DECREASING THE UNITED STATES’ MATERNAL MORTALITY RATE: USING POLICIES OF OTHER HIGH-INCOME COUNTRIES AS A MODEL

Leah Frattellone
Elisabeth Haub School of Law

Follow this and additional works at: https://digitalcommons.pace.edu/pilr

Recommended Citation
Leah Frattellone, DECREASING THE UNITED STATES’ MATERNAL MORTALITY RATE: USING POLICIES OF OTHER HIGH-INCOME COUNTRIES AS A MODEL, 36 Pace Int’l L. Rev. 149 (2024)
DOI: https://doi.org/10.58948/2331-3536.1433
Available at: https://digitalcommons.pace.edu/pilr/vol36/iss1/3

This Article is brought to you for free and open access by the School of Law at DigitalCommons@Pace. It has been accepted for inclusion in Pace International Law Review by an authorized administrator of DigitalCommons@Pace. For more information, please contact dheller2@law.pace.edu.
DECREASING THE UNITED STATES’ MATERNAL MORTALITY RATE: USING POLICIES OF OTHER HIGH-INCOME COUNTRIES AS A MODEL

Leah Frattellone*

ABSTRACT

The United States has the highest maternal mortality rate among high-income countries. This article focuses on policies the United States can implement to decrease the maternal mortality rate, with a focus on access to abortion, the standard of care for pregnant women and new mothers, access to healthcare, and family leave. This article also explores policies surrounding those areas in other high-income countries and analyzes the differences in both the actual policies and the outcomes of those policies. To effectively decrease the maternal mortality rate in the United States, policies from other high-income countries, with lower maternal mortality rates should be enacted. Finally, this article explains the likely result of implementing these policies in the United States. This article is meant to serve as a framework for decreasing the maternal mortality rate in the United States by adopting the policies of other high-income countries.

KEYWORDS
maternal-mortality, abortion, healthcare access, international law, Family Medical Leave Act

* Leah Frattellone is a third-year law student at Elisabeth Haub School of Law at Pace University in White Plains, New York graduating in May 2024. Leah is a Productions Editor for Pace International Law Review.
# Table of Contents

Introduction ........................................................................................................... 151  
I. Abortion Laws........................................................................................................ 153  
   A. The Strict Abortion Laws of the United States .............................................. 153  
   B. The Abortion Laws of Other High-Income Countries ................................. 158  
   C. How Implementing Similar Abortion Policies to those in  
      Other High-Income Countries Will Decrease the  
      Maternal Mortality Rate in the United States ................................. 160  
II. Access to Healthcare and the Type of Care Provided to  
    Pregnant Women ............................................................................................ 162  
   A. Access to Healthcare in the United States ................................................... 162  
   B. Healthcare Policies in Other High-Income Countries with  
      Lower Maternal-Mortality Rates ......................................................... 165  
   C. How Implementation of Similar Healthcare Policies and  
      Care for Pregnant Women Will Ultimately Decrease the  
      Maternal Mortality Rate in the United States .................................... 166  
   D. The Type of Care Provided to Pregnant Women in the  
      United States ............................................................................................. 168  
   E. The Type of Care Provided to Women in Other High- 
      Income Countries with Lower Maternal-Mortality Rates .... 169  
   E. How Implementing Midwifery-Led Care Rather than  
      Obstetrician Gynecologist-Led Care Will Help Decrease  
      the Maternal-Mortality Rate in the United States ...................... 171  
III. Maternity Leave Policies .................................................................................... 172  
   A. Current Maternity Leave Policies Available to Women  
      in the United States .................................................................................. 172  
   B. Maternity Leave Policies in Other High-Income  
      Countries with Lower Maternal Mortality Rates ............................ 175  
   C. How Implementation of Similar Maternity Leave  
      Policies in the United States Will Help Decrease the  
      Maternal Mortality Rate ................................................................. 176  
IV. How Implementing the Proposed Solution in the United  
    States Government with the Solutions Proposed Will Decrease  
    Maternal Mortality in the United States ..................................................... 177  
Conclusion............................................................................................................. 178  

https://digitalcommons.pace.edu/pilr/vol36/iss1/3
INTRODUCTION

The United States has the highest maternal mortality rate among high-income countries. As of 2021, the United States’ maternal mortality rate is 32.9 deaths for every 100,000 live births. This is more than twice the rate of New Zealand, which has the second highest maternal mortality rate among high-income countries of 13.6 deaths per every 100,000 live births. For years, many high-income countries were facing a high rate of maternal mortality and searching for a solution to decrease the rate. However, since 2000, the United States’ maternal mortality rate has been increasing, while the maternal mortality rates of other high-income countries have been decreasing. Further, the rate in the United States continues to surpass the rates of other high-income countries. The World Health Organization defines maternal death 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.” In other words, the term “maternal mortality” is often


3 See Munira Z. Gunja, et al., The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison, COMMONWEALTH FUND: BLOG (Dec. 1, 2022), https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison (showing that in 2019 the maternal mortality rate for New Zealand was 13.6%, while the United States’ maternal mortality rate was 23.8% in 2020).

4 Id. (depicting data on maternal mortality rates since 2018 increasing in maternal mortality in six high-income countries).

5 Id. (depicting data of maternal mortality rates for high-income countries from 2018 to 2020 lower than the United States).

6 Id.

used as a general term to refer to pregnancy-associated deaths, pregnancy-related deaths, and maternal deaths.\(^8\)

To understand why the maternal mortality rate in the United States is more than three times the rate of other high-income countries,\(^9\) it is important to do a deep analysis of the policies that have an impact on maternal health. Through this analysis, the policies in other high-income countries can be compared to the policies currently in place in the United States. Research has shown that there are various areas where the policies significantly differ, which could lead to higher maternal mortality.\(^10\) The first area to analyze is the differences between the abortion laws in the United States and the abortion laws in other high-income countries. The second area to analyze the differences is between the standard of care for women in the United States and other high-income countries, as well as their access to care. The final area to analyze is the differences between the family leave policies in the United States versus those of other high-income nations. By implementing similar policies to those enacted in other high-income countries with lower maternal mortality rates, the United States’ maternal mortality rate will begin to decrease.

Part 1 of this note will describe a comparison between the abortion laws currently in place in the United States and the abortion laws of other high-income nations with lower maternal mortality rates. Part 2 will discuss the extent of healthcare coverage available to women, including Medicaid, currently in practice in the United States versus the comprehensive universal healthcare coverage that is in practice in other high-income nations.

Part 3 will discuss the type of care provided to pregnant women in the United States in comparison to the type of care provided to pregnant women in other high-income nations. Part 4 will discuss maternity leave policies, or the absence of maternity leave policies in the United States, compared to the maternity leave policies of other high-income countries. Part 5 will discuss the attempts and proposals of the United States to decrease maternal mortality and how the policies discussed above, adopted together, would decrease the rate of maternal mortality in the United States and provide a framework for the United States to follow.


\(^9\) See id.

\(^10\) See id. (discussing various reasons for high maternal mortality rates in the United States).
As the research delving into a comparison between these policies in the United States and other high-income countries is rather extensive and given the fact that this is a paper involving international analysis, this paper does not address the fact that maternal mortality in the United States disproportionately affects black women.\textsuperscript{11} While that issue is just as serious, it is beyond the scope of this paper.

