One study that followed mother-infant pairs for five years after birth found that untreated perinatal mood disorders cost California \$2.4 billion in those subsequent five years.²² That is one pregnancy complication in one state, and it cost billions of dollars to treat because it was not addressed properly when presented. If this paper's proposed changes are made on the federal level, they would save lives and save money.

III. THRESHOLD NECESSITY

To begin the fight to improve outcomes for new mothers in the U.S., we need data.²³ To address the maternal mortality rate it is essential to know

17. Ollove, *supra* note 13, at 1.

18. Council on Patient Safety in Women's Health Care, *AIM Program Library*, ALLIANCE FOR INNOVATION ON MATERNAL HEALTH, <https://safehealthcareforeverywoman.org/aim-program/> (last visited Oct. 9, 2020).

19. AMNESTY INT'L, *supra* note 16, at 1.

20. *Id.* at 2.

21. *Id.*

22. Rhitu Chatterjee, 'A Lifeline' For Doctors Helps Them Treat Postpartum Depression, NPR (Jan. 15, 2020, 5:03 AM), <https://www.npr.org/sections/health-shots/2020/01/15/794943944/a-lifeline-for-doctors-helps-them-treat-postpartum-depression>.

23. See Fields et al., *supra* note 1 ("What we choose to measure is a statement of what we value in health," stated Dr. William Callaghan, the head of the CDC's maternal and infant health branch. He also rated the difficulty of measuring maternal deaths at about a 3 on a scale of 10 and

what the contributing factors are, and all parties involved need to be on the same page. The CDC released a report in January 2020 regarding the maternal mortality rate for the first time in over a decade.²⁴ The main reason the CDC delayed releasing any reports was a lack of confidence in the data due to a lack of standardization. Another reason why such data is lacking is because sharing information on maternal mortality is voluntary.²⁵ The U.S. currently has no central way to collect or analyze data, nor general agreement on the data that needs to be collected. The CDC, for example, requests states to send copies of death certificates²⁶ for women who died during pregnancy; these are tracked via the Pregnancy Mortality Surveillance System (PMSS).²⁷ This is not mandatory reporting nor is a death certificate an accurate way to account for all pregnancy related deaths.

In December 2018, Congress passed H.R. 1318, a law aimed at gathering data. This statute allocates 12 million dollars to the research of maternal mortality, starting with data gathering.²⁸ The new law directs HHS to establish a program to support state efforts to establish or expand Maternal Mortality Review Committees (MMRC). In addition, it directs the program to collect consistent standardized data, and work with state departments on prevention.²⁹ But nothing in the bill makes participation mandatory.³⁰ I propose that Congress mandate and standardize the reporting of maternal deaths in order to fully address the problem that is plaguing this country.

The MMRC draws information from a variety of sources including vital records, social media and others. The CDC currently only uses the death certificate. By gathering information from many sources, there is a more complete picture of the underlying cause of the maternal death.³¹ These committees can also determine whether the death could have been prevented

viewed the lack of data as a reflection on the lack of importance America places on expectant and new mothers).

24. BELLUZ, *supra* note 9, at 2.

25. Mayer et. al, *The United States Maternal Mortality Rate Will Continue To Increase Without Access To Data*, HEALTH AFF.: HEALTH AFF. BLOG (Feb. 4, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190130.92512/full/>.

26. Fields et al., *supra* note 1 (noting that it only became standard in 2018 for all states to include a checkbox on death certificates, at the request of the CDC, to indicate if a woman had been pregnant within one year prior to death. This is not reliable data because the person filling out the death certificate may not have access to that information.).

27. Mayer et al., *supra* note 25.

28. *Id.* at 4.

29. Kozhimannil et. al, *Beyond The Preventing Maternal Deaths Act: Implementation And Further Policy Change*, HEALTH AFF.: HEALTH AFF. BLOG (Feb. 4, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190130.914004/full/>.

30. *Id.* at 3.

31. Fields et al., *supra* note 1.

and what steps to take in the future.³² California began using a review committee in 2006, since then maternal deaths have dropped by 55%.³³ Despite the clear benefit of the review committees, many states do not have them. Experts cite resource issues as the main struggle to begin or to keep a review committee going.³⁴ But, by government standards, these committees are not expensive because committee members typically volunteer their time.³⁵

Currently, only thirty-eight states have MMRCs recognized by the CDC, and the data collected is not standardized.³⁶ While this is an increase from the twenty-two committees that existed in 2010,³⁷ it shows why participation needs to be mandatory from the Federal Government. The data collected by these thirty-eight committees varies by how it is collected, what is collected, how often hospitals report, to whom they report, and who has access to the data.³⁸ State laws and regulations also differ in how the information from these committees should be used and what the next steps should be.³⁹ At least thirty states have been able to avoid scrutinizing the medical care that women receive and, instead, solely focus on the women's lifestyle choices to account for the pregnancy related deaths.⁴⁰ All of these variables should be standardized so that the best course of action can be determined.

