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Perspective

Strengthening Maternal and Infant Health Through Integrated Health-System and Policy Approaches in the United States

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Maternal and infant health are widely recognized as core indicators of national well-being. In the United States, these outcomes are shaped by the intersection of legal environments, health-system capacity, and social determinants of health (**Table 1**). [1] "Legal environments" in this commentary refer to the constellation of state-level policies that influence reproductive and maternal health, including abortion legislation, medicaid eligibility and postpartum coverage, licensure and scope-of-practice laws, malpractice climate, telehealth regulation, and broader reproductive rights frameworks. This commentary aims to clarify how these legal and structural factors interact, rather than operate independently, to influence maternal and infant outcomes.

Maternal mortality refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, excluding accidental or incidental causes. [2] Neonatal mortality refers to the death of a liveborn infant within the first 28 completed days of life. [3] Adverse pregnancy outcomes, including preeclampsia, gestational diabetes, preterm birth, and stillbirth, are influenced by chronic disease burden, access to skilled clinicians, and timely emergency obstetric care. [4]

Nationally, maternal mortality declined to 18.6 deaths per 100,000 live births in 2023, following elevated rates during the COVID-19 pandemic. [5] This decline likely reflects stabilization toward pre-pandemic baselines rather than structural improvement. Substantial racial disparities persist. Black women continue to experience markedly higher mortality rates than White women; recent CDC data (2021–2023) show the disparity ratio fluctuating between approximately 2.6 and 3.5 depending on the year, underscoring persistent inequities despite year-to-year variation. **Table 1** describes the major clinical, structural, and health-system determinants associated with maternal and infant outcomes and examples of evidence-informed interventions**,**

Figure 1 presents a conceptual model of maternal-infant health, illustrating the interconnected pathways through which legal and policy environments, health-system capacity, healthcare access, and social determinants collectively shape maternal and infant outcomes in the United States.

Structural determinants—including healthcare policy, insurance coverage, workforce availability, rural healthcare infrastructure, and socioeconomic conditions—directly influence access to high-quality prenatal, intrapartum, and postpartum care. These factors interact with clinical determinants such as chronic medical conditions, mental health disorders, substance use, and obstetric complications to affect maternal outcomes, including maternal mortality, severe maternal morbidity, and overall maternal well-being. Maternal health status, in turn, impacts infant outcomes such as neonatal mortality, preterm birth, low birth weight, infant morbidity, and long-term child development.

Table 1: Key determinants of maternal and infant outcomes and evidence-informed interventions.

Determinant	Associated maternal/infant outcomes	Evidence-informed interventions
Chronic conditions (hypertension, cardiovascular disease)	Severe maternal morbidity, preeclampsia, preterm birth	Chronic disease management programs; remote monitoring; postpartum follow-up; Medicaid coverage continuity
Mental health conditions	Suicide, overdose, impaired bonding, preterm birth	Integrated behavioral health; telepsychiatry; screening and referral pathways
Substance use disorders	Neonatal abstinence syndrome, overdose, preterm birth	Medication-assisted treatment; harm-reduction programs; integrated prenatal–SUD care
Maternal obesity	Gestational diabetes, hypertensive disorders, cesarean delivery	Nutrition support; diabetes prevention programs; community-based interventions
Hospital quality variation	Severe maternal morbidity; preventable complications	AIM bundles; perinatal regionalization; quality-improvement collaboratives
Implicit bias and structural racism	Disparities in morbidity, mortality, and patient experience	Bias training; community-based models; doula support; respectful maternity care initiatives
Workforce shortages	Delayed care, reduced prenatal visits, increased emergency deliveries	Workforce incentives; midwifery integration; rural training tracks
Rural obstetric unit closures	Increased travel time, preterm birth, out-of-hospital deliveries	Rural hospital stabilization; telehealth; mobile maternity units
Insurance discontinuity	Delayed prenatal care, postpartum complications	Medicaid expansion; 12-month postpartum coverage; streamlined enrollment
Telehealth access	Improved continuity; reduced delays; enhanced chronic disease management	Broadband expansion; reimbursement reform; remote monitoring programs
Legal and policy environments	Variable access to reproductive and maternal care	Coverage expansion; scope-of-practice reform; reproductive health protections

This model underscores that maternal and infant health outcomes are driven by dynamic interactions among policy, healthcare systems, clinical care, and social contexts. It highlights the critical importance of coordinated, multidisciplinary, and evidence-informed interventions aimed at improving health equity and outcomes across the continuum of maternal and child healthcare.

