

ADDRESSING THE MATERNAL HEALTH CRISIS

Statement of

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Good morning Chair DeLauro, Ranking Member Cole and members of the Committee.

Thank you for the opportunity to testify today. My name is Dr. Wendy Gordon. I am an Associate Professor and Chair of the Department of Midwifery at Bastyr University, a small natural health college near Seattle, WA. This program is one of the first recipients of the funding from the HRSA Scholarships for Disadvantaged Students grant that was set aside for midwifery education programs in 2020. The SDS grant funding has been available to medical and nursing schools since 1990, but it has only been through the work of this Committee that midwifery education programs were finally allowed to apply last year. I and several of my students are extremely grateful to this Committee for that opportunity.

I have been a midwife for 16 years and am currently in active practice at a freestanding birth center in Seattle. I have a Masters in Public Health and am among the first in the US to receive a Doctorate in Midwifery from an innovative program at Thomas Jefferson University. In 2019, I served as a member of the National Academies Committee on Assessing Health Outcomes by Birth Settings. I thank Representative Herrera-Beutler and Representative Roybal-Allard for your leadership in requesting that National Academies' study, which was sponsored and funded by the Eunice Kennedy Shriver National Institute of Child Health and Human

Development at the National Institutes of Health. The committee's final report was released a year ago in January 2020.¹

I have been asked to talk with you today about the importance of community providers in addressing the maternal health crisis in the United States.

Maternity care in the US today is in crisis for several reasons, and it is only projected to get worse over the next 10 years. The US ranks far lower than most high-income countries (and many middle-income countries) with regard to maternal mortality,² preterm birth,³ low birth weight,⁴ and infant mortality.⁵ The rate of maternal deaths has actually *increased* over the last several years in the US, with 660 deaths in 2018, the last year that these data were reported.⁶ This rate is the highest among all industrialized countries. According to the CDC, severe maternal complications, or what we call “near miss” morbidity, has more than doubled over the last 20 years,⁷ affecting more than 50,000 women and their families every year. Black, Indigenous and Latina families bear the disproportionate burden of these statistics in the US, a country that spends more on healthcare and childbirth than any other country in the world.

Closures of obstetric services across the US, many in rural areas, have created what are called “maternity care deserts,” where there are no maternity care services at all. As of 2018, 35% of US counties were deemed maternity care deserts, and an additional 11% of counties had low access to maternity services.⁸ Again, this lack of access disproportionately affects Black, Brown, Indigenous, and low-income communities.

The maternity care workforce is also in short supply. There is a current shortage of 6000-8000 obstetricians across the US, and this is projected to reach a shortage of 22,000 OBs by 2050, according to a recent CMS issue brief.⁹ Meanwhile, midwives attend only about 10% of US births and are severely underutilized in our maternity care system. In comparison, midwives

are the first-line providers in England,¹⁰ the Netherlands,¹¹ Australia,¹² and New Zealand,¹³ and people only see a physician if they have complications; in the Canadian province of British Columbia, 22% of births are attended by midwives.¹⁴ Globally, midwives who are educated and regulated to international standards can provide 87% of the essential care needed for women and newborns, according to a report by the United Nations Population Fund (UNFPA).¹⁵

In the US, there are three types of midwives:

- Certified Nurse-Midwives (CNMs) are primary health care providers for women from adolescence beyond menopause. Their services include the independent provision of primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life. There are currently about 12,000 nurse-midwives practicing in the US. As implied by the name, nurse-midwives first become nurses before beginning their graduate level midwifery training, which then takes 1.5-2 years to complete. Nurse-midwifery education programs are typically situated in schools of nursing, and training usually takes place in hospital settings. CNMs are legally recognized to practice in all 50 states and the District of Columbia. The majority of nurse-midwives practice in hospital settings, although they may also provide care in both birth centers and homes.
- Certified Midwives (CMs), of which there are only 100, receive a bachelor's degree in any health sciences field before beginning their midwifery training. There are two nurse-midwifery programs in the US that accept applicants without a nursing background, and these students take the same classes, pass the same board exam, and usually have the same scope of practice as the nurse-midwives. Certified Midwives are able to get a license to practice in 6 states.