The government should go beyond H.R. 1318, and establish maternal review committees that make it mandatory to gather data. Congress should also make reporting to the CDC mandatory. This would create a central system that gathers and synthesizes data to make recommendations about best practices and preventative care for pregnancy and postpartum.

The proposed system above would not create any unnecessary burden on the Federal Government because they already require Medicaid to disclose information about care for the elderly as a condition to receive funding, which is then posted online.⁴¹ It would not be hard to require

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

36. Kozhimannil et al., *supra* note 29.

37. *Id.*

38. *Id.*

39. *Id.*

40. Laura Ungar, *Maternal death: What states aren't doing to save new mothers' lives*, USA TODAY (Nov. 14, 2019), <https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/09/19/maternal-death-rate-state-medical-deadly-deliveries/547050002/>.

41. Alison Young & Alison Young, *Hospitals know how to protect mothers. They just aren't doing it.*, USA TODAY (Nov. 14, 2019), <https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/>.

hospitals to disclose pregnancy-related death and complications data as a contingency to receive funding. There has been more than a decade of studies, advice, training, and support from groups such as the American College of Obstetricians and Gynecologists (ACOG), the CDC, the California Maternal Quality Care Collaborative, American College of Nurse-Midwives, and more. Unfortunately, hospitals continue to ignore the best practices that have been presented and proven, instead choosing to provide uneven care.⁴² If hospitals are required to disclose data and implement best practices, this would go a long way in the fight against the rising maternal mortality rate.

IV. WHY BORROW FROM FINLAND, GERMANY AND CALIFORNIA

Finland, Germany, and California are all at the forefront of the fight to end maternal deaths. While Finland and Germany have been at the top of the field for decades, California is relatively new. Each offers innovative and collaborative ways to make the pregnancy and the post-partum time safer for the woman.

Finland, recognizing a problem, began gathering data on infant and maternal mortality around the turn of the 20th century. It immediately began using the data to make healthcare changes that were safer for the mother and the baby.⁴³ Even though Finland is one of the safest countries to give birth in, they continue to explore ways to make it even safer.⁴⁴ Finnish representatives recently attended a conference in the U.S. focused on maternal mortality hosted by the Health Resources and Services Administration (HRSA).⁴⁵ The Finns wanted to learn about any new practices they could bring home and to teach what had worked for their country.⁴⁶ The U.S. should emulate the Finns in constantly striving to get lower maternal deaths.

The Finnish Government began changing healthcare laws early on in the 20th century to benefit pregnant women and families. They created the first maternity and child health clinics in the 1920s.⁴⁷ There, women could receive pre- and post-pregnancy services.⁴⁸ The Finnish Government then introduced

42. *Id.*

43. See generally Tuovi Hakulinen & Mike Gissler, *Finland's low infant mortality has multiple contributing factors*, THL-BLOGI (Jan. 27, 2017), <https://blogi.thl.fi/finlands-low-infant-mortality-has-multiple-contributing-factors/>.

44. U.S. DEP'T OF HEALTH AND HUM. SERV, *supra* note 2, at 4.

45. *See id.*

46. *See id.*

47. *See id.*

48. *Id.* at 2.

the Maternity package in 1938, which contained everything a baby needed in the first year of life.⁴⁹ This was followed by healthcare laws in 1944 that charged local authorities with providing maternity and child services as part of the primary care for each citizen and permanent resident.⁵⁰ These services included midwife home visits which helped new mothers immensely. This deep commitment to a new mother's health is the reason why Finland is the safest country in the world to give birth.

Germany began making health insurance mandatory for all citizens and permanent residents in its 1883 healthcare bill.⁵¹ The Germans began gathering data related to maternal mortality in the 1950s,⁵² as they wanted to address the high maternal and infant mortality rate within their country. At the turn of the 20th century, Germany, like the rest of the world, was experiencing a high rate of maternal and infant mortality.⁵³ Beginning in 1976, the German government convened a commission made up of representatives from all aspects of healthcare to review policies and make recommendations in a wide range of health related areas.⁵⁴

California is the safest state to give birth in within the United States. California has achieved this through the continued use of review committees, which in turn have implemented best practices for many post-partum complications and extensive training for doctors and nurses.

