

Birth Settings in America: Outcomes, Quality, Access, and Choice

POLICY BRIEF

Childbirth services play a critical role in the provision of American health care. But, while the U.S. spends more on childbirth than any other country in the world, it has worse outcomes than other high-resource nations, in terms of maternal and infant deaths, illness, and injury. These negative outcomes are more frequent for Black and Native American individuals and their newborns.

Birth Settings in America: Outcomes, Quality, Access, and Choice (2020), a report from the National Academies of Sciences, Engineering, and Medicine, examines one crucial component of U.S. maternity care: the settings in which childbirth occurs. The report identifies ways to improve childbirth services in hospital settings—where the vast majority of pregnant people¹ in the U.S. experience childbirth—and in birthing centers and for home births. Improving integration across birth settings and investing in the maternity care workforce can also make giving birth safer than it is today.

IMPROVING CARE ACROSS BIRTH SETTINGS

Home, birth center, and hospital birth settings each offer risks and benefits to pregnant individuals and newborns. While no setting is risk free, these risks may be modifiable within each setting and across settings.

Improving hospital settings. There are promising strategies for lowering rates of non-medically indicated interventions, such as the primary cesarean rate. Hospital participation in quality improvement initiatives, such as the Alliance on Innovation in Maternal Health or the National Network of Perinatal Quality Collaboratives, and adoption of national standards and guidelines have been shown to improve outcomes for pregnant people and newborns in hospital settings.

Tying payment to value can incentivize quality, create conditions for innovative systems and leaders to lead delivery system reform, improve care and outcomes, reduce costs, allocate resources to most effective services, and foster emulation and competition, among other improvements. While a number of high-value payment models exist, efforts are needed to pilot, evaluate, and refine these models more extensively and across state Medicaid agencies, Medicaid managed care organizations, and commercial payers.

Improving home and birth center settings. Evidence shows that a lack of integration and coordination and unreliable collaboration across birth settings and maternity care providers is associated with poor birth outcomes for pregnant people and infants in the U.S. Integrating home and birth center settings into a regulated maternity and newborn care system—providing shared care, continuous risk assessment, access to consultation, seamless transfer between birth settings, written birth plans, and well-qualified and trained maternity care providers—can improve maternal and infant outcomes.

Licensing statutes, generally written with great specificity, ensure that planned births in birth centers are limited, to the extent feasible, to healthy, low-risk pregnant individuals, and that midwives provide care that keeps their clients healthy and continually assess and identify problems early so they can be properly and rapidly addressed. Making mechanisms available for all freestanding birth centers to access licensure at the state level, along with requirements for obtaining and maintaining accreditation, could improve quality of care in these settings.

Improving Access to Care. The wide variation in regulation, certification, and licensing of maternity care professionals across the U.S. is an impediment to access to all birth settings. For example, access to midwifery care is limited in some settings because some types of midwives are not licensed in some states, but this varies across the country.

¹Intersex people and people of various gender identities, including transgender, non-binary, and cisgender individuals, give birth and receive maternity care. Thus, we use the terms “pregnant people” or “pregnant individuals” in place of “pregnant women.”

Access to choice in birth settings is also limited by a pregnant person’s ability to pay. Models for increasing access to birth settings for low-risk pregnant people that have been implemented at the state level include expanding Medicaid, Medicare, and commercial payer coverage to cover care provided at home and birth centers within their accreditation and licensure guidelines; cover care provided by certified nurse midwives, certified midwives, and certified professional midwives; and cover care provided by community-based doulas. Additional research, demonstration, and evaluation to determine the potential impact of these state-level models is needed to inform consideration of nationwide expansion, particularly with regard to effects on reduction of racial/ethnic disparities in access, quality, and outcomes of care.

Ensuring that levels of payment for maternity and newborn care across birth settings are adequate to support maternity care options across the nation is also critical to improving access. For improving outcomes, care coverage is needed before or early during pregnancy and through the first year post-partum.

Building and diversifying the maternity care workforce pipeline. To strengthen the diversity of the workforce, investments are needed to enable and support prospective maternity care providers from historically underrepresented groups to enroll in qualified education programs. Some strategies for achieving workforce diversity include:

- creating pipeline recruitment programs beginning in high school and establishing professional and career pathways through such ancillary roles as community health workers;
- casting a wider net for recruitment and reducing both barriers to application and biases in selection criteria;
- increasing opportunities for mentoring and peer support; and
- providing preferential selection for applicants with the potential to address unmet population needs.

The geographic maldistribution of the maternity care workforce is also a concern. To foster optimal geographic distribution of providers by region of the country and to avoid rural and urban maternity care deserts, strategies are needed to retain and reverse the losses of maternity care services in these areas, such as expansion of the National Health Service Corps for maternity care providers. Additionally, investments in research are needed to study and develop sustainable models for safe, effective, and adequately resourced maternity care in underserved rural and urban areas, including establishment of sustainably financed demonstration model birth centers and hospital services.

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For More Information . . . This Policy Brief was prepared by the Board on Children, Youth, and Families with funds from the Hauser Policy Impact Fund and was based on the Consensus Study Report, *Birth Settings in America: Outcomes, Quality, Access, and Choice* (2020). The study was sponsored by the National Institutes of Health. Any opinions, findings, conclusions, or recommendations expressed in this publication do not necessarily reflect the views of any organization or agency that provided support for the project. Copies of the Consensus Study Report are available from the National Academies Press, (800) 624-6242; <http://www.nationalacademies.org/birthsettings>.

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