

## The Pregnant Elephant in the Room: The U.S. Maternity Care Crisis

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A healthy 29-year-old American woman arrives at the hospital in labor. Her obstetrician does an exam; she is two centimeters dilated. When her labor does not progress, she is given Pitocin and put on a fetal monitor—rendering her bed-ridden. Labor support is minimal. The Pitocin escalates her contractions so she is given an epidural for the pain. The labor lags with the epidural, the Pitocin is increased, and subsequently the baby's heart rate shows signs of stress. A cesarean section is ordered, and the baby is delivered surgically and sent to the nursery for observation. Breastfeeding is difficult, and the recovery is long. Her prenatal care consisted of expensive testing, four ultrasounds, and short 15-minute appointments with her obstetrician. The care and delivery cost upwards of \$35,000.

A similar, healthy 29-year-old Dutch woman arrives at the hospital in labor. Her midwife does an exam; she is two centimeters dilated. Her midwife suggests she go home, take a walk, and rest. She returns and is six centimeters dilated. Her midwife provides encouragement, massage, and suggestions for her laboring positions to decrease her pain. She gives birth naturally to a healthy baby, and because they were never separated, the baby begins breastfeeding immediately. A home health nurse visits her every day for the first weeks. During her prenatal care she has had basic testing, one ultrasound, and educational and supportive prenatal visits. Her prenatal care and birth experience cost 4,500 Euros (\$6,000), fully covered by the Dutch health care system.

### THE PREGNANT ELEPHANT IN THE ROOM: THE CRISIS

Maternity and newborn care cost the United States over \$50 billion annually—the largest category of hospital costs for Medicaid and commercial insurers—yet the United States ranks 50<sup>th</sup> in the world for maternal mortality and 36<sup>th</sup> for neonatal mortality (Coeytaux et al. 2011; The World Bank 2012). In light of the changes taking place in the American health care system, what is being done to improve the quality of care, cost, and outcome of the most important medical event in human life? Even though in each scenario a “healthy baby” is the result, the mothers experi-

ence something vastly different. Why do American women routinely get major abdominal surgery? What is driving the maternity care crisis in the United States? Expensive and invasive medical interventions—designed to save lives in high-risk situations—have become routine, rendering them harmful instead of helpful, and costing billions of unnecessary dollars.

### OUTCOMES/QUALITY

Despite the high cost of maternity care, the United States has one of the worst rates of both infant and maternal death among industrialized nations. The maternal mortality rate in the United States has doubled over 25 years, as has the cesarean section rate, which now exceeds 30 percent. The World Health Organization states that a cesarean section rate above 15 percent has no added benefit to health outcomes and constitutes unnecessary surgery (Gibbons et al. 2010).

The outcomes for women and babies of color are dramatically worse, leading Amnesty International to place the United States on a watch list for this human rights violation, documented in its 2010 report *Deadly Delivery*. African-American women are four times more likely than white women to die of childbirth related causes. The infant mortality rate among African Americans is three times that of whites, and pre-term and low birth weight rates are double.

### IMPLEMENTING THE SOLUTION

The United States must improve outcomes and decrease costs. There is a clear solution: increase the percent of births attended by midwives and employ the midwifery model of care as the evidence-based standard.

A critical difference when comparing the U.S. system to countries with better outcomes is that midwives do not deliver the majority of American babies. In most European countries, the standard is for all women to receive midwifery care; in the United States only 10 percent do.

The Cochrane Collaboration released a study in August 2013 comparing various maternity care models; their results stated that the group receiving midwife-led care showed the greatest benefits to mother and baby, including fewer interventions and

fewer pre-term births. The low-tech, more personalized model of care offered by midwives where pregnancy is not treated as an illness, results in better outcomes for low-risk women and is delivered at lower costs (Sandall et al. 2013).

### ADDRESSING DISPARITIES WITH MIDWIFERY CARE

Midwifery care has proven to have a dramatic effect on the outcomes for minority women and their babies. One example in the District of Columbia is the Family Health and Birth Center (FHBC), which provides midwifery care for African-American families who are politically disfranchised and economically impoverished. After only five years, the percentage of preterm births was 9 percent for women at the FHBC compared to 14.2 percent for the District generally. Similarly, the percentage of low birth weight infants was halved at the FHBC compared to the wider District community (7 percent versus 14.6 percent respectively) (FHBC 2007).

