Roughly 55 percent of Medicaid enrollees are working full or part time, and a number aren't eligible for health insurance through their jobs. Read more in an explainer here.

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ISSUE BRIEFS
JUNE 4, 2024

Insights into the U.S. Maternal Mortality Crisis: An International Comparison

TOPLINES

The U.S. maternal mortality rate continues to far exceed those of other high-income nations, despite a decline since the end of the COVID-19 pandemic

Persistent inequities in health care are a big reason why Black women in the U.S. are by far the most likely to die from pregnancy or childbirth

Anna Ruocco (left), a midwife, provides home breastfeeding assistance to a mother with her newborn, on June 17, 2022, in Turin, Italy. Midwifery-led care models have been shown to provide care that is comparable to, or sometimes even better than, that provided by obstetrician-gynecologists, or ob-gyns. In the U.S., Canada, and Korea, ob-gyns outnumber midwives, while in most other countries midwives greatly outnumber ob-gyns. Photo by Diana Bagnoli/Getty Images

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Introduction

The United States continues to have the highest rate of maternal deaths of any high-income nation, despite a decline since the COVID-19 pandemic. And within the U.S., the rate is by far the highest for Black women. Most of these deaths — over 80 percent — are likely preventable.[1]

With policies and systems in place to support women during the perinatal period, several high-income countries report virtually no maternal deaths. As policymakers and health care delivery system leaders in the U.S. seek ways to end the nation's maternal mortality crisis, these countries may offer viable solutions.

This brief updates an earlier Commonwealth Fund study of differences in maternal mortality, maternal care workforce composition, and access to postpartum care and social protections between the U.S. and other high-income countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom.[2] In this edition, we have also included data on Chile, Japan, and Korea — all high-income countries with universal health care systems.

For our analysis, we used the most recently available data from the U.S. Centers for Disease Control and Prevention (CDC) and from the Organisation for Economic Co-operation and Development (OECD), of which the U.S. is a member. Where country-specific data are more than five years old, we note whether more recent published data from other sources are available for that country. Readers should be aware that because the methods we used to derive updated numbers from other sources may be different from methods the OECD uses, data points may not be comparable to the U.S. rates. For complete details on our methods, see "How We Conducted This Study."

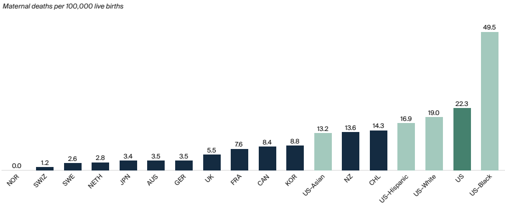
Highlights

- In 2022 there were approximately 22 maternal deaths for every 100,000 live births in the United States — far above rates for other high-income countries. U.S. maternal mortality is lowest for Asian American women and highest for Black women.
- Maternal death rates increased in Australia, Japan, the Netherlands, and the U.S. during the height of the pandemic, between 2020 and 2021. In Chile, Norway, and the U.S., where 2022 data are available, maternal death rates have begun to decline.
- Nearly two of three maternal deaths in the U.S. occur during the postpartum period, up to 42 days following birth. Compared to women in the other countries we studied, U.S. women are the least likely to have supports such as home visits and guaranteed paid leave during this critical time.
- The U.S. and Canada have the lowest supply of midwives and ob-gyns. In the U.S., Canada, and Korea, ob-gyns outnumber midwives.

Findings

Recent Maternal Mortality Trends

The United States continues to have the highest maternal death rate, with the rate for Black women by far the highest of any group.



Notes: The maternal mortality ratio is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. For more information on how maternal mortality is defined, see Organisation for Economic Co-operation and Development, "Maternal and Infant Mortality," in *Health at a Glance 2023: OECD Indicators* (OECD, 2023). 2015 data for FRA; 2017 data for UK; 2018 data for NZ; 2020 data for CAN and SWIZ; 2021 data for AUS, GER, JPN, KOR, NETH, and SWE; 2022 data for CHL (provisional), NOR, and US. Due to sample size limitations, data for US–AIAN cannot be displayed. AIAN = American Indian and Alaska Native. Asian Americans include a wide range of distinct communities. Such groupings are imperfect, as they mask significant difference in maternal mortality rates.

Data: All country data from OECD Health Statistics 2023 extracted on February 29, 2024, except data for US are 2022 data from the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, mortality and natality data files, "Maternal Mortality Rates in the United States, 2022."