I. ABORTION LAWS

A. The Strict Abortion Laws of the United States

A portion of maternal deaths may be attributed to the stricter abortion laws in the United States, especially since the overturning of the Supreme Court precedent, \textit{Roe v. Wade}.\textsuperscript{12} \textit{Roe v. Wade}, which was decided in 1973, held that women have a quasi-fundamental right to abortion.\textsuperscript{13} In 2022, the Supreme Court overturned \textit{Roe v. Wade} through the \textit{Dobbs v. Jackson Women’s Health Organization}\textsuperscript{14} decision. The \textit{Dobbs} decision gave the power to decide abortion laws back to the states.\textsuperscript{15} The holding in \textit{Dobbs} asserts that abortion is not a fundamental right, that it does not rise to the level of an equal protection claim, and passes rational basis.\textsuperscript{16} Post-\textit{Dobbs}, the maternal mortality rate is expected to further increase.\textsuperscript{17}

Even when \textit{Roe v. Wade} was still considered good law, states continued to pass policies and regulations that restricted access to abortion.\textsuperscript{18} In a study done by Tulane University, researchers found that the states with more policies and regulations restricting abortion had higher rates of maternal mortality.\textsuperscript{19} In some of these states, the abortion laws may not have any exceptions or only have a rape or incest

\textsuperscript{11} See Gunja, et al., \textit{supra} note 3 (showing data explaining that the maternal mortality rate for white women in the United States is 19.1\% compared to 55.3\% for black women in 2020).


\textsuperscript{13} Id. at 164.


\textsuperscript{15} Id. at 300.

\textsuperscript{16} Id.

\textsuperscript{17} See Kim Bellware & Emily Guskin, \textit{Effects of Dobbs on maternal health care overwhelmingly negative, survey shows}, \textit{Washington Post} (June 21, 2023), https://www.washingtonpost.com/politics/2023/06/21/obgyn-abortion-poll/ (reporting that the maternal mortality rate has increased after the overturning of \textit{Roe v. Wade}).


\textsuperscript{19} Id.
exception. As of 2017, it was determined that the states with the most restrictive abortion laws had a maternal mortality rate of 28.5 deaths per 100,000 births, whereas, in states where abortion was more readily accessible, the maternal mortality rate was only 15.7 deaths per 100,000 births. Another study in 2021, published by the American Journal of Public Health, found that the states with the most strict abortion laws had a 7% increase in maternal mortality from 2015 to 2018. Researchers also estimate that childbirth in the United States is 14 times more deadly than having an abortion.

In a country without *Roe v. Wade*, some states will no longer allow women to get an abortion at all, especially in states which have enacted what are known as “trigger laws.” A trigger law is a piece of legislation that bans abortion with few to no exceptions; these laws immediately went into effect when *Roe v. Wade* was overturned. The trigger laws in the thirteen states that have implemented them effectively ban abortion either automatically, or within 30 days of the *Dobbs* decision. All of these states permit abortion for life-threatening pregnancies, but not always for rape or incest. States that have enacted trigger laws also plan to criminalize anyone seeking to terminate a pregnancy, and anyone willing to help someone terminate a pregnancy. With only thirteen states

---


22 Id.


25 Id.


27 See id. (reporting that many states have restricted their abortion laws to only allow an exception for life-threatening pregnancies and even those are questionable).

28 Elizabeth Nash & Isabel Guarnieri, *13 States Have Abortion Trigger Bans–Here’s What Happens When Roe Is Overturned*, GUTTMACHER INST. (June 2022),
enacting trigger laws, since the overturning of Roe v. Wade, 25 states have passed restrictive bans on abortion. As a result, women whose pregnancies could become life-threatening have to continue with their pregnancy, despite the risk of fatality.

Even a low-risk pregnancy has a higher risk of death than an abortion would. Pregnant women risk dying from a variety of pregnancy-related complications if left untreated. These complications include, but are not limited to: miscarriages, ruptured ectopic pregnancies, maternal sepsis, and delayed cancer care. Some women who seek abortions are also at a high risk of dying from pregnancy for other reasons such as an unsafe home environment or harassment due to their identity. Due to the fear of being held criminally responsible for aiding in an abortion, doctors are unsure how to proceed when patients have time-sensitive health issues related to their pregnancy. Doctors do not know what they can and cannot do to avoid being prosecuted and by the time the doctors can act if there is an exception that allows for an abortion, it may already be too late.


29 See Kimya Forouzan & Isabel Guarnieri, State Policy Trends 2023: In the First Full Year Since Roe Fell, a Tumultuous Year for Abortion and Other Reproductive Health Care, GUTTMACHER INST. (Dec. 19, 2023), https://www.guttmacher.org/2023/12/state-policy-trends-2023-first-full-year-roes-fell-tumultuous-year-abortion-and-other (reporting that in the first full year since Roe was overturned, 14 states have enforced total bans with limited exceptions); see also Interactive Map: US Abortion Policies and Access After Roe, GUTTMACHER INST. (Jan. 2, 2024), https://states.guttmacher.org/policies/?_gl=1*n3YoZ19*_ga*Njg2NDkzMTExLjE3MDQ2NDc0OTl1_ga_PYBTC04SP5*MTcwMDY0NzQ5MS4xLjAuMTcwNDY0NzY3MjI4wLjAuMA (showing on an interactive map that 15 states have enacted the most restrictive abortion bans, 3 states have enacted very restrictive abortion bans, and 7 states have enacted restrictive abortion bans).

30 See Aria Bendix, How life-threatening must a pregnancy be to end it legally?, NBC NEWS (June 30, 2022, 1:57 PM), https://www.nbcnews.com/health/health-news/abortion-ban-exceptions-life-threatening-pregnancy-rcna36026 (explaining that there is no clear legal definition on which conditions qualify as life-threatening).

31 Ducharme, supra note 21.


33 Id.

34 Schreiber, supra note 23 (explaining that women may face domestic abuse in their homes and pregnant people identifying as transgender may face increased harassment).

