

GREATER AUTONOMY AND INTEGRATION FOR MIDWIVES IMPROVES MATERNITY CARE OUTCOMES

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Chair Manchester, Vice Chair Cutrona, Ranking Member Denson, and members of the House Families, Aging, and Human Services Committee:

Thank you for the opportunity to speak with you today. I am Lauren Hall, professor and chair of the Department of Political Science at Rochester Institute of Technology; author of the book *The Medicalization of Birth and Death*,¹ which explores the role of overregulation in the medical industry; and coauthor of a recent Mercatus Center working paper on midwifery regulation titled “Midwifery Licensing: Medicalization of Birth and Special Interests.”

The main takeaways of my testimony today are the following:

1. Ohio, like many other US states, struggles with poor maternal and infant outcomes, including catastrophic outcomes such as maternal and infant mortality. Ohio’s 2021 preterm birth grade from the March of Dimes is a C-,² and Ohio ranks below the US average in infant mortality,³ maternal mortality,⁴ and a range of other quality markers.⁵ Removing regulatory barriers to high-quality midwifery care has been shown repeatedly to lower all these risks.
2. Access to maternity care through Medicaid is vital, given that more than half of expectant Ohio mothers receive Medicaid coverage for their pregnancies. Midwifery care has been demonstrated to decrease Medicaid expenditures while improving outcomes, the gold standard for public health policy.

1. Lauren K. Hall, *The Medicalization of Birth and Death* (Baltimore, MD: Johns Hopkins University Press, 2019).

2. “2021 March of Dimes Report Card,” March of Dimes, accessed May 17, 2022, <https://www.marchofdimes.org/peristats/tools/reportcard.aspx>.

3. March of Dimes, PeriStats (database), accessed May 17, 2022, <https://www.marchofdimes.org/peristats/>.

4. “PAMR Data and Reports,” Ohio Department of Health, accessed May 17, 2022, <https://odh.ohio.gov/know-our-programs/pregnancy-associated-mortality-review/reports>.

5. March of Dimes, PeriStats (database).

3. Limitations on midwifery practice have been linked to increased costs and decreased access; such limitation do not improve outcomes for mothers and babies. A range of evidence demonstrates that much of restrictive licensing for midwives arises not from genuine public health concerns based on research, but from anticompetitive motives. States that have eliminated requirements for physician supervision and hospital transfer agreements have better maternal health outcomes.

Ohio's maternal mortality and infant mortality rankings are high relative to the rest of the country. Thirteen percent of white expectant mothers and 24 percent of black expectant mothers in Ohio lack adequate prenatal care. Meanwhile, 14 counties in Ohio are considered maternity care deserts, meaning that there are no licensed maternity care providers operating in the area. Moreover, around half of maternal fatalities in Ohio between 2008 and 2016 were deemed preventable.⁶ Crucially, the March of Dimes also finds that Ohio has failed to adopt a comprehensive midwifery policy that would allow trained midwives to practice more autonomously and that would remove barriers to care.⁷

Researchers find that restrictive licensing of midwives increases the number of maternity care deserts, increases travel time for prenatal care and delivery services, endangers mothers and babies, and has outside effects on rural Americans, Amish and Mennonite women, women of color, and low-income women generally. These regressive effects mean that those who may need the most care are often the least likely to be able to access it.

According to the Ohio Department of Medicaid, 53 percent to 55 percent of births in Ohio were paid for by Medicaid during 2017–2019, and in 2019 Medicaid spent \$638,373,292 for 69,532 births.⁸ Infant mortality was roughly twice as high among Medicaid recipients as among non-Medicaid recipients in 2019.⁹ Ohioans are taxed a lot for inefficient, fragmented, and sometimes inappropriate care. Recent analyses find that greater access to midwifery care could save the nation billions in healthcare costs, both at point of care and by limiting expensive and unnecessary interventions later on.¹⁰

Concerns about midwives practicing autonomously often center around specific kinds of home births, but those who hold these concerns fail to recognize that women without legal options for their preferred care can and do seek such care across state lines or engage in riskier behavior, such as giving birth completely unattended, as was the case in Alabama until recently.¹¹ Certified professional midwives (CPMs) are trained in low-risk home birth and are trained to triage care to medical providers when necessary. Arguments from the American College of Obstetrics and Gynecologists and other medical associations about the inherent riskiness of some kinds of births, such as multiple pregnancies

6. Melissa Federman, "The Status of Ohio's Women: Maternal Mortality," Center for Community Solution, November 23, 2020.

7. "2021 March of Dimes Report Card," March of Dimes.

8. Ohio Department of Medicaid, *Report on Pregnant Women, Infants, and Children—SFY 2020*, July 19, 2021, 4, 21.

9. Ohio Department of Medicaid, *Report on Pregnant Women, Infants, and Children*, 10.

10. Katy B. Kozhimannil, Laura Attanasio, and Fernando Alarid-Escudero, *More Midwife-Led Care Could Generate Cost Savings and Health Improvements* (Minneapolis, MN: University of Minnesota School of Public Health, 2019).

11. Rebecca Grant, "The Secret Baby Catchers of Alabama: They Work in Hotel Rooms, Airbnbs and Secondhand RVs Just over the State Line, so That Women Can Give Birth on Their Own Terms," *Highline, HuffPost*, December 19, 2018.

and vaginal birth after cesarian, are not borne out by the evidence, which consistently finds that access to high-quality midwifery can lower risk, even among higher-risk patients.

Moreover, evidence from the Federal Trade Commission and other sources shows that many restrictive policies, such as requiring coordination agreements with physicians and transfer agreements with hospitals, do nothing to improve outcomes but serve primarily as protectionist barriers supporting a medical monopoly on maternity care services.¹²

Finally, other states and countries have set a precedent for allowing midwives (including CPMs) who are integrated into the healthcare system to practice autonomously or near autonomously, and these places have excellent outcomes and lower costs as a result. States such as New Mexico, New York, Oregon, and Washington and countries such as Canada and the United Kingdom all prioritize midwifery-led care, and recent research finds that states with the most integrated midwives who also practice autonomously have some of the best maternal health outcomes.¹³

Given the escalating costs of modern healthcare and the strain on Medicaid that Ohio, like all other states, is facing, granting greater autonomous practice to high-quality primary maternity care providers and integrating them more fully into the healthcare system is basic common sense. From a public health perspective, it's also good medicine.

12. Federal Trade Commission and US Department of Justice, *Improving Health Care: A Dose of Competition*, July 2004.

13. Saraswathi Vedam et al., "Mapping Integration of Midwives across the United States: Impact on Access, Equity, and Outcomes," *PLOS ONE* 13, no. 2 (2018): e0192523.