Source: Munira Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison* (Commonwealth Fund, June 2024). https://doi.org/10.26099/cthn-st75

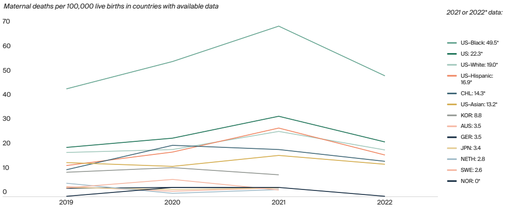
In 2022, there were 22 maternal deaths for every 100,000 live births in the U.S. — more than double, sometimes triple, the rate for most other high-income countries in this analysis. In half of the countries, there were less than five maternal deaths per 100,000 live births.

For Black women, maternal mortality is exceptionally high. Prior research has found Black people receive worse-quality care than white people on 52 percent of measures, including measures of care process, such as the ability to receive needed care; care outcomes, such as death; and patients' perceptions of care.[3]

Other data show that racial disparities exist both within hospitals and between hospitals for maternal morbidity.[4] Inequities in access to care and patients' experience of care are often rooted in discrimination and clinician bias.[5]

While the maternal mortality rate increased in several countries during the COVID-19 pandemic, the rate has begun to decline since then.

Maternal deaths per 100,000 live births in countries with available data



Notes: The maternal mortality ratio is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. For more information on how maternal mortality is defined, see Organisation for Economic Co-operation and Development, "Maternal and Infant Mortality," in *Health at a Glance 2023: OECD Indicators* (OECD, 2023). Only countries with at least 2021 data available are shown. Due to sample size limitations in earlier years, data for US–AIAN cannot be displayed. AIAN = American Indian and Alaska Native. Asian Americans include a wide range of distinct communities. Such groupings are imperfect, as they mask significant difference in maternal mortality rates.

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Source: Munira Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison* (Commonwealth Fund, June 2024). https://doi.org/10.26099/cthn-st75

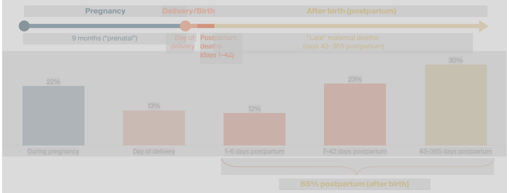
The COVID-19 pandemic challenged health systems across the world and may have played a role in limiting women's access to health care.[6] The increase in maternal deaths in several countries during the pandemic may have been due to a rise in respiratory or viral conditions directly related to COVID or to conditions worsened by the virus, such as diabetes or cardiovascular disease.[7] In addition, around the world, disruptions in health care delivery resulted in delayed or decreased access to needed maternal health care.[8]

During the height of the pandemic in 2020–21, maternal death rates increased in four of the nine countries shown in the chart above — Australia, Japan, the Netherlands, and the United States. These increases were higher in the U.S. for Hispanic women. It's been well documented that the COVID-19 pandemic had a greater impact on Latino people, with one study finding that roughly a third of Latina maternal deaths were linked to COVID.[9] In addition, lower vaccine uptake, especially among Black and Hispanic women, was found to be leading to more maternal deaths by the end of 2021.[10] Owing to sample-size limitations, trends in annual mortality data for American Indian and Alaska Native women cannot be shown.

In Chile, Norway, and the U.S., for which 2022 data are now available, the maternal death rate has begun to decrease once again. In 2022, Norway's maternal mortality rate was 0.[11]

Two-thirds of U.S. pregnancy-related deaths occur during the postpartum period.

Distribution of pregnancy-related deaths by timing of death in relation to pregnancy, 2017–2019



Notes: Data from Maternal Mortality Review Committees in 36 US states; specific timing information is missing (n=2) or unknown (n=14) for 16 (1.6%) pregnancy-related deaths.

Data: Susanna Trost et al., *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019* (Centers for Disease Control and Prevention, 2022).

Source: Munira Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison* (Commonwealth Fund, June 2024). https://doi.org/10.26099/cthn-st75

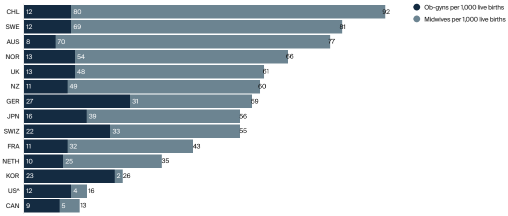
The majority of deaths in the U.S. occur in the postpartum period, from one day after giving birth to a full year later. In the first week postpartum, severe bleeding, high blood pressure, and infection are the most common contributors to maternal deaths, while cardiomyopathy is the leading cause of late deaths.[12]

Still, more than one of five deaths occur during pregnancy itself, with heart conditions and stroke the leading causes.

Differences in Care During Pregnancy, Labor, and Delivery

The U.S. and Canada continue to have the lowest supplies of midwives and ob-gyns.