It is both unfair and unreasonable to ask medical professionals to interpret complex legislation that impacts the services that they provide, especially if a consequence of interpreting it incorrectly is being charged with murder.\(^{37}\)

There are also additional risks involved for women who become pregnant and have pre-existing conditions such as; cardiac malformations, high blood pressure, cardiac dysfunction, or advanced kidney disease.\(^{38}\) These conditions will worsen if women become pregnant and do not have the option to terminate a pregnancy—it may even result in death.\(^{39}\)

Being denied an abortion may also affect the mental health of women, causing an increase in anxiety, depression, post-traumatic stress disorder, and even suicidal ideation.\(^{40}\) According to a 2021 study by Amanda Jean Stevenson, a professor at the University of Colorado, it is predicted that the Dobbs decision will lead to a 21% increase in pregnancy-related deaths.\(^{41}\) Further, those who are denied an abortion are more likely to suffer from serious pregnancy complications, remain in unsafe relationships and be at a greater risk of domestic abuse, and suffer from poor physical health—all of which may lead to maternal mortality.\(^{42}\)

Additionally, reducing access to abortion also reduces access and funding to Planned Parenthood or other similar clinics.\(^{43}\) In addition to abortions, these clinics provide free or low-cost health services to both women and men.\(^{44}\) Without funding for these services, even women who wish to continue with their pregnancy risk their health if they cannot afford to see a regular doctor.\(^{45}\) The imposition of more strict regulations on abortion procedures has caused more than 160 clinics to shut down,

\(^{36}\) Id.  
\(^{37}\) Bain, et al., supra note 24 (referring to a patient who was charged with murder after medical professionals likely reported her for seeking post-abortion medical assistance).  
\(^{38}\) See Stickler, supra note 32.  
\(^{39}\) See id. (explaining that medical comorbidities made up a significant amount of maternal mortality deaths).  
\(^{40}\) Id.  
\(^{41}\) Bain, et al., supra note 24.  
\(^{42}\) Id.  
\(^{43}\) Ducharme, supra note 21.  
\(^{44}\) Id.  
\(^{45}\) See id.; see also Medicaid and Reproductive Health, PLANNED PARENTHOOD (last visited Dec. 12, 2023), https://www.plannedparenthoodaction.org/issues/health-care-equity/medicaid-and-reproductive-health (reporting that approximately 2.4 million people rely on Planned Parenthood for low-cost care during pregnancy, birth control, and cancer screenings).
leaving a handful of states with sometimes only one remaining abortion provider.\textsuperscript{46}

In 2019, Alabama lawmakers proposed a bill that would completely outlaw abortion.\textsuperscript{47} Amy Mackinnon, writing for Foreign Policy, used a real-life example to explain what could happen if the United States bans abortion with the 2019 Alabama bill in mind.\textsuperscript{48} Mackinnon described the situation in Romania, between 1965 and 1989, when the country had completely outlawed abortion, and explained that this could be the future of the United States without access to abortion.\textsuperscript{49} The abortion ban in Romania impacted low-income women significantly more than high-income women.\textsuperscript{50} Because of the lack of access to abortion, women who were seeking abortions turned to unsafe, back-alley abortions.\textsuperscript{51} A back-alley abortion is an illegal and dangerous operation that is not performed by a medical professional which is used to end an unwanted pregnancy.\textsuperscript{52} It is estimated that about 10,000 women died from these unsafe abortions, but the number could be even higher due to the risk of criminal prosecution if these women were caught seeking an abortion.\textsuperscript{53} In the time period between when the law outlawing abortion was passed and when it was lifted, 1965 and 1989, maternal mortality rates doubled.\textsuperscript{54} This is not unlike what could happen in the United States, especially in the states that are attempting to completely outlaw abortion.

The abortion bill passed in Alabama is stricter than the law that was passed in Romania.\textsuperscript{55} In Romania, there were exceptions for rape, incest, and congenital defects, while the law that Alabama proposed only allowed

\textsuperscript{46} Council on Foreign Relations, supra note 26.


\textsuperscript{48} Id.

\textsuperscript{49} Id.

\textsuperscript{50} See id. (explaining how wealthy women in Romania bribed doctors to perform abortions or smuggled contraceptives from Germany).

\textsuperscript{51} See id. (discussing the large number of low-income and disadvantaged women who seek dangerous back-alley abortions in Romania as a last resort).


\textsuperscript{53} See Mackinnon, supra note 47.

\textsuperscript{54} See id. (discussing increased maternal mortality rates between 1965 and 1989); see also Charlotte Hord et al., Reproductive Health in Romania: Reversing the Ceausescu Legacy, 22 STUD. FAM. PLAN. 231, 233 (1991) (stating that by the end of 1989, right before the anti-abortion law was overturned, Romania ended the year with the highest recorded maternal mortality rate in Europe at 159 deaths per 100,000 births).

\textsuperscript{55} Mackinnon, supra note 47.
for an exception when there was serious risk to the mother’s health. The proposed law in Alabama went as far as criminalizing doctors who carry out abortions to life imprisonment. While the Alabama law was not specifically passed, the goal of proposing the law was to eventually make it to the Supreme Court with the hopes of overturning Roe v. Wade, a goal eventually accomplished by the Dobbs decision. This may lead women in the United States, who live in states where abortion is outlawed or highly restricted, to seek unsafe back-alley abortions. This will only further increase the maternal mortality rate if a change is not made. According to the World Health Organization, 4.7% to 13.2% of maternal deaths throughout the world occur from complications involving unsafe abortions.

B. The Abortion Laws of Other High-Income Countries

In other high-income countries with significantly lower maternal mortality rates, there is much greater access to abortion. In fact, most industrialized countries allow abortion without any restrictions. Many international frameworks have held that access to safe abortion is a human right, including but not limited to: the U.N. Human Rights Committee, the European Court of Human Rights, the Inter-American Court of Human Rights, and the African Commission on Human and Peoples’ Rights. The U.N. Population Fund stated that addressing the unmet need for family planning through safe abortions would considerably reduce maternal mortality. In countries where women have access to abortion for any risk factor (age, finances, or health), it is less likely that they will die of a maternal mortality-related death.
In Finland, for example, the country with one of the lowest maternal mortality rates among high-income countries, women have an unrestricted right to abortion up until 12 weeks of pregnancy, free of charge in public hospitals. Even after 12 weeks, an abortion may be permitted, with approval, for “extraordinary reasons,” which includes social reasons such as the pregnant woman being very young, difficult life conditions or financial insecurity, or addiction.

Another country to compare the outcomes of is the Netherlands. The Netherlands has some of the least restrictive laws on abortion and contraception access in the world. The Netherlands, with one of the lowest rates of maternal mortality, has demonstrated the relationship between less strict abortion laws and a lower maternal mortality rate. In the Netherlands, women may terminate their pregnancy simply because it is unwanted or for medical reasons. An abortion may be performed up until 24 weeks of pregnancy, or until the fetus is viable outside of the womb.

Iceland, another country with one of the lowest maternal mortality rates, also has a very liberal abortion policy that has recently become even

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC932143/ (suggesting that changes in abortion policies may negatively impact maternal deaths).

65 Max Roser & Hannah Ritchie, Maternal Mortality, https://ourworldindata.org/maternal-mortality (last visited Dec. 12, 2023) (finding that Finland, Greece, Iceland, and Poland have the lowest maternal mortality ratio worldwide, experiencing only 3 maternal deaths for every 100,000 births).


67 See id. (explaining that with special permission issued by Valvira, an abortion may be granted after 12 weeks); see also Zareba et al., supra note 61, at 3 (stating that the majority of high-income countries, such as Finland permit termination of pregnancy for social reasons).

68 See Friday E. Okonofua, Contribution of anti-abortion laws to maternal mortality in developing countries, 3(2) EXPERT REV. OBSTET. & GYNECOL. 147, 148 (2008) (stating that the Netherlands has unrestricted access to free abortion and contraception).

69 See id. (arguing that liberalizing abortion access leads to a lower maternal mortality rate); see also Maternal mortality ratio (modeled estimate, per 100,000 live births), WORLD BANK, https://data.worldbank.org/indicator/SH.STA.MMRT?most_recent_value_desc=false (last visited Sept. 18, 2023) (showing that the Netherlands had an estimated 4 maternal deaths per 100,000 live births in 2020).


