# Reforming Maternity Care in America

## Recommendations to the Obama-Biden Transition Team on Maternity Health Care

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### Introduction

In her new book, *Pushed: The Painful Truth About Childbirth and Modern Maternity Care*, journalist Jennifer Block states, **"Either women's bodies are failing or the system is failing women."**[1] This is at once a poignant observation of how women feel about a process that used to come naturally to them and a sad commentary on the shortcomings of our maternity care system. Indicators of health status and women's own stories reveal that current childbearing practices and maternity care policies fail to meet the needs of women and babies in fundamental ways.

### Why Maternity Care Deserves Attention in Health Care Reform

With 4.3 million births each year in the U.S. and over three-quarters of all women becoming mothers, maternity care affects large numbers of women and their families.[2] The birth industry is big business. The maternity care system in the United States has become one of the largest and most successful for-profit industries of all medical specialties. Nearly one-quarter of all patients discharged from hospitals in the U.S. are childbearing women or newborns. Hospital charges for mothers and newborns ($86 billion in 2006) far exceed hospital charges for any other condition. Private insurers pay for 49% of births, and Medicaid pays for 43%.[3]

### Design, Organization, and Operation of Maternity Care Services

From state to state, maternity care services have informal or loosely organized coordination with limited involvement of State Maternal and Child Health (MCH) programs. The lack of coordination exists in legislation, policies, regulation, and supervision. The maternity health care system is primarily driven by established relationships and referral patterns among individual MCH providers, payers, and managed care organizations.[4] The voices, wishes, and recommendations of consumers—women of reproductive age and their partners—are often missing, and services are designed and implemented for what the profiteers will bear and not necessarily for what is beneficial for women and infants.[5] In addition, MCH systems are not designed to satisfy cost-benefit ratios and often fail to achieve evidence based performance benchmarks.

What compounds this situation is the lack of transparency regarding services and lack of accountability regarding outcomes. One wonders if MCH policy personnel are asking the question, "Are we achieving optimal outcomes with the maternity care services we are choosing to provide?" The principles of transparency and accountability require that we ask tough questions, and further, that we be willing to change the design, organization, and operation of maternity health care to provide consumers with high quality services and improve outcomes for mothers and babies.

## Considerations Regarding Routine Maternity Care Interventions

Women are subjected to an ever-increasing array of interventions and obstetrical technologies. Of the most common hospital procedures, six out of fifteen involve childbirth.[6] Childbirth is the most common reason for hospitalization of women in the United States.

Cesarean section is the most frequently performed hospital procedure in the U.S. One in three American mother/baby dyads experience surgical birth. In 2004, the cesarean rate was 29.1% at a cost of $14.6 billion dollars.[7] The preliminary data for 2006 released by the Centers for Disease Control and Prevention (CDC) is that the cesarean rate reached an all time high of 31.1%.[8] The percentage of cesarean section deliveries has risen 50% in the past decade. The procedure carries major risks with two to four times the risk of maternal death as compared with vaginal birth. Many experts think that at least half of all cesarean sections are unnecessary. Inducing labor increases the chances of cesarean delivery. Ample medical evidence shows that use of unnecessary interventions—as routinely utilized in the current medical model of care—puts mothers and infants at risk.

## Strain on Health Care Dollars and the Importance of Cost Efficiency

Everyone can agree that health care financing is as strained as it has ever been. In *The Medical Delivery Business*, Dr. Barbara Bridgman Perkins provides an excellent analysis of the historical roots and contemporary consequences of applying an economic and industrial approach to the process of childbirth. Perkins explains how the provision of medical care has become one of the biggest industries in the U.S., the focus of which in maternity care is the rise in medical interventions used in the normal process of birthing a baby in any hospital setting.[9] Yet few women and even fewer physicians question the necessity of many medical interventions that have become commonplace in modern obstetrical practice.

Many childbearing women report being offered and/or coerced into using obstetrical interventions that are not evidence-based.[10] Many interventions offer little or no demonstrated benefit, impose risk on women and their infants, and are very costly. And yet, many practices with established benefits—such as using water therapy rather than epidural anesthesia for pain relief—are underutilized.