*Number of providers (head counts) per 1,000 live births**



Notes: * The sum figures shown to the right of the horizontal bars do not reflect the total maternity care workforce, since primary care physicians/family practitioners also deliver some care in many countries (not shown here). Each sum may not reflect the arithmetic sum of figures shown for ob-gyn and midwife providers because calculations were performed on exact figures, while the graph presents rounded figures.

Data: OECD Health Statistics 2023 data extracted on February 29, 2024, representing "practicing midwives" for all countries except CAN, CHL, and US, where data reflect midwives "licensed to practice." Data for professionals "licensed to practice" tend to be higher than data for "professionally active," while numbers of "practicing" professionals tend to be the lowest. 2021 data for FRA, GER, NETH, NZ, NOR, SWIZ, and US (ob-gyns); 2020 data for AUS, CAN, CHL, JPN, KOR (ob-gyns), SWE, and UK; 2016 for US (midwives); 2015 for KOR (midwives).

Source: Munira Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison* (Commonwealth Fund, June 2024). https://doi.org/10.26099/cthn-st75

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. In many countries, they are key providers of reproductive health care for women. A recent study found that a midwife workforce, integrated into health care delivery, could provide 80 percent of essential maternal care around the world and potentially avert 41 percent of maternal deaths, 39 percent of neonatal deaths, and 26 percent of stillbirths.[13] By placing a priority on natural reproduction processes and relationship-building, midwives also can help address the social needs of mother, baby, and family.[14]

Midwifery-led care models have been shown to provide care that is comparable to, or sometimes even better than, that provided by obstetrician-gynecologists, or ob-gyns.[15] In the U.S., Canada, and Korea, ob-gyns outnumber midwives, while in most other countries midwives greatly outnumber ob-gyns.

The U.S. and Canada have the lowest overall supply of midwives and ob-gyns — 16 and 13 providers per thousand live births, respectively. Nearly 7 million women in the U.S. currently live in counties where there are no hospitals or birth centers offering obstetric care and no obstetric providers, and the shortage is expected to only get worse in coming years.[16]

High-quality postpartum care is intended to ensure the physical and emotional recovery of mothers and their babies and can help reduce maternal deaths.[17] Visits by a midwife or a nurse are associated with improved mental health and breastfeeding outcomes as well as reduced health care costs. Home visits give providers an opportunity to address maternal and mental health concerns as well as to assess the mother's available supports and social drivers of health, including needs for food, housing, financial security, and protection from domestic violence.

All countries, apart from the U.S., guarantee at least one such home visit within one week postpartum, although Medicaid programs in some U.S. states cover these visits.

Paid maternity leave allows women to better manage the physiological and psychological demands of motherhood, helps ensure financial security for families, and leads to lower infant mortality.[18] All countries included in this study, apart from the U.S., mandate at least 14 weeks of paid leave from work. Several countries provide more than a year of parental or home care leave. While U.S. states and employers can opt to provide paid leave, just over a quarter of American workers have access to paid family leave through either their employer or the state where they reside.[19] In the U.S., women who are white and have higher incomes are more likely to take paid leave than Black women. Women who are able to take paid leave have lower rates of postpartum depression.[20]

Policy Implications

Black women continue to die from pregnancy and childbirth complications at unacceptably high rates, and U.S. women overall are more likely to die from maternal complications than women in other high-income countries. While the number of maternal deaths is lower in 2022 than in earlier years — primarily because there were fewer COVID-related maternal deaths — the United States faces continuing challenges in reducing maternal mortality.

Our findings suggest that an undersupply of maternity providers, especially midwives, and lack of access to comprehensive postpartum support, including maternity care coverage and mandated paid maternity leave, are contributing factors. Because both these factors disproportionately affect women of color, centering equity in any future policy changes will be a key to addressing the crisis.

Although overall maternal mortality rates in the other high-income countries we studied are lower than in the U.S., it should be noted that health inequities among women exist in these other countries, too.[21] In the United Kingdom, for example, Black women are four times more likely to die than white women are.[22] In Australia, Aboriginal women are about twice as likely as non-Aboriginal women to die from maternal complications.[23]

Midwifery Care

Outside the U.S., midwives are often considered the backbone of the reproductive health system. But the U.S. health system does not systematically incorporate midwives into the provision of essential maternity care services, even though these clinicians could improve the quality of care and experience of care for women, particularly women of color.

Some U.S. states have strengthened access to midwives and achieved positive outcomes, but midwifery services are not uniformly covered by private insurance plans across the country. While the Affordable Care Act (ACA) requires state Medicaid programs to cover midwifery care, Medicaid's low provider reimbursement rates, coupled with a low supply of midwives, often mean that beneficiaries are unable to access these services.