71 Id.
more liberal. In Iceland, abortion is solely in the hands of the pregnant woman up until the first 22 weeks of pregnancy. Minors in Iceland are also legally able to terminate a pregnancy without the consent of a parent or guardian. Finland, the Netherlands, and Iceland all have some of the lowest rates of maternal mortality among high-income countries. It is thus demonstrated that if a woman is not forced to carry a life-threatening pregnancy or to undergo an unsafe abortion, she is less likely to die of a pregnancy-related death or to die during childbirth.

C. How Implementing Similar Abortion Policies to those in Other High-Income Countries Will Decrease the Maternal Mortality Rate in the United States

With more widespread and unrestricted access to abortion, women will be less likely to face pregnancy-related deaths, decreasing the rate of maternal mortality. Additionally, with safer access to abortion—fewer women would die from unsafe abortion procedures. If the United States implements abortion laws like those of other high-income countries the maternal mortality rate would likely decrease.

If the United States were to declare abortion as a fundamental right again, they would need to ensure that there is equal access to abortion for everyone. Additionally, if there must be exceptions to the law then the exceptions must allow for abortion in extraordinary circumstances, and including social ones similar to Finland. Restricting access to abortion does not decrease the number of abortions, it only increases the chance that women will have unsafe back-alley abortion procedures, resulting in

---

73 Id. (discussing that on May 14, 2019, the Icelandic parliament passed a bill which legalized abortion on request within the first 22 weeks of pregnancy regardless of circumstances).
74 See id. (stating that while a minor can obtain an abortion in Iceland without parental consent, they must be offered information and counseling on contraception).
75 Roser & Ritchie, supra note 65 (reporting that as of 2020, the maternal mortality rates of Finland, the Netherlands, and Iceland were 4.3%, 1.2%, and 3.3% respectively).
76 See PLOS Medicine Editors, supra note 64 (citing a study that found maternal mortality rates are lower in countries with more flexible abortion access).
78 See Abortion, supra note 66 (presenting examples in Finland in which it’s possible to terminate pregnancy before 12 weeks of pregnancy).
death. Studies from Romania and the United States have shown a decrease in maternal mortality rates in countries that initially denied access to abortion but later provided it.

Romania went from forbidding abortion access to now permitting abortion. While Romania is not a high-income country, it is an important example because of the effects of its previous outlaw on abortion. From 1965 to 1989, abortion was completely outlawed in Romania. When the outlaw on abortion was finally repealed in 1990, abortion was legalized for up to 14 weeks of pregnancy, and contraception was made readily available. With this change, Romania saw a 50% decrease of its maternal mortality rate in just the first-year abortion was legalized.

Another example is the United States, in the period before Roe v. Wade compared to the period after it was decided. Unfortunately, the United States has taken a step backwards by overturning Roe v. Wade. According to Dr. E. Hakim-Elahi, in 1972, the year before Roe v. Wade was decided, the maternal mortality rate was 34 deaths for every 100,000 births. In the year Roe v. Wade was decided, 1973, maternal mortality in the United States decreased by 50%.

Therefore, there are proven results showing that ensuring women have safe and legal access to abortion plays a huge part in decreasing the maternal mortality rate. This has been demonstrated through the more liberal abortion policies in other countries with lower maternal mortality rates, a demonstrated decrease

---

80 See, e.g., Su Mon Latt, et al., Abortion laws reform may reduce maternal mortality: an ecological study in 162 countries, BMC WOMEN’S HEALTH, Jan. 2019, at 6 (stating that maternal mortality rates in Romania decreased after the restrictive abortion law was abolished in 1989); Willard Cates, Jr., et al., The Public Health Impact of Legal Abortion: 30 Years Later, 35 GUTTMACHER INST. 25, 25 (2003) (explaining the impact on and decrease in maternal mortality following the Roe v. Wade decision in 1973).
81 See Mackinnon, supra note 47 (explaining how Romania’s maternal mortality doubled following a 1966 abortion ban and lasted until the ban was lifted in 1989).
83 Id.
85 Id.
86 See supra text accompanying notes 65-69, 72-75.
in maternal mortality when Romania repealed the outlaw on abortion, and in the United States’ own history.

II. ACCESS TO HEALTHCARE AND THE TYPE OF CARE PROVIDED TO PREGNANT WOMEN

A. Access to Healthcare in the United States

Death during pregnancy, or shortly after childbirth, can be attributed to the limited access to healthcare in the United States. Despite significantly outspending other countries on healthcare, the United States does not come close to having the best healthcare system in the world. According to a study conducted by the Commonwealth Fund, “[t]he U.S. health system trails far behind a number of other high-income countries when it comes to affordability, administrative efficiency, equity, and health care outcomes.” The United States also ranks last in providing equitably accessible, affordable, high-quality care. In the United States, insurance is needed to see any doctor because out-of-pocket costs are extremely expensive; however, access to health insurance is not the same for every woman. Access to healthcare in the United States depends largely on income more than it does in any other high-income country. In the United States, 38% of adults reported that they did not receive recommended medical care because of cost. In fact, only 91.4% of the

87 See supra text accompanying notes 80-83.
88 See supra Part I.
91 Press Release, Commonwealth Fund, NEW INTERNATIONAL STUDY: U.S. Health System Ranks Last Among 11 Countries; Many Americans Struggle to Afford Care as Income Inequality Widens (Aug. 4, 2021) (on file with author) [hereinafter New International Study].
92 Id.
93 See id. (stating that half of lower-income people in the U.S. list costs as a deterrent from seeking medical treatment).
94 Id.
95 Id.
United States population has health insurance, while in other high-income countries, 99% to 100% of citizens have health insurance.\textsuperscript{96}

Without a universal healthcare system, the United States leaves nearly 8 million women of reproductive age without insurance.\textsuperscript{97} A study conducted by the Peterson Center on Healthcare and the Kaiser Family Foundation (“KFF”) found that “health costs associated with pregnancy, childbirth, and postpartum care average a total of $18,865 and the average out-of-pocket payments total $2,854 for women enrolled in large group plans.”\textsuperscript{98} This number is the cost that a woman pays if she has decent health insurance, which not all women have.\textsuperscript{99} In 2020, about 11.6% of women of childbearing age were completely uninsured in the United States.\textsuperscript{100} In 2020, 42.0% of mothers in the United States had Medicaid coverage at the time of childbirth.\textsuperscript{101}

Medicaid is an option for women facing financial insecurity.\textsuperscript{102} Medicaid, a joint state and federal program, helps cover medical costs for those with limited income who cannot afford private health insurance.\textsuperscript{103} Medicaid eligibility requirements vary from state to state.\textsuperscript{104} According to Forbes, “Medicaid is the largest payer for maternity care in the United States.”\textsuperscript{105} However, low-income women still struggle to obtain medical


\textsuperscript{97}Gunja, et al., supra note 3.

