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POLICY BRIEF

Policies to Address Low Availability and High Costs in Maternity Care

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Maternal morbidity and mortality have nearly doubled over the past 25 years in the United States, largely owing to poor obstetrical access and quality of care.[1] Supporting the wholistic healthcare model of nurse midwife deliveries in community birth centers would go a long way toward lowering the cost and improving the outcomes of low-risk pregnancies. Many pregnant women could safely deliver in an outpatient setting without expensive inpatient treatment.

The United States ranks 60th in the world in maternal survival after childbirth and is the only developed nation with rising maternal mortality rates.[2] Those who are poor, minorities, foreign born, or rural all suffer from inadequate access to obstetrical care. Black women and their infants are two to three times more likely to die during childbirth than white women and infants in the United States.[3] Rural hospitals and obstetrical units are closing at an alarming rate,[4] with 25.4 percent of rural women having to give birth in a nonlocal hospital.[5]

Over the past 100 years, pregnancies and deliveries have become increasingly medicalized, much to the detriment of patient care. Most US deliveries occur in the hospital owing to a significant lack of acceptable alternatives. Pregnant women desire autonomy, respect, and a sense of security and connectedness.[6] These values are often lost within the typical obstetrical office and hospital labor and delivery unit, whose primary focus is on medical screening and management of complications. Critical issues for wholistic patient well-being, such as education about and preparation for pregnancy, parenting, breastfeeding, and psychosocial support (i.e., mental health, food security, and housing) are neglected.[7] The midwifery model of obstetrical care provides value as well as a respect for the importance of the social determinants of health. Unfortunately, midwives and the community birth centers in which they often practice are not well integrated into the US

healthcare system and often have to function without the direct backup of obstetricians and hospitals in their area. The majority of birth centers act as isolated businesses without a collaborative agreement with a neighboring hospital.[8] The end result for women is lack of choice and autonomy in the healthcare market.

The predominant model of obstetrical care currently available is expensive and invasive. Costs for US maternity care are among the most expensive in the world, with Switzerland coming in a distant second according to a comparison by the International Federation of Health Plans.[9] The US C-section delivery rate is higher than in most other countries but does not produce better birth outcomes.[10] Hospital delivery management often intervenes with no clear medical need, leading to increased cost of care and higher preventable patient morbidity and mortality rates.[11] According to the Health Care Cost Institute, the cost of an uncomplicated vaginal childbirth in 2016–2017 ranged from $8,361 in Arkansas to $19,771 in New York.[12] Average spending was $12,235 per vaginal birth and $17,004 per C-section.[13] The most important contribution to cost was geographic location of the birth. According to the study, states varied widely in cost of delivery and C-section rates, making state-level policy advocacy exceedingly important.

Home and birth center births are typically one-half to one-third the cost of hospital births.[14] The majority of births are delivered by midwives, with only 2.7 percent of birth center deliveries performed by a physician.[15] Birth centers are available in most but not all states.[16] In 2017, Alabama, Hawaii, Illinois, Iowa, Mississippi, Nevada, New Jersey, North Dakota, Rhode Island, South Dakota, Vermont, and Wyoming each had fewer than 20 births at a birth center.[17] The state of Alaska accounted for the most, with 5.65 percent of deliveries occurring in a birth center in 2017. The next most frequent were Washington (1.54 percent), Idaho (1.44 percent), Oregon (1.40 percent), Montana (1.34 percent), Delaware (1.29 percent), Pennsylvania (1.24 percent), and New Hampshire (1.00 percent).[18] A state's willingness to support birth center deliveries with Medicaid funds is an important component of a woman's ability to access this model of care. Using national birth certificate data, researchers Marian MacDorman and Eugene Declercq find that, in 2017, Medicaid covered 17.9 percent of birth center births and 43.4 percent of hospital births.[19] Private insurance paid for 47.5 percent of birth center births and 49.4 percent of hospital births. Thirty-two percent of birth center births were paid for by the women themselves compared with just 3.4 percent of hospital births. Importantly, the finding that one-third of birth center births are self-pay suggests that, despite multiple pilot projects showing that birth centers are a safe and cost-effective means of providing care, most payers are not prepared to support this option for women seeking an out-of-hospital birth.