Midwives also could help address maternity workforce shortages in the U.S., where nearly half of counties lack a single ob-gyn. An estimated 8,000 more ob-gyns are needed to meet demand — a number that may rise to 22,000 by 2050.[24]

Insurance Coverage

Universal, comprehensive maternity care coverage, along with exemptions from cost sharing, also are the norm in other high-income countries.[25] The U.S. is the only one of these countries that does not have universal health care, leaving nearly 8 million women of reproductive age uninsured. The racial or ethnic groups that are the least likely to have health insurance and the most likely to face cost-related barriers to getting care are Black, Hispanic, American Indian and Alaska Native, and Native Hawaiian and other Pacific Islanders.[26]

The ACA's expansion of eligibility for Medicaid coverage has been associated with better maternal health outcomes in the states that have opted in, particularly rates of maternal mortality for Black and Latina mothers.[27] Ten states have yet to expand their Medicaid programs, leaving hundreds of thousands of women of reproductive age, disproportionately Black or Latina, in the Medicaid coverage gap and vulnerable to having their coverage terminated 60 days postpartum, as current policy allows. (Forty states have extended their postpartum Medicaid coverage, with several more states planning to do so.[28]) In addition to gaining postpartum support, expanding Medicaid would improve access to preconception health care for women of reproductive age who are in the Medicaid coverage gap.

The unwinding of the pandemic-era policy of continuous Medicaid enrollment — states restarted eligibility redeterminations in April 2023 — poses an imminent threat to pregnant and postpartum women, who stand to lose their health coverage during this critical period.

Postpartum Support

Since roughly two of three maternal deaths occur after birth, strengthening postpartum health services should be a priority. The World Health Organization recommends at least four health contacts in the first six weeks following birth, yet two of five U.S. women — more often than not younger, low-income, and uninsured — skip their one postpartum check-up.[29] Eliminating barriers that cause people to skip postpartum visits is critical. In Chile, for example, conditional cash-transfer programs provide financial incentives to ensure that mothers can take advantage of health and social benefits, including home visits from midwives and nurses during the postpartum period. Such cash transfers have proven successful in increasing accessing to health services and reducing inequities within the country.[30]

The U.S. is the only high-income country that does not guarantee all mothers paid parental leave, although 13 states and the District of Columbia have introduced some mandatory paid leave, ranging from six to 12 weeks.[31] A federally mandated paid leave policy would be especially beneficial to Black and lower-income women, who are less likely to have a paid leave policy through their employers.[32]

The well-being of mothers and babies should be a top policy priority in all countries. In the United States, which spends more on health care than any other high-income country, but has much worse maternal health outcomes, policymakers and delivery system leaders could learn a lot from international models of maternity care, including those related to postpartum support and workforce composition. In combination with equity-centered efforts, these examples could inspire the kind of reforms necessary to end the U.S. maternal health crisis.

HOW WE CONDUCTED THIS STUDY

OECD Data Analysis

This analysis used data from the 2023 release of health statistics compiled by the Organisation for Economic Co-operation and Development (OECD), which tracks and reports on a wide range of health system measures across 38 high-income countries. Data on paid maternity leave are from the OECD's Family Database.[33]

Data on maternal mortality ratios, supply of midwives, and supply of ob-gyns were extracted in February 2024. While the information collected by the OECD reflect the gold standard in international comparisons, it may mask differences in how countries collect their health data. Full details on how indicators were defined, as well as country-level differences in definitions, are available from the OECD.

CDC Data Analysis

For U.S. maternal mortality data, we used the latest data from the U.S. Centers for Disease Control and Prevention (CDC) National Vital Statistics Systems, 2022. For timing of maternal deaths in the United States, we used the latest data from the CDC's Maternal Mortality Review Committees in 36 states.[34]

While international data on timing of maternal and pregnancy-related deaths may be available, findings for the U.S. did not correspond with the latest CDC data. Because of potential data comparability concerns, we therefore omitted these findings from this data brief.

Data on postpartum home visits were compiled from a variety of country-specific sources, as specified in the notes on the exhibit.

Individual Country Data Updates

France: The latest OECD data for maternal mortality are from 2015. Other sources have confirmed the maternal mortality rate has stayed roughly the same, at eight maternal deaths per 100,000 live births.[35]

United Kingdom: The latest OECD data for maternal mortality are from 2017. Research from other studies has found the maternal mortality rate to have increased to 13.41 deaths per 100,000 live births over a three-year period (2020–2022).[36] The methods used to derive this number may be different from that used for other countries and therefore may not be comparable in this analysis.

United States: OECD data regarding the supply of ob-gyns and midwives are from 2016. A 2022 report confirmed there are roughly 12 ob-gyns and four midwives per 1,000 live births in the U.S.[37]

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