Due to their pioneering practices in this field, I propose implementing laws borrowed from Finland, Germany and California. Although these places differ from one another in many ways, their innovative practices and procedures can be easily incorporated into existing U.S. federal healthcare laws without a huge expenditure.

V. LAWS AND PRACTICES TO BORROW

A. *Home Healthcare from a Trained Professional:*

Both Finland and Germany, and virtually all of Europe, require a trained professional to make home visits as part of the post-natal care. These care givers are trained in a wide array of skills to care for the mother and the baby.

49. *Id.* at 11.

50. *See id.*

51. *Healthcare in Germany*, WIKIPEDIA, https://en.wikipedia.org/wiki/Healthcare_in_Germany (last visited Nov. 2, 2020).

52. Max Rosner & Hannah Ritchie, *Maternal Mortality*, OUR WORLD IN DATA (2013), <https://ourworldindata.org/maternal-mortality> (last visited Nov. 2, 2020).

53. *Id.*

54. WIKIPEDIA, *supra* note 51.

In Finland, this medical professional is a health nurse who comes to your home to assess the health of the mother and baby.⁵⁵ The health nurse will make trips to the pregnant mother's home at least once a month and will arrange for post-natal doctor's visits within two weeks of the mother giving birth.⁵⁶ The health nurse is trained in a vast skillset for the mother and baby wellness including post-natal assessments, looking for signs of depression, looking for signs of potential postpartum complications, baby feeding, and family planning. Part of the health nurse's job is to educate the family so the new mother can take care of herself and the baby.

Germany has the same holistic approach to postpartum care that includes home care by a midwife. The midwife will visit the new mom at home the day after she is discharged.⁵⁷ In the days that follow, the midwife will visit every day for the first 10-14 days and will then continue to visit up to eight weeks after the mother has been discharged from the hospital.⁵⁸ The midwife in Germany assesses the baby and the mother's health and will help schedule follow ups with a doctor, if needed. After the initial eight weeks, visits will become less frequent, but the midwife will continue to answer questions and help with the transition of being a new mother.⁵⁹

B. "Motherpass:"

Germany uses a Mutterpass, or "motherpass." A Mutterpass is a booklet that all German women are given during pregnancy and it acts as a complete record for the pregnancy and post-partum period.⁶⁰ All medical professionals who see the mother put information from the pregnancy, birth and postpartum period into the Mutterpass.⁶¹ During pregnancy and up to a year after, it is recommended this document be carried at all times in case an emergency arises.⁶² This document has all the medical information about the mother and the baby in one place. A new mom does not have to worry about

55. ULLA HOPPU ET AL., *HAVING CHILDREN IN FINLAND*, 20 (Hanna Talasniemi trans., Ministry of Labor, Migration Division, 2nd rev. ed. 1997).

56. *Id.*

57. *Having a baby in Germany*, EXPATICA (Oct. 9, 2020), <https://www.expatica.com/de/healthcare/womens-health/having-a-baby-in-germany-107643/>.

58. Sabine Devins, *The midwife: Your best friend in natal care*, THE LOCAL (Oct. 5, 2010), <https://www.thelocal.de/20101005/30273>.

59. *Id.* (noting that sometimes midwives even offer fitness classes with the baby).

60. Berlin for all the Family, *The Mutterpass: An English Explanation & Translation*, ¶ 2, (Jul. 22, 2013), <http://www.berlinforallthefamily.com/pregnant/the-mutterpass-an-english-explanation-translation>.

61. *Id.* ¶ 3.

62. *Id.*

transferring data from doctor to doctor,⁶³ nor do they have to worry about emergency responders not having all of the pertinent information available.

