



## Midwives: The Answer to the US Maternity Care Provider Shortage

### Shortages in the Maternity Care Workforce Deny Women and their Families Access to Highly-Qualified Providers

- In 2013, there were approximately 3.93 million US births, a number that is projected to be more than 4.4 million in 2050. The population of women over the age of 15 is expected to grow by 36 million in that same timeframe.<sup>i</sup>
- The character of the OB/GYN workforce has gone through a dramatic transformation in the last four decades. In 1975, only 15 percent of first year OB/GYN residents were women. In 2013, that figure was 82.6 percent.<sup>ii</sup>
- Female and male physicians balance their professional and personal lives differently. Women work fewer hours, work part time more frequently when given the option and cease obstetric practice several years earlier.<sup>iii</sup> This has significant ramifications for workforce capacity in the coming years. In 2000, 7% of OB/GYN residents were entering a subspecialty field. In 2012, that figure had grown to 19.5%.<sup>iv</sup> Of the four OB/GYN subspecialty fields, three do not involve attendance at births.
- In 2011, 40 percent of US counties had no certified nurse-midwife (CNM)/certified midwife (CM) or OB/GYN.<sup>v</sup>
- ACOG has projected a shortage of between 15,723 – 21,723 OB/GYNs by 2050.<sup>vi</sup>

### Midwives Play an Important Role in Filling the Maternity Care Provider Shortage.

- Most women are able to have normal, physiologic births and midwives are experts at low risk, normal births. In 2013, CNMs/CMs attended 8.2% of all US births. In the five states with the highest percentage of midwife attended births, the average was 24%.<sup>vii</sup> CNMs/CMs could independently attend a larger proportion of normal physiologic births, freeing OB/GYNs to use their specialized skills to assist women with significant complications.
- As midwives attend an increasing percentage of normal births, physicians will benefit economically as they migrate to those patients for whom physician skills are most needed, and for which the compensation is commensurately higher.<sup>viii</sup>
- Many countries make much more significant use of midwives. Typically, in the developed world, there are approximately 2.5 midwives per OB/GYN.<sup>ix</sup>
- Educating CNMs/CMs is cost effective: Educational programs typically require 2 years of post-baccalaureate graduate-level study and cost on average around \$54,000.<sup>x</sup>
- The most significant barrier to educating more midwives is the capacity of educational programs to secure sites for clinical precepting to take place. Sixty-two percent of midwives who precept students receive no remuneration from the educational program.<sup>xi</sup> An overwhelming percentage of physician residents have their specialty education funded through graduate medical education programs.<sup>xii</sup>

### Economic Forces that Inhibit the Growth of the Midwifery Workforce

- The Institute of Medicine reports that in 2012, public investment into the education of physicians amounted to \$15 billion, or approximately \$127,000 per resident.<sup>xiii</sup> The only comparable program that supports midwifery students is currently in a demonstration phase. The amount of money used to support precepting of midwifery students in that demonstration in 2014 is roughly equivalent to \$25 for each midwifery student in the US.
- Medicare pays teaching physicians for the services of medical interns/residents under their instruction.
- CNMs/CMs may work as clinical faculty in obstetric programs where they instruct medical interns and residents. They also precept midwifery students. When an intern, resident or midwifery student

performs a service as part of their clinical education under the supervision of a teaching CNM, the teaching CNM/CM has no mechanism for billing for those services unless the teacher entirely repeats the service previously done by the student. It is impossible to repeat many OB services (e.g., birth). These services frequently go unpaid. This strongly discourages inter-professional education programs and is a significant barrier to midwifery education.

- Ninety-five percent of the births that CNMs and CMs attend take place in a hospital setting. However, as explained above, these facilities experience powerful economic incentives to prioritize the education of medical residents over midwifery students.<sup>xiv</sup>

