The growing crisis of declining obstetric services in rural America

Benjamin Mateus
2 March 2023

President Joe Biden's ending of the public health emergency declaration related to the COVID-19 pandemic on May 11 will take a catastrophic toll on the already precarious state of rural hospitals and obstetric care.

Millions of Americans will abruptly lose their Medicaid health insurance, which means that many rural hospitals across the US that serve poorer, underserved populations will lose the federal assistance that has kept their doors open and theirs lights on, and helped pay their skeleton crews of health care workers.

At present, more than 600 rural hospitals, or about one-third, are at risk of closure due to receiving less reimbursement than the cost of delivering their life-saving services. Over 200 such facilities are poised to close in the next two to three years. Administrators, trying to keep their systems afloat, are curtailing or discontinuing unprofitable services like maternity care, endangering the reproductive health of these communities, such as in the Southeast, rural Ohio and Appalachia, where chronic poverty is systemic.

In all, 36 percent of US counties, mostly rural, are considered maternity care deserts, defined as a county without a hospital or birth center that offers obstetric care and has no obstetric providers. More than 7 million women live in areas where there is limited or no access to such obstetric services.

A survey of hospital administrators before the COVID-19 pandemic found that 20 percent had indicated their system would not be providing labor and delivery services in the next five years. The onset of the pandemic accelerated the shutdown of obstetric services.

In particular, lack of access to prenatal care and follow-up care with their doctors or midwives after the end of their pregnancies has serious health consequences for women and their infants. Chronic health issues like high blood pressure can go unrecognized, leading to severe complications such as preterm delivery, preeclampsia and even massive life-threatening hemorrhage.

Not surprisingly, a 2018 investigative study on the loss of hospital-based obstetric services and birth outcomes in rural counties published in JAMA found higher rates of out-of-hospital and preterm births, as well as low utilization of prenatal care.

Expectant mothers in rural areas typically drive close to 25 miles to see their doctor for a prenatal visit. With the closure of obstetric services, that distance will usually double to 60 miles on average. Studies have shown that the longer the distance to prenatal care, the higher the chance of developing high blood pressure, which remains one of the leading causes of maternal mortality.

This leads in turn to complications for infants, who will most likely need to stay longer in the hospital after delivery under a higher level of care, such as in a neonatal ICU. This also means that the medical costs of pregnancies can skyrocket. The average cost of preterm and low-birthweight care and deliveries is above $76,000, but can exceed $110,000. According to the Kaiser Family Foundation, in 2023 the average cost of pregnancy, delivery and postpartum care in the US is $18,865.

Driving the abandonment of obstetric services are low Medicaid reimbursement rates, an epidemic of staffing shortages, as well as the declining birth rates experienced in these areas. According to Becker's Hospital Review, at least 89 obstetric units were shuttered in rural hospitals across the country between 2015 and 2019. Since 2020, the number of US counties that are categorized as maternity care deserts has increased by 2 percent.

The American Hospital Association noted that in 2020 only half of rural community hospitals were offering maternity care. Yet one in 10 babies are born in rural community hospitals, which has significantly contributed to the disproportionate rates of maternal mortality in rural America compared to the rest of the country.

Dr. Anne Rossier Markus, PhD, chair of the Department of Health Policy and Management at the Milken Institute School of Public Health at the George Washington University, explained that she had reservations about the term "maternity care deserts." As a visual representation of the issue, "it implies that there's nothing there, which isn't

true. The community is living there. There's history, there are relationships, there are practices there."

The rural and urban divide was recently placed into context by a National Center for Health Statistics study published in May 2022 by Lauren M Rossen et al., which found that in 2017 rural women had a maternal mortality ratio (MMR) 45 to 65 percent higher than other women. (Rural MMR 34.4 per 100,000 live births versus medium/small urban MMR 23.7 per 100,000 live births and urban MMR 20.9 per 100,000 live births.) While rates of MMR were relatively stable from 1999 to 2017 in urban regions, they have increased by 60 percent in rural areas during this period, according to the authors.

As an aside, while it had appeared that maternal mortality rates in the US had been climbing over the last two decades, the implementation of a pregnancy checkbox on death certificates after 2003—but adopted by states in a staggered fashion—made it seem that trends in MMR were rising when in fact these rates were already much higher than previously thought.

The authors summarized in their conclusions, "Currently, we are unable to determine how much of the increase in rural MMRs during 1999-2017 was due to true increases in maternal mortality, increased identification of maternal deaths (i.e., under-ascertainment after the checkbox), or false positive deaths (i.e., over-ascertainment before the checkbox). True increases in maternal mortality in rural areas are plausible given recent trends in rural mortality overall, and documented barriers to maternal and obstetric care in rural areas, which could contribute to inadequate obstetric care for rural women."

They also stated that it was possible that many of these deaths were misclassified. They called for initiatives to improve the National Vital Statistics System.

With respect to the Rossen et al. report, a 2021 US Government Accountability Office (GAO) report noted that "many rural counties lack hospital obstetric services, meaning those hospitals or emergency rooms lack trained staff or the necessary equipment to manage prenatal care. This occurs in part due to difficulties recruiting and retaining maternal health providers in rural areas. … When hospitals and obstetric units close, rural and underserved areas lose the infrastructure that supports providers, like obstetrician-gynecologists, specialists, and licensed midwives." Pregnant women living in rural areas face delays in necessary care due to the long distances they need to travel and the associated prohibitive costs.

Not frequently mentioned is the fact that maternal deaths rose by 25 percent during 2020 and 2021 due to COVID-related deaths. The state of pregnancy compounds the risks associated with SARS-CoV-2 infection. While maternal deaths not related to COVID-19 remained on par with pre-pandemic years—754 in 2019, 759 in 2020, 777 in 2021—there were 102 COVID deaths among pregnant women in 2020 and 401 in 2021. In 2021, COVID caused 34 percent of all maternal deaths.

Also significantly aggravating maternal mortality in rural US regions was the overturning of *Roe v. Wade* in June 2022. States like Kentucky, Indiana, Kansas and Nebraska, which have some of the strictest abortion laws, also have some of the worst maternal and child health outcomes and the lowest investment in at-risk populations, according to National Public Radio (NPR).

Dr. Anne Banfield, an OB-GYN with experience working in rural West Virginia, told NPR, "The post-Roe situation, and the issues we have with maternal mortality, and the issues that we have with access to care in rural areas in the United States … are all coming together in a way that is going to make our battle against maternal mortality 1,000 times worse."

The United States, which spends more on health care than other high-income countries, both on a per capita basis and as a share of GDP, has one of the highest maternal mortality rates among these nations. This is attributable to high rates of cesarean section, inadequate prenatal care and social factors of poverty that drive obesity, diabetes, heart disease and other chronic illnesses that are increasingly affecting younger populations.

The US maternal mortality rate is currently three times higher than in other high-income countries. These atrocious rates reflect in large part reliance on a profit-driven system of health care delivery that disenfranchises the well-being of the US population on the basis of simple economics.

The maternal mortality rate functions as a sentinel indicator of the state of public health in any country. Given the advances that have been made in the last century in obstetric and neonatal care, persistently high maternal mortality rates reflect systemic socioeconomic inequalities that restrict working class access to such quality health services. Public health is a fundamental universal right that the working class must fight to assert through the eradication of capitalism, the real disease afflicting humanity.