C. *Maternity Package*

One of the first ways Finland addressed infant mortality problems was by introducing the Maternity package in 1938.⁶⁴ Originally, this package was distributed by the social welfare of the mother's municipality depending on income.⁶⁵ In 1949, this benefit was extended to all pregnant women regardless of income.⁶⁶ The package is a "welcome pack" from the Finnish Government to the new family. The package contains all clothing, diapers, bedding, and outerwear that a baby will need in the first year of life, including a bed.⁶⁷ The Finnish Government used this package as an incentive for women to receive prenatal care. A mother could only receive this benefit after obtaining a certificate that affirms the pregnancy has lasted 154 days or more and that the mother had a health examination before the fifth month of pregnancy.⁶⁸ This package helped incentivize prenatal care in Finland (with wonderful results) and has since been implemented in other countries, like Mexico and Sweden, to try to achieve the same result.⁶⁹

D. *California Practices*

Federal policymakers should look to California for guidance in policies regarding gathering and reporting data, and also for the implementation of narrowly focused solutions to help make birth safer. In 2006, after noticing an alarming increase in maternal deaths, California created a pregnancy-

63. The author's personal experience illuminates this point:

"At two weeks my baby had to go to the hospital for a fever and shortness of breath, due to her complicated delivery and pneumothorax. The hospital she was delivered in did not have an ER that served infants, so we went to another hospital. This new hospital did not have her medical records and were relying on two scared parents to try and remember everything we were told during the four days she had been in NICU, including every medical term. The ER staff was trying to call the birthing hospital but with everyone busy they were not getting the answers they needed. If we had a Mutterpass this would not have been so complicated since the information would have been on hand." (citation omitted).

64. Hakulinen et al., *supra* note 43, at ¶ 4.

65. *Id.* ¶¶ 4, 5.

66. *Id.*

67. Helena Lee, *Why Finnish Babies Sleep in Cardboard Boxes*, BBC NEWS, (Jun. 4, 2013), [www.bbc.com/news/magazine-22751415.com](http://www.bbc.com/news/magazine-22751415).

68. Hakulinen et al., *supra* note 43.

69. Emily Matchar, *Finnish Baby Box Is Becoming Popular Around the World*, SMITHSONIAN, (Mar. 30, 2017), <https://www.smithsonianmag.com/innovation/finnish-baby-box-is-becoming-popular-around-world-180962723/>.

related mortality review board.⁷⁰ This board looked at the cause of every pregnancy-related death.⁷¹ In turn, this agency created the California Maternal Quality Care Collaborative, which brought people from many fields to sift through the data and identify solutions.⁷² This data is compiled into the Maternal Data Center and researchers analyze down to the hospital level to see if providers are following the best practices.⁷³ Hospitals report their data every forty-five days, a quick pace for the medical field.⁷⁴ Medicaid-managed plans in the state require hospitals to participate to receive money. This is the model the Federal Government should employ.⁷⁵ This approach helped California cut their maternal mortality rate by 55% from 2006 to 2013, and this trend continues.⁷⁶ California has been able to implement these practices for \$950,000 a year,⁷⁷ making it attainable for all states.

Hospitals in California implemented best practice standards and regular postpartum treatment for common complications. These relatively simple changes have quickly brought down the maternal mortality rate for all,⁷⁸ not just the wealthy.⁷⁹ Some of the changes include quantifying the mother's blood loss instead of estimating it and giving blood pressure medication within sixty minutes of a high blood pressure reading.⁸⁰ One striking example is where the oversight committee recognized that when a woman was hemorrhaging during birth, nurses had to run to where the blood was stored, taking up to fifteen minutes.⁸¹ The simple fix was to keep a storage of blood in the labor and delivery department, cutting down the time it took to treat a hemorrhage.⁸²

70. Ollove, *supra* note 13.

71. *Id.*

72. *Id.* ¶ 1.

73. *Id.* ¶ 6.

74. *Id.*

75. *Id.*

76. *Id.* ¶ 1.

77. *Id.* ¶ 3.

78. *Id.*

79. *Id.*

80. Am. Coll. of Obstetricians and Gynecologists, *ACOG Committee Opinion: Quantitative Blood Loss in Obstetric Hemorrhage*, 134 J. OBSTETRICS & GYNECOLOGY 1129, e151 (2019), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2019/12/quantitative-blood-loss-in-obstetric-hemorrhage.pdf>.

81. Ollove, *supra* note 13.

82. *Id.*

For preventative measures, California uses toolkits to address emergency complications.⁸³ It identified the most commonly treated complications and created a toolkit for each, similar to a crash cart for heart-attacks.⁸⁴ For instance, there is an obstetrical hemorrhage cart stocked with all equipment that would be needed in the emergency: a checklist, IV line, oxygen masks, speculum, and Bakri balloon.⁸⁵ Having everything at their fingertips and a checklist of what needs to be done as a reference enables the staff to work quickly. California's practices should be implemented on a nationwide basis.