- Certified Professional Midwives (CPMs), which number about 2500 across the US, are trained to provide continuity of care from preconception through the postpartum period, which means that the same midwife or small team of midwives provides care to a person throughout all of their prenatal visits, attends their birth, and provides high-touch postpartum care for parent and baby for the first 6 weeks after birth. These midwives are trained to provide care for labor and birth in community settings including homes and freestanding birth centers. The education and training that CPMs receive averages about 3 years in duration and may result in a certificate of midwifery all the way up to a Master's degree, such as the program that I run. Certified Professional Midwives are currently licensed in 34 states and the District of Columbia.

All nationally credentialed midwives in the US share similar competencies that align with the standards of the International Confederation of Midwives.¹⁶ The research on midwifery care in the US demonstrates care that is of high quality, high satisfaction, and is cost effective. In Washington State alone, the Health Care Authority found that Licensed Midwives providing care in community settings reduces Medicaid costs by \$2 million annually,¹⁷ and we only attend 3% of the births in the state. I'd like to note here that the continuity of care model -- the one where the birthing person gets to have the same midwife throughout the entire childbearing year -- is the ONLY system-level intervention that has been shown to reduce preterm birth and infant mortality in a recent review of studies.¹⁸ Health services in England and Australia are working to implement this type of midwifery-led care for as many people as possible.¹⁹

In addition to midwives, there are many other types of community-based providers that have shown to improve outcomes for families but are also underutilized in the US healthcare system. **Doulas** are people who help the birthing person during labor; they provide continuous, one-to-

one physical and emotional support during the intense time of giving birth. Studies have over and over demonstrated the value of doulas in the birthing space. Dr. John Kennell, who conducted some of the earliest studies on doula support, said that “If a doula were a drug, it would be unethical not to use it.”²⁰ More and more hospitals are welcoming doulas and some are even finding ways to employ them as staff. However, the services of a doula are not typically reimbursed by a person’s health insurance, so those who might benefit the most from doula support are not able to afford it.

Lactation consultants are another underutilized provider type, particularly when we know that babies who are breastfed have a 21% lower risk of death in their first year, compared with babies who were never breastfed. The risk is 38% lower if babies are breastfed for 3 months or more.²¹ But breastfeeding can be challenging, and people often need support after they’ve been discharged from the hospital. Fewer than 25% of infants are breastfed exclusively through the first 6 months of life, and our Healthy People 2030 goals aim to increase that to 42%.²² Lactation consultants are experts in this kind of support, but we need to figure out how to make this care much more accessible after hospital discharge, as well as increase the diversity of the workforce to better support Black families, who receive the least breastfeeding support.²³ Community midwives often work together with lactation consultants to provide several home visits in the first postpartum weeks, and this kind of intensive support has resulted in breastfeeding rates that are nearing 100% by the six-week mark.²⁴

Many families who have been able to access the care of a midwife, a doula, and/or a lactation consultant, would say that they wouldn’t have it any other way. These are cost-efficient, high-touch models of care that actually improve outcomes. Other high-income countries are way ahead of us in this regard, and the outcomes show it.

Miller and colleagues²⁵ offer a framework for understanding this. They laid out a spectrum of care from “too little, too late” at one end, where people who need interventions can’t access them, to “too much, too soon” on the other end, where healthy people are getting routine interventions they don’t actually need. The risk of bad outcomes is increased at both ends of this spectrum, and both can simultaneously exist in a country with inequities in access to care. There’s a sweet spot somewhere in the middle where people only get interventions when they need them and in a timely manner.

Community-based providers have the potential to positively impact these statistics as well as the race and class disparities within them. Midwifery-led care is *designed* for that sweet spot. Nearly 32% of babies in this country are delivered via cesarean section, an intervention that is sometimes absolutely necessary but is widely considered to be an overused intervention that increases the risk of maternal complications by 3 times²⁶ and maternal death by 3-4 times²⁷ over vaginal birth. These statistics are even higher for Black, Indigenous and people of color. Research demonstrates that midwives in hospital settings can reduce the cesarean rate by one third;²⁸ midwives in freestanding birth centers can reduce it by half;²⁹ and when people plan to give birth at home with a midwife, even when they have to transfer to the hospital in labor, the cesarean rate goes down to 5-6%.²⁴ The Strong Start study on midwifery-led care in freestanding birth centers also demonstrated dramatic reductions in racial disparities for both maternal and newborn outcomes.²⁹