\textsuperscript{98}See Matthew Rae, et al., Health costs associated with pregnancy, childbirth, and postpartum care, HEALTH SYS. TRACER (July 13, 2022), https://www.healthsystemtracker.org/brief/health-costs-associated-with-pregnancy-childbirth-and-postpartum-care/ (partnering with the KFF to monitor how well the US healthcare system performs in terms of quality and cost).


\textsuperscript{100}Id.

\textsuperscript{101}Id.

\textsuperscript{102}Id.


\textsuperscript{104}Id.

care during and after pregnancy, despite having Medicaid.\textsuperscript{106} Studies show that women who have Medicaid coverage compared to women with private health insurance were more likely to have no postpartum visit and to return to work within two months of giving birth.\textsuperscript{107} Further, these women were more likely to have no decision-making autonomy during the labor and delivery process and to be treated unfairly or disrespected by healthcare providers because they had Medicaid coverage.\textsuperscript{108}

Even though the Affordable Care Act requires that Medicaid cover midwifery care, “the supply of providers is often so low that beneficiaries are often unable to access these services.”\textsuperscript{109} Some states have also refused to provide Medicaid funding to Planned Parenthood and other similar clinics that provide low-cost, accessible pregnancy services and postpartum care.\textsuperscript{110} Currently, almost half of women giving birth are covered by Medicaid.\textsuperscript{111} However, this coverage is only available for up to 60 days after a woman gives birth.\textsuperscript{112} Logically, Medicaid should extend for a longer period after the woman gives birth, considering that 70% of women develop at least one or more birth-related complications up to a year after giving birth.\textsuperscript{113} States do have the option to extend postpartum Medicaid coverage to a full year after giving birth, but most states fail to exercise this option.\textsuperscript{114} Therefore, while Medicaid is an option for low-income women, it is not always practicable.

Women having access to healthcare is important not only to monitor and control difficulties from pregnancy, but also to control and monitor conditions that may worsen after becoming pregnant. Doctors are seeing an increase in deaths from chronic conditions that are exacerbated while

\textsuperscript{106} See id. (explaining how mothers on Medicaid lose their Medicaid eligibility two months after giving birth).


\textsuperscript{108} Id.


\textsuperscript{110} Id. (explaining that in some states, appellate courts have ruled to end Medicaid funding).

\textsuperscript{111} Id.

\textsuperscript{112} Id.


\textsuperscript{114} Cohen, \textit{supra} note 105.
pregnant, rather than the traditional maternal mortality deaths.\textsuperscript{115} However, it follows that if a woman has access to affordable healthcare to manage chronic conditions, she would be less likely to die of the chronic condition becoming worse while pregnant.\textsuperscript{116}

B. Healthcare Policies in Other High-Income Countries with Lower Maternal-Mortality Rates

Most other high-income countries have universal healthcare coverage.\textsuperscript{117} Universal healthcare coverage is exactly what it sounds like. With universal healthcare, every person has access to healthcare services that they need, regardless of cost, and without causing any financial hardship.\textsuperscript{118} In almost all other high-income nations, “pre- and post-natal care is comprehensive and universal.”\textsuperscript{119} In other high-income countries, the government controls the cost of healthcare by negotiating prices.\textsuperscript{120} The government in other countries can thus negotiate lower drug, medical equipment, and hospital costs,\textsuperscript{121} causing both citizens and the government in these countries to pay significantly less for health care costs than the citizens and the government do in the United States. Currently, the United States spends the most amount of money per person on healthcare.\textsuperscript{122} In Norway and Canada, only 7% of people reported not going to a doctor due to cost concerns, in Sweden, 5% of people reported this, and in the United Kingdom only 1% reported this—all of these countries have universal healthcare coverage.\textsuperscript{123} Whereas in the United States, a staggering 39% of people reported not going to the doctor due to cost.\textsuperscript{124}

\textsuperscript{115} See Jamie Crow, The Rising Maternal Health Risks Facing American Women, JOHNS HOPKINS UNIV. HUB (May 4, 2022), https://hub.jhu.edu/2022/05/04/maternal-health-andreea-creanga/ (explaining that chronic conditions, specifically cardiovascular conditions and obesity, have become common causes of maternal mortality).

\textsuperscript{116} Id.


\textsuperscript{118} Universal health coverage, WORLD HEALTH ORG., https://www.who.int/health-topics/universal-health-coverage#tab=tab1 (last visited Dec. 14, 2023).

\textsuperscript{119} Cohen, supra note 105.

\textsuperscript{120} See Boyle & Velasquez, supra note 96.

\textsuperscript{121} See id. (explaining that most developed countries use government intervention to control healthcare costs).

\textsuperscript{122} See Carome, supra note 90.


\textsuperscript{124} Id.
One country to look at as an example of both a universal healthcare system in action and a lower maternal mortality rate is Sweden.\textsuperscript{125} Sweden has a publicly funded and largely decentralized healthcare system.\textsuperscript{126} Childbirth costs are not a financial burden in Sweden—the government offers services to promote a mother’s health free of charge.\textsuperscript{127} This is done through government-funded clinics which monitor pregnancies to ensure there are no life-threatening complications.\textsuperscript{128} In Sweden, the health of the mother is considered a human right. The importance of a human rights-based, universal healthcare system is clearly demonstrated by Sweden’s significantly lower maternal mortality rate when compared to the United States’ needs-based approach.\textsuperscript{129}

\textbf{C. How Implementation of Similar Healthcare Policies and Care for Pregnant Women Will Ultimately Decrease the Maternal Mortality Rate in the United States}

Universal healthcare has been proven, as shown when implemented in other high-income countries, to decrease their maternal mortality rate.\textsuperscript{130} A strong universal healthcare coverage system should be based on the people and the communities it serves.\textsuperscript{131} The high-income countries that currently have universal healthcare coverage have lower maternal mortality rates.\textsuperscript{132} It logically follows that if more women have access to affordable healthcare, they can receive the treatment they need and avoid death from pregnancy-related conditions or conditions worsened by pregnancy. Implementing universal healthcare coverage in the United

\begin{itemize}
\item \bibnote{125}{Nils Jänöv, et al., Sweden Health System Review (European Conservatory on Health Systems 2023) at 67.}
\item \bibnote{126}{Id. at 15.}
\item \bibnote{127}{Id. at 111.}
\item \bibnote{128}{Id. at 25.}
\item \bibnote{129}{Id. at 13.}
\item \bibnote{130}{Cf. Katrina Braxton, For Maternal Health, What Role Will Universal Health Coverage Play in a Post-MDG World? New Sec. Beat (Apr. 3, 2014), https://www.newsecuritybeat.org/2014/04/maternal-health-role-universal-health-coverage-play-post-mdg-world/ (reporting that universal health coverage programs have shown positive impacts in low resource countries in bridging the gap for poor and marginalized groups); see also New International Study, supra note 91 (reporting that the U.S. rate of preventable mortality, including maternal mortality, was more than double that of the best-performing country, Switzerland, which has universal health insurance coverage).}
\item \bibnote{131}{See Bain, et al., supra note 24.}
\item \bibnote{132}{See New International Study, supra note 91 (reporting that the U.S. ranks worst in health care outcomes when compared to 10 other high income countries, because those countries have universal health insurance coverage).}
\end{itemize}
States would allow more access to pre- and post-natal visits that lead to a healthy pregnancy and a healthy delivery.\footnote{Braxton, supra note 130.}