VI. LAWS THE U.S. SHOULD IMPLEMENT

A. *Earlier Postpartum Care*

The U.S. needs to implement a healthcare regulation that mandates a woman to see a trained medical professional within three days of giving birth or being discharged from a hospital. This would be similar to what Finland and Germany have in place where a woman is seen within days of giving birth.⁸⁶ In addition, this regulation should mandate that the postpartum care continues and is covered by health insurance for twelve months after the birth.

Currently in the U.S., a woman does not see a health professional for a routine post-natal checkup until six weeks after giving birth.⁸⁷ If the mother suspects that something is wrong, but does not know for certain, due to lack of information, then the mother must go to the emergency room for treatment. This six-week check-in happens once and is not a comprehensive, ongoing support tailored to the needs of the mother, as the ACOG recommends.⁸⁸ This lack of attention to postpartum maternal health is alarming, since more than one-half of pregnancy-related deaths occur after the birth of the infant.⁸⁹

83. Renee Montagne, *Lost Mothers: Maternal mortality in the U.S.*, N.P.R. (July 29, 2018 8:02 AM), <https://www.npr.org/2018/07/29/632702896/to-keep-women-from-dying-in-childbirth-look-to-california>.

84. *Id.*

85. *Id.*

86. See, ULLA HOPPU ET AL., *SUPRA* NOTE 55; see also *Delivery and Aftercare*, INTERNATIONALS GO!, <https://www.internations.org/go/moving-to-germany/healthcare/delivery-and-aftercare> (last updated Dec. 6, 2018).

87. Am. Coll. of Obstetricians and Gynecologists, *ACOG Committee Opinion: Optimizing postpartum care*, 131 J. OBSTETRICS & GYNECOLOGY 853, e141 (2018), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/05/optimizing-postpartum-care.pdf>.

88. *Id.*

89. *Id.* at e143.

According to the CDC, 18.6% of pregnancy-related deaths occur 1-6 days postpartum and 21.4% of pregnancy-related deaths occur 7-42 days postpartum.⁹⁰ Thus, 40% of pregnancy-related deaths occur before a woman would typically see a healthcare provider. The ACOG advises that “the timing of the comprehensive postpartum visit be individualized, and woman centered,” and should begin within the first three weeks postpartum, not the “arbitrary 6-week check.”⁹¹

With so many pregnancy-related deaths occurring soon after delivery, the U.S. should begin postpartum care within three days after delivery or discharge. This postpartum care should last for twelve months, what the CDC considers the entire postpartum period, to address any late onset complications or mental health issues.⁹² This would give women ongoing care if they had injuries during birth, ongoing pregnancy-related complications such as heart disease, or if they have mental health issues.

Within the U.S., this approach in postpartum care could be implemented within the existing health insurance framework. Congress should enact a statute mandating public and private insurance to begin covering post-natal visits from trained healthcare professionals within three days of birth or discharge from the hospital and that such coverage be continued for at least twelve months postpartum.

To implement this regulation for private insurance, Congress merely needs to pass a law mandating that women see a medical provider within three days after giving birth and that the insurance covers postpartum care for an additional twelve months. This could be done by mandating coverage for twelve visits per year, or more, as needed depending upon any complications that may arise. The law should also mandate that postpartum care cover mental health. Generally, under private insurance, a woman can see a specialty provider any time she wishes, therefore this would not be a big change for the private insurance companies. If the woman is covered by an HMO, a visit to her post-partum caregiver should fall outside of the need for a referral and be seen as a primary point of care to alleviate the hassle of a referral and encourage women to receive post-partum care.

To implement this change for Medicaid, Congress will have to change how long a woman is covered after birth and how payments are disbursed. Medicaid is the government-sponsored health insurance program for low-income families who have inadequate or no medical insurance.⁹³ States are

90. Petersen et al., *supra* note 3, at 425.

91. Am. Coll. of Obstetricians and Gynecologists, *supra* note 87.

92. Petersen et al., *supra* note 3, at 426.

93. *Medicaid for Pregnant Women*, AM. PREGNANCY ASSOC. (Aug. 25, 2019), <https://americanpregnancy.org/healthy-pregnancy/planning/medicaid-for-pregnant-women-71027>.

required to cover certain groups in their Medicaid plan including “categorically needy” and “medically needy” groups, both of which can include pregnant women.⁹⁴ The “categorically needy” group covers pregnant women whose income level is at or below 133% of the Federal Poverty Level.⁹⁵ The “medically needy” group covers pregnant women who make too much money to qualify under the “categorically needy” group.⁹⁶ This means a woman who was previously denied Medicaid may qualify once they are pregnant.⁹⁷ Medicaid finances 45% of births in the U.S., so changes to postpartum treatment within Medicaid would benefit a lot of new mothers.⁹⁸