Legal and Structural Determinants of Maternal and Infant Health

Maternal and infant outcomes vary widely across states due to interacting legal, structural, and health-system factors. States with fragile maternal health infrastructures, such as limited postpartum Medicaid coverage, high rates of rural obstetric unit closures, and shortages of obstetric clinicians, consistently report worse outcomes. [6–8] Conversely, states with robust insurance coverage, strong perinatal regionalization, and sustained investment in community-based services demonstrate more favorable trends.

Louisiana

Louisiana's maternal mortality rate averaged 37 deaths per 100,000 live births from 2018 to 2022, well above the national average. [5] High infant mortality rates, particularly among low-income and minority families, reflect systemic challenges including chronic disease burden, inadequate prenatal care, and socioeconomic hardship. [9] Persistent rural hospital closures and limited access to specialty care further exacerbate disparities.

Texas

Following implementation of Texas Senate Bill 8 (SB8) in 2021, infant and neonatal deaths were reported to increase between 2021 and 2022, including a rise in deaths due to congenital anomalies. [10] National rates declined during the same period. These findings require cautious interpretation. Ecological analyses cannot establish causation, and competing explanatory factors, including socioeconomic variation, county-level health-system capacity, interstate migration, differential reporting practices, and changes in fertility patterns, may contribute to observed trends. Data lags, heterogeneous county-level conditions, and the absence of individual-level linkage between policy exposure and outcomes further limit causal inference.

California

California consistently reports among the lowest maternal mortality rates in the country, supported by longstanding investments in perinatal quality improvement, Medicaid expansion, and comprehensive reproductive health access. The California Maternal Quality Care Collaborative (CMQCC) has implemented statewide hemorrhage and hypertension bundles, contributing to reductions in severe maternal morbidity. [11] California's Medicaid program (Medi-Cal) provides broad postpartum coverage and supports midwifery integration and telehealth reimbursement, strengthening continuity of care. [12] These coordinated legal, clinical, and public-health strategies illustrate how sustained investment can mitigate risk even in a large, diverse state.

Mississippi

Mississippi has one of the highest maternal and infant mortality rates in the United States, driven by high chronic disease burden, limited Medicaid eligibility, and substantial rural hospital closures. Until 2023, Mississippi did not offer

12-month postpartum Medicaid coverage, contributing to significant gaps in continuity of care. [13] Workforce shortages, particularly in rural counties, and limited access to high-acuity obstetric services compound risk. Mississippi represents a policy environment where structural constraints, rather than legal restrictions alone, drive persistently poor outcomes. [14]

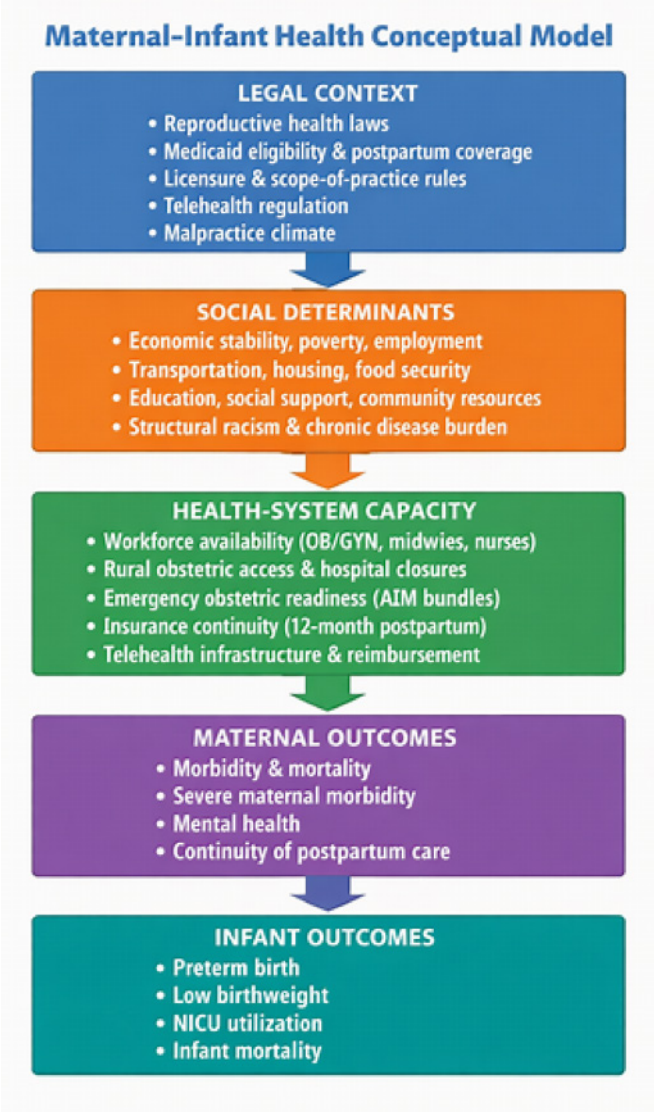

Figure 1: Maternal-infant health conceptual model.