Universal healthcare coverage programs address five critical factors: an essential services package; reliable easy access to services; elimination of financial and social barriers; and performance indicators.\footnote{\textit{Id.}} Universal health care can be an especially important force in helping to reach marginalized women.\footnote{\textit{Id.}} If the United States implements a more affordable, efficient healthcare system, pregnant women would never be denied or refuse important treatment due to cost concerns.\footnote{\textit{Id.}}

The United States’ proposal to expand Medicaid was on the right track to help pregnant women,\footnote{\textit{Bradley Corallo \\& Brittni Frederiksen, \textit{How Does the ACA Expansion Affect Medicaid Coverage Before and During Pregnancy?} (Oct. 26, 2022), https://www.kff.org/medicaid/issue-brief/how-does-the-aca-expansion-affect-medicaid-coverage-before-and-during-pregnancy/.}} but experts warn that the Affordable Care Act, which expands access to Medicaid, will never be enough to solve the problem alone.\footnote{\textit{Carome, supra note 87.}} Even if expanding Medicaid will provide more access to healthcare, the biggest problem is that it will retain for-profit health insurance and healthcare institutions.\footnote{\textit{Id.}} These for-profit companies will always put their goal of making money above the goal of patient health.\footnote{\textit{Id.}} With this issue remaining, the United States will never catch up to the other high-income countries with universal healthcare.\footnote{\textit{Id.}} Experts stress the importance of universal healthcare and suggest that it may be the only solution to this increasing problem.\footnote{\textit{Id.}}

However, many democratic candidates in 2020 supported expanding Medicaid coverage for mothers, and while as mentioned above, this will never be enough to solve the problem, it would still help for the time being.\footnote{\textit{Li Zhou \\& Anna North, \textit{How 2020 Democrats would tackle the problem of startlingly high rates of maternal deaths in the U.S.}, Vox (June 26, 2019).}} Some of these proposed programs included a proposal to expand
Medicaid coverage to a year postpartum and expand the services that mothers on Medicaid can receive while pregnant and after giving birth.\textsuperscript{144} Kamala Harris, the current Vice President of the United States, for example, proposed through her Maternal CARE Act to allocate $125 million to programs that would provide support to mothers throughout their pregnancies—an effort modeled after North Carolina’s Medicaid initiative.\textsuperscript{145} She is also a co-sponsor of bills from Gillibrand and Booker, which try to expand postpartum Medicaid coverage.\textsuperscript{146} While these efforts by no means will solve the problem completely, it is a step in the right direction and would bring the United States a step closer to countries that have universal healthcare coverage.

D. The Type of Care Provided to Pregnant Women in the United States

In the United States, there is a shortage of maternity care providers relative to the number of births.\textsuperscript{147} The United States primarily has private obstetrician-gynecologists (OB-GYNs) to take care of pregnant women and to perform the delivery of the baby.\textsuperscript{148} However, studies have shown that midwifery-led care generally leads to better outcomes than OB-GYN-led care.\textsuperscript{149} Due to the medical training required of OB-GYNs, there is a high risk of over-intervention in the United States.\textsuperscript{150} Over-intervention, in terms of pregnancy and birth, occurs when cesarean sections, ultrasounds, and antibiotics are used when they are not needed.\textsuperscript{151} The harms of over-intervention for both women and newborns at times

\begin{flushleft}
\textsuperscript{144} Id.
\textsuperscript{145} Id.
\textsuperscript{146} Id.
\textsuperscript{147} Tikkanen, et al., supra note 8.
\textsuperscript{148} Id. (discussing how OB-GYNs typically work in hospital-based settings and are “trained to identify and intervene in abnormal conditions that come up before, during, and after pregnancy”).
\textsuperscript{149} Id. (explaining how midwifery-led care for pregnancies is comparable to physician led care for pregnancies regarding maternal and neonatal outcomes, efficient use of health system resources, and improved maternal well-being).
\textsuperscript{151} Id.
\end{flushleft}
outweigh their benefits.\textsuperscript{152} Over-intervention also applies to early inductions of labor.\textsuperscript{153} These interventions elevate the cost of giving birth\textsuperscript{154} in the United States, in addition to making child birth more dangerous for women.\textsuperscript{155} Oftentimes, since OB-GYNs are doctors with extensive medical training, who have a lot of patients, they will routinely induce labor instead of allowing labor to proceed naturally.\textsuperscript{156} Over-intervention involving Cesarean sections (C-sections) is alarming to many experts because a C-section is a major surgery that may involve many complications such as bleeding, infections, and longer recovery than a vaginal birth.\textsuperscript{157} Therefore, the United States should consider reforming the way they take care of pregnant patients or patients giving birth to match the standard of care given to patients in other high-income countries, as discussed below.

\textbf{E. The Type of Care Provided to Women in Other High-Income Countries with Lower Maternal-Mortality Rates}

In countries with more midwifery-led care there is also a greater proportion of midwives to pregnant women.\textsuperscript{158} Countries with a larger proportion of midwifery-led care have a lower maternal mortality rate compared to the number of childbirths.\textsuperscript{159} Midwifery-led units are best used for low-risk women as they reduce the chance of over-intervention by avoiding medicalizing everything.\textsuperscript{160} Those units also have lower rates of medical intervention during labor and higher satisfaction with no increased risk to the mother.\textsuperscript{161} Generally, there are lower costs associated

\textsuperscript{152}Dorothy Shaw, et al., \textit{Drivers of maternity care in high-income countries: can health systems support woman-centered care?}, 388 \textit{Lancet} 2282, 2283 (2016).
\textsuperscript{153}See Chong, \textit{supra} note 150 (regarding performing routine and induced augmented labors instead of allowing them to develop naturally).
\textsuperscript{155}Id.
\textsuperscript{156}See Chong, \textit{supra} note 150.
\textsuperscript{157}Id.
\textsuperscript{158}See, e.g., Tikkanen, et al., \textit{supra} note 8 (noting that many countries have a maternal care workforce, including midwives, that is two to six times higher than the U.S.).
\textsuperscript{159}See, e.g., id. (showing that countries with a high number of midwives, estimated per 1,000 live births, have a lower maternal mortality rate compared to countries such as the U.S.).
\textsuperscript{161}Tikkanen, et al., \textit{supra} note 8.
with midwifery-led care especially due to the fact that it usually does not take place in a hospital.\textsuperscript{162} Additionally, “[a] review of continuous care led by licensed midwives showed several benefits for mothers and babies and identified no adverse effects compared with models of medical-led or shared care.”\textsuperscript{163}

An example of a different level of care being implemented is in the Netherlands, where there were almost no deaths from maternal complications.\textsuperscript{164} Research determined that in the Netherlands, where maternal mortality decreased during the pandemic, there was an increase in home births and vaginal deliveries.\textsuperscript{165} There was also a decrease in Cesarean sections.\textsuperscript{166} It is presumed that these changes helped to decrease the maternal mortality rate.\textsuperscript{167}