Currently Medicaid postpartum coverage ends after sixty days⁹⁹ and only covers one visit for a vaginal birth and two visits for a c-section.¹⁰⁰ This falls well below the recommendations of the ACOG and the WHO.¹⁰¹ Both agencies recommend that women begin receiving postpartum care before the current six-week mark in the U.S., and that women receive postpartum care for at least three months, but suggest a year would be better.¹⁰² The WHO recommends that all mothers and newborns receive, at a minimum, one postnatal contact during the third day, the second week, and the sixth week after giving birth.¹⁰³ By redesigning the reimbursement for postpartum care, women could get the care they need after the birth of a baby.

B. *Midwife Care:*

The U.S. should pass a federal law standardizing the definition and necessary qualifications for a midwife and mandate that health insurance cover midwives for postpartum care. A midwife is someone who is skilled and knowledgeable in the care of women, infants, and families throughout

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. Alison Stuebe et al., *Extending Medicaid Coverage for Postpartum Moms*, HEALTH AFF.: HEALTH AFF. BLOG (May 6, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190501.254675/full/>.

99. BELLUZ, *SUPRA* NOTE 9 (Illinois has extended Medicaid to cover 12 months of postpartum care and is seeing good results from this).

100. Stuebe et al., *supra* note 98.

101. *See* Am. Coll. of Obstetricians and Gynecologists, *supra* note 87, at e141.

102. *Id.*

103. World Health Org., *WHO Recommendation on Postnatal Care of the Mother and Newborn*, at 3, 16 (Oct. 2013), https://www.ncbi.nlm.nih.gov/books/NBK190086/pdf/Bookshelf_NBK190086.pdf.

pre-pregnancy, pregnancy, birth, and postpartum.¹⁰⁴ The midwife could be the point of contact rather than a doctor. Both Finland and Germany use midwives as point people for women's health during pregnancy and in the postpartum period with great success. A midwife can assess medical and mental health needs and instruct women on who to see and where to get help. Studies show about 40% of women do not attend a postpartum appointment¹⁰⁵ due to long wait times and high costs. However, allowing women to see midwives makes it more likely that women would attend their postpartum appointments.

The use of midwives would be a great advantage to all women, but especially to women in rural areas. Many women in rural areas do not live near a hospital and do not have access to traditional post-natal care. 2019 was a record breaking year for rural hospital closures, with nineteen hospitals closing.¹⁰⁶ According to the ACOG, 22.8% of U.S. women of childbearing age live in rural America.¹⁰⁷ Of those women, less than half live within a thirty-minute drive of a hospital with perinatal care (there are no numbers on postnatal care).¹⁰⁸ Even worse, 10% of those women have to drive over 100 miles for care.¹⁰⁹ These women would benefit from trained professionals, not just doctors, being able to assess and help guide them to the care they need. These women would benefit from home visits, or, if those are not possible, from telemedicine where they would be able to speak over the phone or internet to someone who can assess their symptoms, listen to concerns, and give advice. A midwife could also give guidance about when they need to make that drive to the doctor.

Currently, most states do not allow midwives to be fully integrated into the medical system or to be legal practitioners.¹¹⁰ Some states severely limit what midwives are allowed to do despite evidence showing they are a

104. World Health Org., *The Case for Midwifery*, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH, https://www.who.int/maternal_child_adolescent/topics/quality-of-care/midwifery/case-for-midwifery/en/ (last visited Oct. 3, 2020).

105. Am. Coll. of Obstetricians and Gynecologists, *supra* note 87.

106. Dylan Scott, *1 in 4 Rural Hospitals is Vulnerable to Closure, a New Report Finds*, VOX MEDIA (Feb. 18, 2020, 4:00 PM), <https://www.vox.com/policy-and-politics/2020/2/18/21142650/rural-hospitals-closing-medicaid-expansion-states>.

107. Sharon T. Phelan & Linda Marie Wetzel, *Maternal Death in Rural America*, CONTEMP. OB/GYN (Aug. 17, 2018), <https://www.contemporaryobgyn.net/obstetrics-gynecology-womens-health/maternal-death-rural-america>.