Colorado

Colorado demonstrates mid-range maternal and infant outcomes but has emerged as a leader in telehealth expansion and perinatal mental health policy. The state's Medicaid program supports telepsychiatry, remote monitoring for hypertensive disorders, and integrated behavioral health models. [15] Colorado also maintains relatively strong midwifery licensure laws and has invested in rural obstetric stabilization programs. [16] Despite these strengths, geographic barriers and uneven distribution of clinicians continue to challenge access in frontier regions.

Across these states, patterns illustrate that legal environments interact with, but do not independently determine, maternal and infant outcomes. California's strong outcomes reflect coordinated investment in quality improvement and coverage expansion; Mississippi's persistently high mortality reflects structural and economic constraints; Colorado demonstrates the benefits of telehealth and workforce innovation; Louisiana and Texas highlight the consequences of fragile health-system capacity and socioeconomic inequities. These contrasts underscore that policy environments, health-system infrastructure, and social determinants collectively shape maternal and infant health, and that legal restrictions alone cannot explain state-level variation. **Table 2** summarizes the key characteristics of the five representative states discussed in this commentary and highlights how variations in health policy and infrastructure may influence maternal health outcomes.

The comparisons among California, Colorado, Louisiana, Mississippi, and Texas illustrate that maternal and infant health outcomes are shaped by the interaction of legal environments, health-system capacity, insurance continuity, workforce availability, and broader social determinants. Rather than acting independently, these factors operate within an interconnected health system in which improvements or deficiencies in one domain may influence multiple aspects of maternal and infant health. **Figure 2** presents a conceptual framework illustrating these interrelationships and the pathways through which structural, policy, and healthcare determinants collectively influence maternal and infant outcomes.

Beyond Abortion-Related Evidence

While the Turnaway Study provides insights into the socioeconomic and health consequences of being denied a wanted abortion, [17] it represents only one component of the evidence landscape. A broader set of determinants

Table 2: Comparative overview of maternal health systems across selected U.S. states.

State	Maternal mortality	Medicaid expansion	Postpartum coverage	Rural obstetric access	Major policy challenge
California	Low	Yes	12 months	Good	Maintaining equity
Colorado	Moderate	Yes	12 months	Moderate	Geographic access
Louisiana	High	Yes	12 months	Limited	Chronic disease burden
Mississippi	Very high	Limited	Recently expanded	Poor	Workforce shortages
Texas	Moderate-high	No	Limited	Variable	Regional disparities

CMQCC, California Maternal Quality Care Collaborative; Medicaid, U.S. federal-state health insurance program.