Last year, the COVID-19 pandemic created seismic shifts in how people thought about their births. For the first time in a long time, hospitals didn’t seem like the safest place for healthy people with low-risk pregnancies, and many people turned to community-based midwives and freestanding birth centers for their care. In Washington State where I practice, midwives of all

types came together to deal with the surge of people looking for alternatives, and how we could ensure that they could be safely and seamlessly transferred back to the hospital if they needed to. We enjoy a fairly collaborative environment here in Washington State, and midwives are relatively well integrated into the maternity care system already. But there are still some states in this country where midwifery care is rare in hospital settings and outright prohibited in home and birth center settings. It is critical to have trained and licensed providers who can provide safe care in ALL settings, and whose demographics represent all communities. There is a lack of options for Indigenous families on reservations to give birth to their babies on their Native land. There is a lack of options for Black families to hire a midwife who looks like them and who understands not only the stress of racism but the cultural birthing traditions of their ancestors. There is a lack of options for Hispanic families to hire a midwife who speaks their language and doesn't have to have an interpreter or a family member translate for them while they're trying to give birth.

But in the system we currently have, it's hard to even become a midwife. The systems of education don't support midwifery. Even though it is quicker and more cost effective to educate midwives than physicians, there are no dedicated federal streams of funding for the education of midwives in the way that nurses and physicians are funded. It was 2020 when midwifery education programs were, for the first time, allowed to apply for the HRSA grant for Scholarships for Disadvantaged Students, and I urge this committee to advocate for continued or even expanded set-aside funding through this program. Midwives' salaries are among the lowest for healthcare professionals, especially those of us working in community settings. The cost of malpractice insurance is almost always covered by the hospital for those who are employed there, but for those of us working outside of institutions, we bear that cost ourselves, and it is

prohibitive for most. Although we are trained to provide reproductive health care throughout the lifespan, our scope is sometimes limited to only the time between conception and 6 weeks postpartum. Midwives in some states are required to be supervised by a physician, and if there are no physicians in the area, there is no legal way to practice. Many private healthcare insurers will not cover midwifery services in community settings. The general public is unaware of the availability, training, and competencies of midwives in the US, and the professional role of midwives is undervalued within the healthcare system.

These gaps in our healthcare infrastructure, resources, and systems are pervasive, they have adverse impacts on the maternity care workforce, and all of these barriers disproportionately impact communities of color, including Black and Native communities, resulting in a workforce that is not adequately resourced or representative of the communities being served. I urge Congress to pass the Black Maternal Health Momnibus Act so that these racial health disparities might finally be addressed.

In a more ideal world – one that is outlined in the National Academies’ study of *Birth Settings in America*,¹ and that many other high-income countries have already implemented – all women of reproductive age, including adolescents, should have universal access to midwifery care when needed. The policy environment and healthcare infrastructure should be fully supportive of midwifery care across all settings: home, freestanding birth centers, and hospitals. Midwifery education should be funded, especially for people from underrepresented racial and class origins, and programs should have the resources to expand so that anyone who wanted to become a midwife could do so without incurring levels of student debt that they can never repay. To this end, I strongly encourage Congress to pass HR 3849, the Midwives for MOMS Act, to help expand the midwifery workforce.

Health insurance should cover midwifery care in all settings, and midwives could collaborate respectfully and seamlessly with other healthcare professionals to provide the best possible care to birthing people in the setting that is most appropriate for their risk profile and their choice. Freestanding birth centers should be funded and new models of care developed that put childbearing people at the center. The BABIES Act would expand the birth center model that proved to be so successful in the Strong Start Initiative in reducing preterm birth, low birth weight, and cesarean birth rates. Barriers to choice and access can be removed; rates of unnecessary interventions can be reduced; costs can come down; the pressures on the shrinking physician workforce can be relieved; and our maternal and infant outcomes might come into alignment with the goals we have set for ourselves.

Thank you for the opportunity to testify. I would be happy to address any questions that you might have.

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