Maternity care overuses expensive and often unnecessary medical practices such as surgery, pharmacology, and technology, and underuses other cost-effective practices such as preventive health care modalities, including nutritional counseling, continuous labor support, and breastfeeding promotion. Many of these preventive measures will not only reduce health care spending but will improve overall health status and increase client satisfaction.[11]

## Maternity Care Outcomes

While the United States has the highest per capita spending on health care in the world, this has not led to the best outcomes. Infant and maternal mortality are primary indicators of the health status of a nation. There has been no improvement in maternal mortality in the U.S. since 1982. In 2005, the World Health Organization identified twenty-nine developed nations with lower estimated maternal mortality than the United States and thirty-three developed nations with lower neonatal mortality rates.[12] In addition, preterm birth and low birthweight rates have continued to rise in the U.S. since 1981 and remain higher than approximately thirty other developed nations. Outcomes are worse yet for racial and ethnic minorities, where differences in health status are significant, and sources of disparities are complex and rooted in both historical and contemporary inequities.

The use of obstetrical procedures has doubled in the past fifteen years. The Centers for Disease Control and Prevention (CDC) reported that induction of labor has risen sharply over the past 15 years from 9.5% in 1990 to 21.2% in 2004, and these numbers are believed to be underreported according to the National Center for Health Statistics.[13] The national *Listening to Mothers Survey II* found the rates to be twice what the CDC found as reported by the women surveyed. Respondents stated that providers tried to induce labor in four out of ten cases even though these women were considered low risk. Women reported receiving at least seven to ten obstetrical interventions.[14] While the U.S. outspends all other nations on health care and promulgates a medical model of childbirth, our outcomes are not nearly as good as those countries that rely heavily on public health and midwifery models of care.

In October 2008, the United States received a "D" on the "Premature Birth Report Card" by the March of Dimes in its state-by-state perinatal health care mapping to track progress towards meeting the Healthy People 2010 goal of lowering preterm births.[15]

## A Need for Maternity Care Reform

In contemplating women's health, maternity care deserves priority consideration for reform. The current obstetrical status quo is unsustainable for three primary reasons:

1. It fails to meet the practical needs of the childbearing population
2. It is profit-driven rather than driven by the best research evidence about childbirth practices
3. It fails to meet the cost-benefit test in terms of dollars spent versus outcomes for investment

We have an urgent need to replace the present maternity care system that focuses on specialization, pathology, technology, pharmacology, and surgery, with a primary maternity care system that focuses on optimal primary care for women and newborns. Specialized maternity care has unnecessarily turned a normal physiological process into an intensive care situation without improving outcomes.[16]

In a new study (2008) published by the Milbank Memorial Fund entitled *Evidence-Based Maternity Care: What It Is and What It Can Achieve*, researchers concluded, **"Effective care with least harm is optimal for childbearing women and newborns."** The report goes on to suggest that maternity care reform must **"foster broad access to safe, effective midwifery care."** In an exhaustive treatise on the current maternity care system, the Milbank Report demonstrates how using the best available research on the safety and effectiveness of specific practices to help guide maternity care decisions will facilitate optimal outcomes for mothers and infants. This report identifies significant barriers as well as key policy strategies for widespread maternity care reform in the United States.[17]

## High Quality Care, Optimal Outcomes, and Cost-Efficiency

The countries with the best maternal and child outcomes in the world have a low-tech, high-caring system that utilizes midwives as the appropriate caregiver for most women of reproductive age. Midwives are an integral part of a team of health care providers along with family practice physicians and obstetrical and neonatal specialists. Midwives provide optimal collaborative care with the least amount of intervention. These highly successful countries also offer clients the choice of birth center and home birth options as a regular feature of informed consent. These options are safe. They enhance access to care and focus on health education. They are associated with a highly favorable liability record, they are well-received by childbearing women, and they are cost effective.