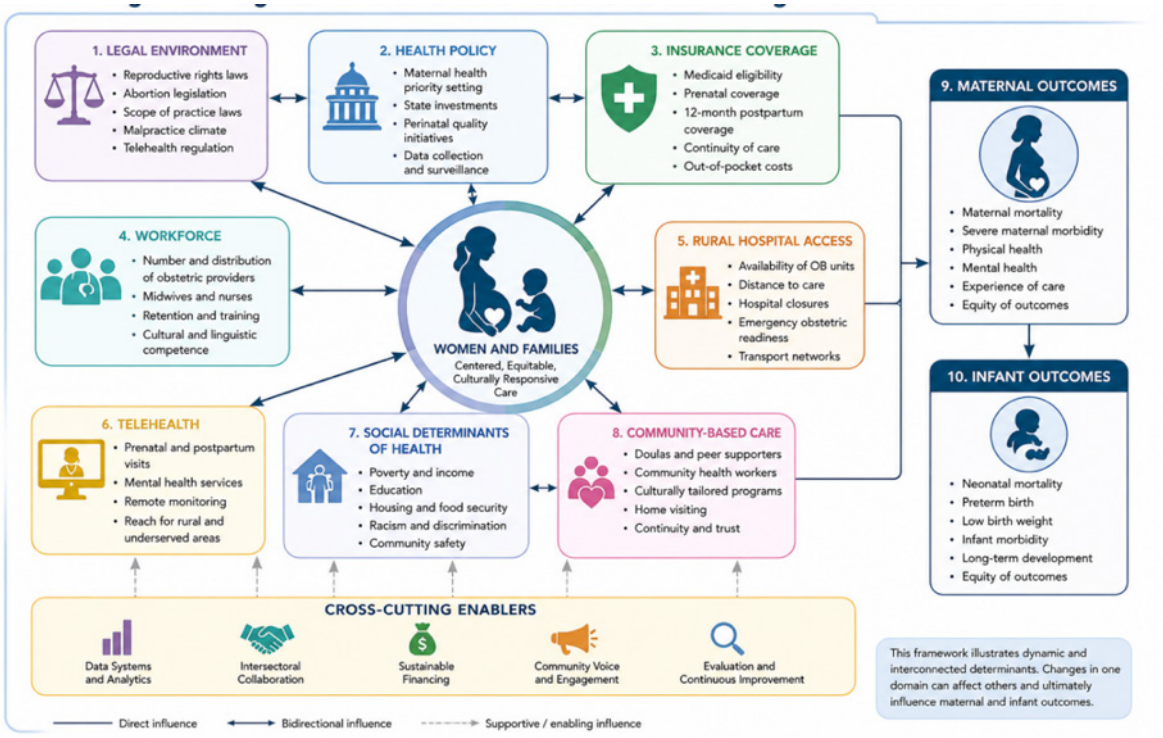

Figure 2: Integrated framework of determinants influencing maternal and infant health. The framework illustrates the dynamic interactions among legal environment, health policy, insurance coverage, healthcare workforce, rural hospital access, telehealth, social determinants of health, and community-based care. These interconnected determinants collectively influence maternal outcomes (including maternal mortality, severe maternal morbidity, physical and mental health, and equity of care) and infant outcomes (including neonatal mortality, preterm birth, low birth weight, infant morbidity, and long-term development). Cross-cutting enablers—including data systems, intersectoral collaboration, sustainable financing, community engagement, and continuous quality improvement—support implementation across all domains.

exerts substantial influence on maternal and infant outcomes, including hypertension and cardiovascular disease, [18] mental health conditions, [19] substance use disorders, [20] maternal obesity, [21] hospital quality variation, [22] implicit bias, [23] workforce shortages, [24] and variability in severe maternal morbidity surveillance. [25] These determinants interact with legal environments but also operate independently of them, underscoring the need for multilevel strategies that address clinical, structural, and social contributors simultaneously.

Health System Capacity

Workforce Shortages

Many states face declining numbers of obstetric clinicians, particularly in rural regions. Workforce shortages contribute to delayed care, reduced frequency of prenatal visits, and increased reliance on lower-resourced facilities. [24] These shortages amplify the effects of legal and policy environments by constraining the system's ability to absorb increased demand or respond to emergencies.

Rural Obstetric Unit Closures

Rural hospital closures and obstetric unit shutdowns have accelerated over the past decade, increasing travel times for labor and emergency care. Longer travel distances are associated with higher rates of preterm birth, unplanned out-of-hospital deliveries, and severe maternal morbidity. [26,27] States with limited Medicaid reimbursement or unstable hospital financing structures experience the highest closure rates.

Emergency Obstetric Readiness

Emergency obstetric care requires timely management of hemorrhage, hypertensive disorders, sepsis, and complications of early pregnancy. Implementation of standardized quality-improvement bundles, such as the AIM hemorrhage and hypertension bundles, has been shown to reduce severe maternal morbidity when applied consistently. [28] Variation in adoption and fidelity contributes to state-level differences in outcomes.

Insurance Continuity

Insurance churn during pregnancy and postpartum disrupts continuity of care. Medicaid expansion and 12-month postpartum coverage reduce preventable morbidity and improve long-term outcomes, particularly for low-income and minority populations. [29,30] States that have not expanded Medicaid continue to report higher rates of uninsurance and delayed prenatal care.

Telehealth Capacity

Telehealth expands access to prenatal counseling, chronic disease management, mental health services, and postpartum follow-up. Benefits are greatest in rural and

underserved communities. Telehealth improves continuity of care and reduces delays, though broadband access and reimbursement variability remain barriers. [30–32] States with supportive telehealth policies, such as Colorado and California, demonstrate higher uptake and more consistent integration into perinatal care.