108. *Id.*

109. *Id.*

110. THE EDITORS, *The U.S. Needs More Midwives for Better Maternity Care*, SCIENTIFIC AM. (Feb. 1, 2019), <https://www.scientificamerican.com/article/the-u-s-needs-more-midwives-for-better-maternity-care/>.

beneficial tool for pregnancy, birth, and postpartum periods.¹¹¹ According to the WHO, 83% of maternal deaths, stillborn, and newborn deaths could be eliminated by allowing midwives to implement full care; 87% of services can be carried out by a midwife with proper training; maternal mortality would be reduced by 82% with universal midwifery coverage.¹¹² These statistics suggest that there would be a major immediate benefit to mothers by standardizing and mandating coverage for midwives during and after a pregnancy.

It is difficult to utilize these services even in states that are not hostile to midwives. The Affordable Care Act mandates that Medicaid cover all midwifery services. However, private insurers are not required to cover midwives. As a result, many insurers do not cover midwives and, if they do, there are no in-network midwives. The cost of an uncomplicated birth that is attended by a midwife is vastly less expensive than one that is attended by a physician.¹¹³ Insurance networks should embrace births and postpartum care by midwives in hospitals because the cost is lower. Further, if there is a need for a doctor, the midwife can facilitate it.

Since many states do not embrace midwives and insurance companies refuse to cover their services, a federal law is needed to standardize the education and licensing of midwives across all states. In addition, the law should direct all insurers that midwives are to be covered for their full range of services beginning with pregnancy and extending into the postpartum period.

C. *Motherpass*:

A third change the U.S. should adopt is requiring a “Motherpass” for all mothers upon confirmation of their pregnancy. This pass would be a comprehensive record of the pregnancy and postpartum period for each woman. This pass, either a physical booklet or online portal, would be a place where the mother has access to her record at all times. Each and every doctor, trained professional, and anyone the mother sees during this time would add information to this record. For example, if the mother sees an obstetrician and a midwife, both would record the visit, all tests, results and anything else that occurred during the appointment. Having one area where all medical notes are kept would allow medical staff to quickly diagnose and treat a pregnancy-related complication before it causes the mother’s death.

111. *Id.*

112. World Health Org., *supra* note 103.

113. THE EDITORS, *supra*, note 110.

Currently, in the U.S., it is very difficult and cumbersome to gain access to one's medical records from one doctor, let alone from an array of specialists. While the Health Insurance Portability and Accountability Act (HIPAA) affords everyone the right to access their own medical records, it does not make the acquisition of one's medical records uncomplicated.¹¹⁴ A patient in the U.S. has to fill out a form and request his or her own records for every medical professional they see.¹¹⁵ This is cumbersome and time consuming. HIPAA allows medical providers thirty days to respond to an individual's record request.¹¹⁶ In the case of a woman who has a serious pregnancy-related complication, thirty days is simply too long to wait. Another obstacle that patients encounter are the fees associated with obtaining a copy of their own records as providers are allowed to charge a flat fee or to base the fee on the work necessary to copy and provide the file.¹¹⁷

This pass would allow medical professionals to see a new mother's health history and arrive at a diagnosis more quickly. If a new mother had to go to the emergency room, the attending physician may see her headache as something mundane. However, if there was a comprehensive file, the doctor could see that in addition to the headache, she had high blood pressure as well. The doctor may then diagnose preeclampsia, one of the most common postpartum complications.

The Motherpass could be implemented with a physical book in the beginning, which is also accessible for those who do not have internet access. The woman would then bring the Motherpass book to each of her appointments. The physical book should be used while states explore transitioning to an electronic "Motherpass." This would not be a HIPAA violation because the woman, who is the owner of the medical records, would allow all of the medical professionals to see her records.

D. *Maternity Package:*

Lastly, the United States should try to incentivize prenatal care by enacting a joint state and federal maternity benefit package similar to Finland's Maternity Package. This would include necessary clothing for the first year of the baby's life, a small mattress, a cardboard box to be used as a

114. Chris Dimick, *How to Request your Medical Records*, AM. HEALTH INFO. MGMT. ASS'N., <http://bok.ahima.org/doc?oid=300996#.X3jiO5NKiu4> (last visited Oct. 3, 2020).

115. *Id.*

116. *Id.*

117. *Id.*

bed, and information about how the mother can stay healthy. Prenatal care can help reduce the pregnancy-related deaths in the U.S. by screening for illnesses and pregnancy-related complications that may become emergencies.¹¹⁸

The U.S. should initiate this benefit package when the mother receives prenatal care. The doctor would indicate that the woman received care prior to her fourth month of pregnancy, enabling the mother to receive the package. This would be a great benefit but would also be costly. This is why it should be implemented at the community level with financial help from the state and federal governments. The logistics of this package would be better carried out at a local level, but not all cities would be able to afford the cost of the benefit package. Jumpstarting prenatal care in this way would have lasting beneficial effects and help prevent pregnancy-related deaths.