It is also important to consider the difference that Doula and midwifery-led care makes, which is often implemented in other high-income countries.\textsuperscript{168} A Doula provides physical, emotional, and informational support during labor and delivery and to expectant and postpartum mothers—they are, however, non-clinical healthcare personnel.\textsuperscript{169} In countries with universal healthcare coverage, a Doula’s services are covered.\textsuperscript{170} Universal healthcare also covers the services of home nurse visiting programs and midwives.\textsuperscript{171} Again, in the Netherlands, the obstetrical model relies heavily on midwives and Doula care, and their maternal mortality rate, which is three times lower than the United States’, demonstrates the positive results of implicating this type of care.\textsuperscript{172}

\textsuperscript{162} Id. (discussing how midwives conduct home visits for postpartum mothers which has a lower cost than if the visit occurred in the hospital).
\textsuperscript{163} Shaw, et al., supra note 152, at 2289.
\textsuperscript{164} Gunja, et al., supra note 3 (showing a rate of 1.2 deaths per 10,000 live births).
\textsuperscript{165} Id.
\textsuperscript{166} Id.
\textsuperscript{167} Id.
\textsuperscript{168} Cohen, supra note 105.
\textsuperscript{169} Id.
\textsuperscript{170} Id.
\textsuperscript{171} Id.
\textsuperscript{172} Id.
E. How Implementing Midwifery-Led Care Rather than Obstetrician Gynecologist-Led Care Will Help Decrease the Maternal-Mortality Rate in the United States

Midwives have various duties, such as “helping to manage a normal pregnancy, assisting with childbirth, and providing care during the postpartum period.” On the other hand, OB-GYNs, who are most commonly used in the United States, are trained to identify issues with pregnancy and to intervene under abnormal conditions. In general, midwifery-led care leads to better outcomes for pregnant women and their babies. In healthy pregnancies, midwifery-led care has demonstrated benefits, such as reduced stillbirths and preterm births, a lower risk of unnecessary cesarean sections and epidurals, and a lower risk of postpartum depression. Other benefits of midwifery-led care include reductions in epidurals, episiotomies, and instrumental births. Another difference between midwifery-led care and OB-GYN-led care is that midwives can provide care in a hospital setting or at home, but an OB-GYN mostly provides care in a hospital setting.

It is clear that the United States would benefit from implementing a system with midwifery-led care as a general practice. California, the largest state by population, implemented a midwifery-led care system and experienced favorable results. Implementing the midwifery-led care system in California has led to a maternal mortality rate that is half that of the national rate.

It is clear both from the favorable results experienced in other high-income countries and in California, that the United States’ maternal mortality rate would likely decrease with the implementation of midwifery-led care.
a midwifery and Doula care model, rather than an OB-GYN model.\textsuperscript{182} Therefore, expanding Medicaid to cover Doula and midwife care may put the United States in a slightly better position with respect to their maternal mortality rate, but it is not probable that this alone will allow them to catch up with their peers.\textsuperscript{183}

III. MATERNITY LEAVE POLICIES

A. Current Maternity Leave Policies Available to Women in the United States

Because the term “maternal mortality” includes the death of a mother within 42 days after childbirth,\textsuperscript{184} it is important to analyze the differences in maternity leave policies in the United States versus those of other high-income countries. In the United States, employers are not required to provide paid maternity leave, or any maternity leave at all.\textsuperscript{185} In fact, the United States is the only high-income country that does not guarantee paid leave to mothers after childbirth,\textsuperscript{186} and one of only two countries in the entire world without a statutory national paid maternity leave policy, with the other being Papua New Guinea.\textsuperscript{187} Additionally, only eight states in the United States have paid leave policies for new mothers, with none providing a full wage replacement.\textsuperscript{188}

There are a few options for women who want to take maternity leave after the birth of their child; paid leave options, however, are very

\textsuperscript{182} See Cohen, \textit{supra} note 105 (discussing how the Dutch obstetrical model includes midwifery and Doula care, which has resulted in a maternal mortality rate nearly three times lower than the U.S.).
\textsuperscript{183} See \textit{id}. (stating that the U.S. has the highest rate of avoidable deaths in the world, and that addressing persistent problems with maternal and infant mortality is a good first step to lower this rate).
\textsuperscript{184} Tikkanen, et al., \textit{supra} note 8.
\textsuperscript{185} Shaw, et al., \textit{supra} note 152, at 2288.
\textsuperscript{186} See \textit{id}. (noting that other OECD countries have maternity leave ranging from 6-39 weeks, while the International Labour Organization convention provides for a minimum of 14 weeks of maternity leave ).
limited. The first option is to take short-term disability benefits, which is inherently unfair because having a child should not be termed a “disability.” If a woman decides to take short-term disability, she likely can only receive a portion of her pay, forcing women who live paycheck-to-paycheck to prefer going back to work earlier, rather than taking a pay cut.

Another option is to take leave under the Family Medical Leave Act (FMLA). The FMLA is the only national policy in the United States that addresses this issue. The data from 2012 suggests that “a little less than 60 percent of American private sector workers [were] eligible for FMLA.” There are extensive criteria that the employee must meet in order to qualify for FMLA. For example, the employee must be employed at her job for at least a year and work 1,250 hours in that year leading up to the date of the leave. For the employer to be considered covered under FMLA, they must have at least 50 employees and be located within 75 miles of the home of the employee. If someone is eligible to take family medical leave, they can only take 12 weeks of leave within a period of one year.

The most devastating part of the FMLA for most women is that this is unpaid leave for a 12-week period, which is not feasible for many women. However, there are some rights associated with the FMLA.

189 See Rossin-Slater, supra note 187, at 8 (describing how only 12% of private sector workers had access to paid family leave in 2015, and how only a few U.S. states had enacted paid leave family programs).
192 Rossin-Slater, supra note 187, at 7 (stating that the FMLA is the United States’ only national policy for maternity and family leave).
193 Id.
194 See id. at 8 (adding emphasis to show that the FMLA is only applicable to private sector workers).
195 Id. (outlining the requirements that employees must meet to receive FMLA).
196 Rights and Protections, supra note 190.
197 Id.
198 Id.
199 Id.
200 Id.
One who takes family medical leave has the right to return to the same or a job of an equal position, cannot be discriminated against for taking leave or due to the fact that she was pregnant, and has the right to return to work on an intermittent schedule or for only part-time work. While these important rights sound like a great advantage to the FMLA, they are not always implemented in practice. Employers sometimes do not comply with these rights, making subtle changes in the employee’s employment. In all states that have enacted paid family leave programs, there is a ceiling on the percentage of prior earnings that the employee can receive.

The third option is through employer-provided leave, which again, not all employers offer. It is great if a mother’s employer offers this—it provides paid parental leave for both mothers and fathers—however, the truth of the matter is that only 25% of workers for businesses with 500 or more employees will be able to take advantage of this option.