One in five women over the age of 18 live in a rural county.[20] Unfortunately, rural hospitals and maternity units are closing at a significant rate.[21] High costs and low reimbursement rates result in obstetric units being a source of loss in rural hospitals. Birth centers could fill in the gap left by hospitals without reducing quality. One study reports that, between 2012 and 2020, 88,574 fami-

lies obtained care through birth centers.[22] The outcomes of those births were similar to those in hospitals; moreover, the outcomes were similar for urban and rural birth centers.

A community birth center model involves the provision of prenatal, labor, and postpartum care using midwifery and a focus on wellness.[23] The federal definition of a *freestanding birth center* is "a health facility—(i) that is not a hospital; (ii) where childbirth is planned to occur away from the pregnant woman's residence; [and] (iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan."[24] There is excellent clinical evidence that midwifery plays an essential role in providing high-quality, affordable obstetrical care for low-risk pregnancies.[25] A comprehensive review of maternal outcomes in US birth centers published in 2016 shows very positive outcomes for mothers and infants and shows low rates of medical interventions and an excellent safety record.[26] Women who receive prenatal care with midwives are less likely to have interventions such as epidurals, episiotomies, instrumental births, or C-section deliveries.[27] One study projects that if birth centers were routinely available and integrated into the current US healthcare delivery system, total maternity care spending would fall by 12 percent.[28]

The lack of collaboration between hospitals and birth centers and physicians and midwives is an unfortunate result of the regulatory and payer environment within the United States. Strong evidence supports the benefits of interprofessional, collaborative practice models. Researcher Nicole Carlson and coauthors performed a retrospective cohort study using data from the Consortium on Safe Labor on low-risk parous women delivering in centers with interprofessional care (i.e., midwives and physicians practicing collaboratively) or without interprofessional care (i.e., physicians practicing alone).[29] The study shows that women delivering at centers with interprofessional care were 85 percent less likely to have labor induced and 36 percent less likely to undergo a primary C-section than women at centers without interprofessional care. The probability of a vaginal delivery after a C-section in the former group was 31 percent higher. There were no appreciable differences in neonatal outcomes between the two groups.

Some have proposed a nationwide network of hospital-affiliated outpatient birth centers as a key reform in obtaining higher-quality and cost-effective national obstetrical care. Currently, birth centers suffer from high variation in integration, accreditation, and standards of obstetrical care, making their universal acceptance controversial. A hospital-affiliated model would help ensure uniform utilization of best practice protocols across birth centers and immediate availability of a higher level of care should an obstetrical emergency arise.[30] Researcher Victoria Woo and coauthors project that with the achievement of comprehensive guidelines for patient selection and transfer to a facility that can provide more advanced care when needed with adequate communication between birth settings, 40 percent of women could safely deliver in outpatient birth centers.[31]

The University of Washington School of Medicine conducted a retrospective study on risk factors associated with hospital birth among women planning to deliver at a birth center in Wash-

ington between 2004 and 2011.[32] Ninety-three percent of the women successfully delivered at a birth center, whereas 7 percent had to transfer for a hospital birth. The strongest risk factors for transfer were never having given birth, advanced maternal age, and obesity. The authors advised accounting for risk factors during antepartum counseling when women are considering delivery at a birth center. The American College of Obstetricians and Gynecologists recommends that each birth center account for risk identification and establish a clear clinical threshold for transfer from a birth center to a hospital.[33]

Expanding community birth centers in rural America is a potential solution to the rural closures of hospital-based labor and delivery units. Community birth centers provide basic obstetrical care at affordable cost, promoting the safety of women who wish to deliver close to their home. Currently, 25 percent of rural women must deliver in a nonlocal hospital.[34]