In order to provide high quality care and optimal outcomes with cost efficiency in the U.S., it is necessary to examine the most effective practices and interventions. As maternal and child health clinicians and researchers evaluate care practices that are both high-quality and cost-effective, it is important to have measurement tools that assess differences among all women giving birth. Evaluating perinatal outcomes within a framework of normalcy, rather than pathology, is a new focus of measurement. For example, the "Optimality Index-US" shifts the focus from rare, adverse events to evidence-based, optimal events.[18] Tools such as this can be used to measure "maximal results with minimal intervention," which should be the goal of maternity care care policies and practices.

## Midwives Model of Care: A Public Health Model of Maternity Care

In contemplating maternity care reform, we must emulate successful models from other countries that have achieved superior outcomes at lower cost. The nations with the best perinatal outcomes are those in which midwives are the cornerstones of maternity care. There are also successful and replicable models in the U.S., such as the DC Birth Center operated by midwives located in our nations' capital in a very vulnerable community with one of the highest infant mortality rates in the country. The outcomes of their programs are extraordinary. While the medical model of childbirth emphasizes the pathological potential

inherent in pregnancy and childbirth, the midwifery model of care championed by midwives focuses on the normalcy of pregnancy and birth as conditions of health. These two models are very different in practice, style, and values.

The world over, midwives are recognized for their contribution to public health. Because of their unique relationship with women, midwives are well-positioned to impart health messages. The midwife-woman relationship focuses on healthy lifestyle choices, fosters self-empowerment, and furthers a long-term life-cycle perspective on health. Midwives hold a traditional role as educator providing women with information about preventative health care topics such as nutrition, exercise, healthy lifestyles, sexual practices, family planning, and breastfeeding. Even for women with pre-existing medical complications cared for by physicians, scientific literature shows that midwives can make valuable contributions as part of the health care team. Evidence based research has shown that midwives can improve the health of high-risk women and their infants by providing support for behavioral changes, encouraging healthy lifestyle choices, teaching about nutrition, encouraging cessation of tobacco and alcohol use, and providing support in maintaining blood sugar levels.[19] Midwives accomplish this by utilizing a public health framework that treats each woman as an individual within the context of her own life while providing an awareness of how genetics, lifestyle choices, environment, values, and health-seeking behaviors impact health status.

Historically and across cultures midwives have been primary care providers to women during pregnancy and birth and throughout the female life cycle. Midwives monitor the physical, psychological, and social well-being of the mother throughout the childbearing year, provide continuous assessment and support while minimizing technological interventions during labor and birth, identify and refer women who require obstetrical attention, and provide outstanding and personalized postpartum care for women and their newborns. The application of this woman-centered model of care has been proven to maintain the safety of mothers and newborns, reduce the incidence of unnecessary interventions, decrease cesareans deliveries, improve breastfeeding rates and duration, encourage mother-infant attachment, provide consumer satisfaction, and reduce health care spending.[20]

According to the PEW Commission on Health Professions, **"the midwifery model of care is an essential element of comprehensive health care for women and their families that should be embraced by, and incorporated into the health care system, and made available to all women."**[21]

### Recommendations for Maternity Health Care Planning and Reform

1. Ensure affordable maternity care for all women and infants, remove barriers to accessing high-quality services, and improve disparities in health status.
2. Ensure that women have control over the manner and circumstance of birth, including choice of provider, place of birth, and adequate preparation for making informed decisions.
3. Focus on optimal normal birth rather than birth as potential pathology utilizing evidence-based research to make maternity care decisions.
4. Utilize midwives as primary maternity care providers for hospital-based care and out-of-hospital care.
5. Promote collaborative maternity care teams utilizing midwives and family practice physicians for low-risk clients and reserving obstetrical specialists and surgeons for high-risk situations.
6. Utilize a standard set of performance measures for all providers in all settings that links priority reimbursement with improving performance and that involves public and private payers.

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## Supplementary Document

*An Issue Brief: Certified Professional Midwives in the United States*. July 2008. North American Registry of Midwives, Midwifery Education Accreditation Council, National Association of Certified Professional Midwives, Midwives Alliance of North America. At: http://mana.org/pdfs/CPMIssueBrief.pdf.


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