Evidence-Informed Strategies

1. Strengthen emergency and miscarriage care through standardized protocols and rapid-response systems. [28,31]
2. Leverage telehealth to expand access to prenatal, postpartum, and chronic disease management services. [32–35]
3. Strengthen insurance coverage and continuity of care through Medicaid expansion and extended postpartum eligibility. [29,30]
4. Expand community-based and home-based services, including midwifery, doula care, and home visiting programs. [36]
5. Support families through childcare, education, and economic stability initiatives. [37]
6. Align fiscal priorities with maternal and child health goals to ensure sustainable investment in high-impact programs. [38]

Implementation Considerations

Implementation requires coordination across health systems, public agencies, and community organizations. Key domains include insurance continuity, community-based services, emergency care readiness, social supports, fiscal alignment, and telehealth expansion, each with specific actors, barriers, and measurable indicators. [39–41] Effective implementation depends on aligning policy design with on-the-ground capacity, including workforce availability, hospital infrastructure, and community partnerships. [42] Importantly, sustainable implementation of services such as doula care, home visiting, and telehealth requires payment reform; fee-for-service Medicaid and many commercial plans currently under-reimburse these services, making value-based or bundled payment models a prerequisite for long-term viability. States that have adopted such models demonstrate more stable program uptake and improved continuity of care. [43]

Economic and Policy Implications

Medicaid finances over 40% of U.S. births. Policies that expand eligibility, extend postpartum coverage, and streamline enrollment processes improve continuity of care and reduce preventable morbidity. [29,30] Workforce investments in obstetric clinicians, midwives, doulas, and community health workers yield high returns by reducing emergency care utilization and improving chronic disease management. [24,36] Rural hospital sustainability depends on payment models that stabilize essential services, particularly in regions with declining birth volume. [26,27,44] Telehealth reimbursement policies influence access and continuity of care, and states with supportive reimbursement frameworks report higher adoption and more consistent integration into perinatal care[45–47]

Community-based models—including midwifery, doula support, and home visiting—are cost-effective, particularly for high-risk populations. [36,44] However, without reforms to Medicaid and commercial reimbursement structures, many of these models remain financially fragile despite strong evidence of benefit. Aligning fiscal priorities with maternal and child health goals therefore requires not only investment but also structural payment redesign to ensure sustainability.

Limitations

This commentary synthesizes evidence from heterogeneous data sources, including surveillance systems, administrative datasets, policy analyses, and program evaluations. These sources vary in definitions, reporting practices, and methodological rigor, which may introduce reporting biases and limit comparability across settings. Because this is an interpretive synthesis rather than a systematic review, some nuances in regional variation and study design could not be fully explored.

In conclusion, Maternal and infant health outcomes in the United States reflect the complex interplay of legal environments, health-system capacity, insurance continuity, workforce availability, and broader social determinants of health. Although legal and policy frameworks influence access to reproductive and maternal healthcare, they operate alongside structural, clinical, and socioeconomic factors that collectively determine health outcomes. Strengthening access to comprehensive prenatal and postpartum care, expanding insurance continuity, enhancing emergency obstetric readiness, investing in rural healthcare infrastructure, and supporting community-based models of care remain high-impact strategies for improving maternal and infant health across diverse settings.

Sustained progress will require interdisciplinary collaboration among clinicians, public health professionals, policymakers, health systems, researchers, and community organizations to develop coordinated, equitable, and evidence-informed solutions. Such partnerships are essential for addressing persistent disparities, improving healthcare delivery, and ensuring that policy initiatives are responsive to the needs of women, infants, and families.

As maternal health policies continue to evolve, ongoing evaluation of policy implementation and health-system reforms is critical to determine their effectiveness, unintended consequences, cost-effectiveness, and impact on health equity across different populations and geographic regions. Future policy decisions should be guided by rigorous evidence rather than isolated indicators or ecological associations.

Finally, there is a pressing need for prospective longitudinal studies, implementation research, and comparative policy evaluations that examine the interactions among legal environments, healthcare infrastructure, and social determinants of health. Such research will provide stronger causal evidence to inform future maternal health policies and identify scalable interventions that improve maternal and infant outcomes while reducing longstanding inequities. By fostering interdisciplinary collaboration, investing in robust health systems, and generating high-quality evidence, policymakers and healthcare leaders can build a more

resilient, equitable, and effective maternal and child health system for future generations.

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CONFLICT OF INTEREST

None.

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