So, while there are a few options for women to take leave from work, most of them will not help women who are financially unstable, single, or who want to advance their careers. There is also the possibility that a woman’s employer will not offer any type of maternity leave because not all employers are required to comply with any of these types of leave, or if they are, the employee must meet certain requirements. These facts force women to go back to work earlier than they would have liked to, risking their health and potentially their lives, for their job. Many women return to work early for financial reasons—because they cannot afford to take unpaid leave, out of fear of not being seen as equivalent to their male counterparts in their workplace, or to avoid losing their place in the

201 Rights and Protections, supra note 190.
203 See id. (providing examples of subtle violations which include: reinstating the employee to a lower position, postponing reinstatement, and failing to reinstate benefits).
204 See Rossin-Slater, supra note 187 at 8 (stating that California, Rhode Island, New Jersey, and New York are states that have enacted paid family leave policies).
205 Id. at 11.
206 Rights and Protections, supra note 190.
207 See Rossin-Slater, supra note 187, at 8.
company or in the progress of their career. Therefore, many women in the United States go back to work too soon, in turn, risking their lives.

B. Maternity Leave Policies in Other High-Income Countries with Lower Maternal Mortality Rates

The majority of countries guarantee some type of paid maternity leave to new mothers. In other high-income countries, women are not forced to take the risk of either losing their job or their lives because they are guaranteed paid maternity leave. In countries where the maternal mortality rate has significantly decreased in the past few decades, maternity leave policies are generous. Of the countries included in the Organization for Economic Co-operation and Development (OECD), eight European countries offer 100% equivalent pay for maternity leave, offering this equivalent pay for at least three months. Additionally, all ten of the high-income countries included in the study mandate at least 14 weeks of paid leave, and several of those countries provide more than a year of maternity leave.

An important model for the United States to look at is Greece's maternity leave policy. Greece has the lowest maternal mortality rate—tied with Finland, Iceland, and Poland. Greece also has the most favorable maternity leave policy compared to all countries included in the

---

209 See Lynn Falletta et al, Work Reentry After Childbirth: Predictors of Self-Rated Health in Month One Among a Sample of University Faculty and Staff U.S., 11 PUB. MED. 19, 25 (2020).
210 Rossin-Slater, supra note 187, at 1.
211 Id.
212 See id. at 15.
214 Tikkanen et al., supra note 8.
OECD. Greece has obligatory leave for any pregnant woman, meaning that she must take at least eight weeks before giving birth and at least nine weeks after giving birth. This amount of time is only the minimum amount of paid leave that she must take. This obligatory maternity leave in Greece is compensated by 100% of the woman’s earnings.

There are still some requirements for a woman to be eligible for full maternity leave, but they are not anywhere near as strict as those required in the United States. Additionally, even if she does not meet the requirements for fully paid maternity leave, she can still take maternity leave—just without generous compensation. To meet the requirement for fully compensated maternity leave in Greece, she must work 200 days within the past two years, which is significantly less than the requirement in the United States. Even self-employed mothers can receive some form of compensation. The United States would greatly benefit from implementing a similar model.

C. How Implementation of Similar Maternity Leave Policies in the United States Will Help Decrease the Maternal Mortality Rate

The fact that women are not guaranteed paid maternity leave in the United States puts women at risk of other health conditions after pregnancy, including postpartum depression. Paid maternity leave, for longer periods, generally leads to better outcomes for women. For

---


217 Id.

218 Id.

219 Id.

220 Id.

221 Id. at 288.

222 Kazassi & Karamessini, supra note 216.

223 See id. (explaining that self-employed mothers are eligible for two government programs that provide full coverage for medical and pharmaceutical care at the time of the child’s birth. The eligibility lasts for four months whereupon they are able to receive granted benefits in a lump sum).

224 Tikkanen et al., supra note 8 (expressing concern for postpartum mental health).

225 Suzanne Leigh, National Paid Maternity Leave Makes Sense for Mothers, Babies, and Maybe the Economy, Univ. of Cal. S.F. (Mar. 9, 2020),
example, in Norway, there was a study that evaluated a maternity leave policy that was implemented there, which provided four months of paid maternity leave for women. The favorable results included lower body mass index, lower rates of obesity, lower blood pressure, less pain, and improved mental health. With required paid maternity leave, women will have time to heal from childbirth, breastfeed, care for newborns, attend postpartum care visits, and receive postpartum depression screening—all without the fear of losing their jobs or source of income. Greece’s model as discussed earlier also has shown proven results of decreasing their maternal mortality rate when implemented.

IV. HOW IMPLEMENTING THE PROPOSED SOLUTION IN THE UNITED STATES GOVERNMENT WITH THE SOLUTIONS PROPOSED WILL DECREASE MATERNAL MORTALITY IN THE UNITED STATES

The United States’ maternal mortality rate would decrease if they implemented similar policies to other high-income countries, regarding their abortion policies, their healthcare system, and their maternity-leave policies. The United States, however, is on the right track. In 2022, President Biden and Vice President Harris released a blueprint of a plan to increase maternal health in the United States, known as the “Blueprint for Addressing the Maternal Health Crisis.”

The five priorities proposed to improve maternal health in the United States include:

“(1) increasing access to and coverage of comprehensive high-quality maternal health services…; (2) ensuring those giving birth are heard and are decisionmakers in accountable systems of care; (3) advancing data collection, standardization, harmonization, transparency, and research; (4) expanding and diversifying the perinatal workforce; and (5) increasing family and paid leave opportunities.”


227 Id.

228 Id.

229 Kazassi & Karamessini, supra note 216.

230 Press Release, President Biden & Vice President Harris, President Biden’s and Vice President Harris’s Maternal Health Blueprint Delivers for Women, Mothers, and Families (June 24, 2022) (on file with the White House) [hereinafter Blueprint].
strengthening economic and social supports for people before, during, and after pregnancy."  

The first proposed outcome of this initiative is to improve and expand Medicaid coverage. Once implemented, this would require continuous Medicaid coverage for 12 months after birth. This would also ensure that women do not experience changes or lose coverage of insurance during or after pregnancy. This initiative will also provide better access to Doulas and midwives, encouraging insurance companies to cover their services. Additionally, the initiative will provide stronger workplace protections for mothers—including accommodations for new parents. The United States government has already taken a few steps to combat maternal mortality. With this multi-year initiative, the maternal mortality rate will likely begin to decrease. However, the United States should still consider allowing access to safe abortions, implementing a universal healthcare system, and making it a requirement that all employers provide paid maternity leave. While the plan that the United States has proposed will likely decrease the rate, the United States will never catch up with other high-income countries without a change in policies.

CONCLUSION

The United States maternal mortality rate continues to increase, affecting more and more women every day. To properly address this issue, the United States should enact similar policies to those of other high-income nations. The United States can make improvements to its abortion laws, its healthcare system, and its maternity leave policies. Improvements to policies in these areas in other high-income countries have shown proven results in reducing the maternal mortality rate, so they would likely do the same if implemented in the United States. In the future, the United States may come closer to the lower maternal mortality

---

231 Id.
232 Id.
233 Id.
234 Id.
235 Id.
236 Blueprint, supra note 230.
237 See id. (explaining that the United States has made attempts at expanding postpartum Medicaid coverage, announcing a new “birthing friendly” hospitals initiative, hosting a meeting of Cabinet Officials on maternal health, and leading a Maternal Health Day of Action).
rates of high-income countries with the implementation of the “Blueprint for Addressing the Maternal Health Crisis,” but there is still a significant amount of work to do.

\[238\] Id.