VII. SAVING MONEY THROUGH THE IMPLEMENTATION OF NEW LAWS

In the U.S., \$98 billion is spent each year on hospital bills related to childbirth.¹¹⁹ Since Medicaid covers 45% of all births in the U.S. each year, a large portion of that \$98 billion is used to cover those expenses. The money Medicaid uses comes from taxes. In the long run, these laws would lower the cost of giving birth in the U.S. and subsequently, lower the cost that Medicaid has to pay. The cost of giving birth in Finland and Germany is much less than in the U.S.¹²⁰ Diagnosing pregnancy-related complications quickly, before they turn catastrophic, would help lessen the amount of money spent on postpartum issues.

These proposed laws would bring healthcare costs down by diagnosing post-partum complications before a mother needs emergency room care. This is important because emergency hospital care is expensive.¹²¹ The Affordable Care Act considers maternal and newborn care as preventative because it is cheaper to provide this care than to treat the potential complications.¹²² This concept should be expanded on to include early postpartum care. By treating

118. *HOW PRENATAL CARE CAN IMPROVE MATERNAL HEALTH*, SAFE MOTHER (Mar.-Jun. 1993), <https://pubmed.ncbi.nlm.nih.gov/12286437/>.

119. AMNESTY INT'L, *supra* note 16.

120. *It Costs Less than \$60 to have a Baby in Finland. How?*, CBS NEWS (Mar. 5, 2019, 8:28 AM), <https://www.cbsnews.com/news/why-finland-is-consistently-ranked-one-of-the-best-places-in-the-world-to-be-a-mom/>; *see also* Melissa Willets, *Interactive Map Shows Cost of Childbirth Around the World and It's Shocking*, PARENTS MAGAZINE (Jan. 4, 2017), <https://www.parents.com/pregnancy/everything-pregnancy/interactive-map-shows-cost-of-childbirth-around-the-world-and-its/>.

121. Kimberly Amadeo, *Why Preventive Care Lowers Health Care Costs*, THE BALANCE (Sept. 17, 2020), <https://www.thebalance.com/preventive-care-how-it-lowers-aca-costs-3306074>.

122. *Id.*

complications as early as possible, the cost to the individual and the taxpayers will be lower than if a complication becomes catastrophic.

The COVID-19 pandemic has unleashed many new complications to the healthcare system and has incurred incalculable costs to individuals and governments. Emerging research has shown that pregnant women are at a heightened risk of complications due to the virus. It is imperative that pregnant women are eligible for treatments and vaccines when they become available. To address this problem, Senators Warren and Underwood put forth a new bill that would, among other things, mandate that one of the vaccines is safe for pregnant women, and provide funding for non-clinical healthcare workers to monitor postpartum health.¹²³ While this law has not yet been introduced for debate, laws like this are imperative for the health of women in the time of COVID-19 and after.

VI. CONCLUSION

These four proposed laws would have an immediate impact on keeping new mothers alive. These proposed laws need to be implemented on the federal level because states have failed to address the problem of rising maternal mortality in the two decades in which it has been happening. Even as some states investigate and propose changes to help, others have failed to even provide data on the subject.¹²⁴ While some states have changed insurance laws to make access to post-natal care easier, others have not. The Federal Government needs to step in and pass common-sense laws that could be implemented quickly within our existing insurance framework and help save the lives of women.

There is not going to be a quick fix for some of the problems that the United States has within the healthcare industry, but by passing the proposed laws, the maternal mortality rate will decline, while the larger issues within the healthcare industry are researched, analyzed and addressed. When the health of the mother is protected, the new baby and family thrive; this is good for all people.

123. Shefali Luthra, *Democrats Focus New Legislation on the Pandemic's Effect on Maternal Mortality*, THE 19TH (Aug. 10, 2020), <https://19thnews.org/2020/08/democrats-focus-new-legislation-on-the-pandemics-effect-on-maternal-mortality/>.

124. Laura Ungar, *What States aren't doing to Save New Mothers' Lives*, USA TODAY (Nov. 14, 2019, 11:15 AM PST), <https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/09/19/maternal-death-rate-state-medical-deadly-deliveries/547050002/>.