'Birth Settings' report explores medical disparities of childbirth in the US

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A report released earlier this month dives deep into the ongoing inequities surrounding childbirth in the U.S., with Oregon emerging as a leading example of how to do better.

Oregon State University associate professor Missy Cheyney, a medical anthropologist who focuses on midwifery, was one of 15 authors on the "Birth Settings in America" report from the National Academies of Sciences, Engineering and Medicine, which was commissioned by Congress. She helped present the findings to lawmakers in Washington, D.C. on Feb. 6.

Despite the U.S. spending more on maternity care than any other country—an estimated $110 billion each year—it has the worst outcomes among peer countries for mothers and babies.

"People giving birth today are more likely to die in childbirth than they were in our parents' generation," Cheyney said. "And that risk is unevenly distributed: It disproportionately affects black and Native American women, who are dying at a rate of 3 to 4 times more than white women."

For the report, authors examined hundreds of articles documenting birth outcomes in three settings: hospitals, birthing centers and home births , and compared them with the medical literature from other countries whose birth outcomes are better than in the U.S.

Based on the report's findings, Cheyney says it is imperative that the U.S. make midwives and home and birth center births more accessible to families who want them, which will help to:

- Lower health care costs;
- Reduce complications from unnecessary interventions, including some cesarean sections;
- Improve patient experience; and
- Provide more respectful care that aligns with cultural and personal values, as well as clinical needs

Currently, 98.4% of all U.S. births occur in hospitals, with about 0.6% in birthing centers and 1% at home. Overall, 89% of U.S. births here are attended by physicians, and only 11% by midwives. Very few families are able to access midwifery care in home and birth center settings due to high out-of-pocket costs, limited insurance coverage and a shortage of midwives.

That's the opposite of our peer nations, Cheyney said, where a majority of pregnancies start with a midwife and only receive a higher level of care if complications arise. And in many of those countries, the health care system better supports cooperation across provider types and birth settings.

"In our peer countries, you triage up to a higher level of care when it's indicated," she said, and there is greater exposure to, and acceptance of, a full range of birth settings. "Here, we start everyone at the highest level of care under the assumption that everyone will need a surgeon. In other high-

resource nations, they assume that as long as you're healthy, most people can start with a midwife."

Other countries' systems more effectively integrate midwives than in the U.S., where midwives are covered by a state-by-state patchwork of regulations that often serves to further limit access to care and can impact safety.

In those countries, midwives are enabled to perform immediate interventions for complications that can arise in childbirth, such as excessive bleeding by the mother or difficulty breathing by the infant.

With portable oxygen tanks and injectable medications, those are not hard to safely manage in a home or birth center, Cheyney said. But midwives need consistent access to necessary training, licensure and integration into the health care system, including seamless transfers to a hospital when indicated.

Another major issue is the high rate of cesarean births in the U.S.: Today, nearly 1 in 3 mothers give birth via cesarean, and efforts to reverse that trend have been largely unsuccessful.

Cesarean births are associated with a number of complications, including greater blood loss, risk of infection stemming from the incision and risk of complication in future pregnancies. While cesarean births can be life-saving, the World Health Organization finds that rates higher than 10% are not associated with lower maternal and newborn mortality rates.

In comparison, Cheyney said, when low-risk women start their childbirth process at home or in a birth center, only about 5 to 7% result in a cesarean birth.

In hospitals, women of color report higher incidence of being ignored and threatened by providers, having care withheld, and receiving care they did not consent to, compared with other birth settings. Culturally matched midwifery can improve maternal outcomes by connecting families with providers who understand the challenges people of color face when navigating the U.S. health care system.

"We should not separate the outcomes of care from the experience of care," Cheyney said. "How we treat mothers matters as much as the clinical outcome, and we have lost track of that in some places."

On a positive note, Oregon is leading the way when it comes to integrated care and access to midwives and doulas.

In Corvallis specifically, the Community Doula Program, headed by Cheyney, works to match traditionally underserved populations with culturally matched doulas, and the services are free for Medicaid patients.

The integrated care system in Corvallis also means that families can freely choose to give birth at home, in a birthing center or at a hospital, and when someone needs to transfer to the hospital, it is a midwife-to-midwife transfer.

This allows some obstetricians in Corvallis to focus their care at the top of their license, Cheyney said: They can be called in to work on the medically complex births they're actually needed for, rather than on every birth.

Oregon still has its challenges, especially with low insurance reimbursement to birthing centers, but it's "definitely ahead of the curve," Cheyney said.

The next step is to learn how the programs that have been successful here can be scaled up and used nationwide.

Provided by Oregon State University