### **Public Investment in Midwifery Education Would Create a Great ROI.**

- Public investment into midwifery precepting would facilitate the education of more midwives, resulting in more women being cared for under the midwifery model of care—better health and greater patient satisfaction at a lower cost. Multiple studies have demonstrated that women attended by midwives experience lower rates of cesarean birth than women with the same underlying health characteristics and risks attended by physicians.<sup>xv</sup>
- ACNM estimates that savings to Medicaid programs from reduced cesarean births alone would, within three years, completely offset state investments to fully support precepting for midwifery students. Savings accruing to commercial payers in that same time period would be approximately triple that amount, resulting in lowered premiums and out of pocket costs for citizens of such states.
- Because of the far larger costs associated with physician education, a \$10 million investment into the education of OB/GYNs would result in approximately 25 additional OB/GYNs who would collectively be expected to attend approximately 3,050 births annually once in practice. That same money, used to support midwifery precepting, would result in approximately 417 midwives, who would be expected to attend approximately 29,190 births annually once in private practice.<sup>xvi</sup>

### **With Proper Investment, Midwives Are the Solution to the Maternity Care Provider Shortage.**

- Expand the Graduate Nurse Education demonstration so that its reach is nationwide. Under this program, federal monies are directed to hospitals, who then share them with schools of nursing specifically to support precepting of advance practice nursing students, including CNMs.
- Pass legislation to ensure that CNMs who instruct medical interns and residents or midwifery students can be paid for the services rendered under their supervision. Allow educational programs flexibility to use existing HRSA grants to support clinical education.
- Georgia has developed a tax incentive program under which individual providers who precept students in their clinics for a sufficient number of hours can receive a tax credit of up to \$10,000. This model might be adopted by other states or at the federal level.
- Revise requirements for medical student obstetric rotations and for OB/GYN residents to make sure that clinical training opportunities related to birth are reserved for those who plan on pursuing a course where their practice will involve regular attendance at birth, thus freeing up clinical education opportunities for student midwives.

For a fuller discussion of these issues, see the presentation developed by ACNM, available at:

<http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005794/MaternityCareWorkforce-11-18-15.pptx>

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- <sup>i</sup> CDC Vital Stats, Births - Available at: [http://www.cdc.gov/nchs/data\\_access/vitalstats/vitalstats\\_births.htm](http://www.cdc.gov/nchs/data_access/vitalstats/vitalstats_births.htm). See also: US Census Bureau Population Projections. Available at <https://www.census.gov/population/projections/data/national/2014/downloadablefiles.html>
- <sup>ii</sup> American Congress of Obstetricians and Gynecologists. (2011). The Obstetrician Gynecologist Workforce in the United States: Facts, Figures, and Implications, William F. Rayburn, MD.
- <sup>iii</sup> Ibid.
- <sup>iv</sup> Rayburn, W., Gant, N., Gilstrap, L., Elwell, E., & Williams, S. (2012). Pursuit of accredited subspecialties by graduating residents in obstetrics and gynecology, 2000-2012. *Obstetrics & Gynecology*, 120(3), 619-625.
- <sup>v</sup> Health Resources and Services Administration, Area Resource File. Analysis originally conducted on 3/1/2014 by Kate Crawford, Birth by the Numbers ([www.birthbythenumbers.org](http://www.birthbythenumbers.org))
- <sup>vi</sup> Rayburn, 2011.
- <sup>vii</sup> CDC Vital Stats, Births.
- <sup>viii</sup> Medical Group Management Association. (2014, March). NPP Utilization in the Future of US Healthcare, Available at: <https://www.mgma.com/Libraries/Assets/Practice%20Resources/NPPsFutureHealthcare-final.pdf>
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- <sup>xi</sup> Germano, E. (2014, March/April). Factors that Influence Midwives to Serve as Preceptors: An American College of Nurse-Midwives Survey. *Journal of Midwifery & Women's Health*, 59(2), 167-175.
- <sup>xii</sup> Institute of Medicine. (2014, July 29). Graduate Medical Education that Meets the Nation's Health Needs. Available at: <http://www.iom.edu/Reports/2014/Graduate-Medical-Education-That-Meets-the-Nations-Health-Needs.aspx>
- <sup>xiii</sup> Institute of Medicine, 2014.
- <sup>xiv</sup> CDC Vital Stats, Births.
- <sup>xv</sup> Chambliss, L. R., Daly, C., Medearis, A. L., Ames, M., Kayne, M., & Paul, R. (1992) The role of selection bias in comparing cesarean birth rates between physician and midwifery management. *Obstetrics and Gynecology*, 80(2):161-5.
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