The birth center model is difficult to effectively scale across the country because of an inflexible provider licensing system, a lack of supportive state policies, and significant barriers to adequate reimbursement.[35] States vary widely in scope-of-practice and licensure regulations for midwives, and some have placed regulatory hurdles so high as to make the practice of midwifery impractical and unprofitable.[36] The American Association of Birth Centers and the American College of Nurse-Midwives have issued statements regarding the difficulty of obtaining adequate compensation for their professional services from insurance companies despite federal Medicaid mandates.[37]

The impact of the state regulatory environment is significant. The proportion of midwife-attended births in the United States in 2017 ranged from 0.4 percent in Arkansas to 28.9 percent in Alaska.[38] Studies have shown that there are more midwives and more midwife-attended births in states that allow midwives to practice autonomously and in states that mandate insurance coverage for midwifery services.[39] Most community (nonhospital) births are attended by midwives, and only half of those deliveries are covered by insurance.[40]

It is widely recognized that the United States is failing in maternal care, with areas of low availability of obstetrical care resulting from closure of obstetric units and scarcity of maternity care professionals.[41] Policies supporting the integration of birth centers are desperately needed to ameliorate the burdens of high cost, poor quality, and barriers to access in the current US maternal care system. To address these problems, I propose the following policies:

- Support scope-of-practice laws that ensure certified nurse midwives' ability to practice as autonomous, independent practitioners. Scope-of-practice laws determine which healthcare services are allowed under a midwife's license, and they often restrict the services that can be performed independently, without the supervision of a physician. The regulatory environment for certified nurse midwives (CNMs) varies tremendously from state to state. There is compelling evidence that CNMs provide care of equivalent quality when practicing autonomously and that scope-of-practice restrictions lead to increased health-

care costs,[42] delays in care, and loss of continuity of care.[43] Sara Markowitz and coauthors find that states without scope-of-practice barriers to midwife practice have lower rates of induced labor and C-section births.[44] State legislatures should remove barriers restricting autonomous practice by CNMs, which would likely attract more midwives to states and diversify states' obstetrical workforces.

- Exempt birth centers from certificate-of-need (CON) laws, which act as barriers to entry into the market. CON laws regulate the creation and expansion of healthcare facilities in a community through regulatory oversight. Without CON approval, a business cannot obtain licensure to practice. According to a 2021 position statement by the American Association of Birth Centers, CON laws are associated with fewer birth centers in a state. Of the 35 states without CON requirements for birth centers, 7 states (20 percent) have zero or one birth centers; of the 14 states with CON requirements for birth centers, 9 states (60 percent) have zero or one birth centers.[45] CON laws significantly reduce the entrance of birth centers into the market, reducing women's choices for birth setting. State legislators should work toward overturning their CON laws, thereby helping reduce medical cost and improve outcomes for low-risk births through support for the building of birth centers.
- Integrate birth centers into a broader network of surrounding hospitals capable of handling surgical and emergency obstetrical needs. Such integration can be encouraged with accreditation policies and quality standardization of birth centers. Although rare, obstetrical emergencies, such as placental abruption, maternal hemorrhage, or cord prolapse, can lead to loss of maternal and fetal life unless intervention occurs quickly. This risk is amplified by system-level failures, such as when birth centers seeking to transfer care to a hospital do not have a collaborative agreement with that hospital. Midwives, obstetricians, and administrators need to come together through their professional organizations to create nationally recognized guidelines ensuring the best evidence-based care with respect to birth setting while respecting a birthing woman's autonomy.[46] Interprofessional collegiality and regard is critical to making this happen.

Strong evidence shows that enabling successful expansion of midwife and birth center care models reduces maternity care costs, improves quality, and ensures adequate access while diversifying the healthcare market. Further delaying positive reform will result in needless loss of money, choice, and autonomy for pregnant women in the United States.

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NOTES

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