Another example is Commonsense Childbirth, led by midwife Jennie Joseph. In her Florida clinic she cares for a high-risk population using a unique midwifery model. She has significantly reduced the number of preterm and low birth weight babies born to her clients (Joseph 2013). Foundation for the Advancement of Midwifery (FAM) has supported Joseph's work by funding opportunities for her to teach her method to other midwives.

### THE ROLE FOR HEALTH FUNDERS

Three member funds recently created an affinity group for funders who recognize that increased access to midwifery is an essential step in maternity care reform: the Health Foundation for Western and Central New York, The Transforming Birth Fund (a donor advised fund of the New Hampshire Charitable Foundation), and FAM. There are many approaches for grantmakers to fund increased access to midwifery care. The Transforming Birth Fund has had a policy focus, funding blueprints for this new direction in maternity care. The Health Foundation for Western and Central New York has funded community-based care to support the midwifery practices that serve specific populations vulnerable to poor outcomes.

FAM supports policy, education, research, and certain direct care initiatives. As an example of its strategic investments, The Transforming Birth Fund and FAM funded the 2011 Homebirth Consensus Summit (HBCS), which included stakeholders in U.S. maternity care who historically have a contentious relationship. The HBCS did not debate the idea of home birth, but convened a strategic conversation on how to best serve the families that fall between the two systems: those that intend to birth at home but transfer to a hospital for additional medical intervention.

This facilitated summit opened unprecedented dialogue and resulted in nine consensus statements. FAM is now funding the HBCS Regulation and Licensure Task Force, a working group moving to manifest one of the consensus statements (HBCS 2013). Resources are small by comparison to many other funds, but this strategic investment has changed the conversation between maternity care providers.

Only 2 percent of all U.S. births are planned home births

attended by midwives; this number, however, is on the rise. From 2004 to 2011, home births increased by 50 percent nationally (Birkner 2013). Still, 98 percent of women continue to deliver in hospitals, and they deserve the highest quality care available. Our three funds believe that if we fully integrate the midwifery model of care into U.S. hospitals—as do those countries with superior results—we can improve outcomes, reduce costs, and decrease disparities.

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For those interested in joining this affinity group or learning more, contact Robin Hutson at [robin@formidwifery.org](mailto:robin@formidwifery.org).

### SOURCES

Amnesty International, *Deadly Delivery: The Maternal Care Crisis in the USA*, <<http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf>>, 2010.

Birkner, Gabrielle, "Home Births on the Rise for New York Families," *Wall Street Journal*, August 25, 2013.

Coeytaux, Francine, Debra Bingham, and Nan Strauss, "Maternal Mortality in the United States: A Human Rights Failure," Association of Reproductive Health Professionals, <<http://www.arhp.org/publications-and-resources/contraception-journal/march-2011>>, March 2011.

Family Health and Birth Center (FHBC), *Briefing Statement to the Committee on Health of the Council of the District of Columbia* (Washington, DC: February 22, 2007).

Gibbons, Luz, José M. Belizán, Jeremy Lauer, et al., *The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage* (Geneva, Switzerland: World Health Organization, 2010).

Home Birth Consensus Summit (HBCS), "Common Ground Vision Statements," <<http://www.homebirthsummit.org/summits/vision/statements>>, 2013.

Joseph, Jennie, Commonsense Childbirth, "Outcomes of the JJ Way and Other Research," <<http://commonsensechildbirth.org/index.php/outcomes>>, 2013.

Sandall, J., H. Soltani, S. Gates, et al., "Midwife-Led Continuity Models versus Other Models of Care for Childbearing Women," <<http://summaries.cochrane.org/CD004667/midwife-led-continuity-models-versus-other-models-of-care-for-childbearing-women>>, August 21, 2013.

The World Bank, *Level and Trends in Child Mortality. Estimates Developed by the United Nations Inter-Agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA, UNPD). Data from 2008-2012*, <<http://data.worldbank.org/indicator/SH.DYN.NMRT>>, 2012.

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