ties facing mergers of religious and secular institutions; and

4. Recommend that state and local agencies in regulating health care facilities exercise their authority to secure the availability of comprehensive reproductive health services and end-of-life choices.
5. Urge that health care facilities receiving public funding assure the availability of comprehensive reproductive health services and end-of-life choices.
6. Develop a set of principles to guide community action when religious and secular hospitals or health systems propose to merge, including:
   –advance notice to the affected community;
   –opportunity for public comment;
   –assurance that services lost through the merger will be available elsewhere in the community; and
   –protection of the right of physicians and hospital staff to discuss reproductive health services and end-of-life choices no longer provided in the hospital and to assist patients in obtaining those services elsewhere.

While voluntary, negotiated creative solutions are desired, for those instances in when no such approach is achieved, federal and state legislation is needed to ensure communities are not left without access to vital reproductive health services and end-of-life choices.

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20004: Supporting Access to Midwifery Services in the United States (Position Paper)

I. Goal

The American Public Health Association (APHA) takes a position in support of the expansion of midwifery as a key strategy to improving access to care for childbearing families for the purpose of increasing their health care options and thereby to the subsequent improvement of birth outcomes.

II. Statement of the Problem

The United States spends more per capita on health care than any other country, and yet substantial gaps in maternal and child health care access remain.[1,2] Although a large majority of the nearly 4 million children born annually in the U.S. result from an uncomplicated vaginal delivery, childbirth is increasingly viewed as a medical event, with over 90% of all births attended by a physician trained to focus on the pathologic potential of pregnancy and birth. Childbirth is one of most common reasons to seek health care and

the single most common cause for hospitalization. Even with advances in prenatal care technology, low birth weight and preterm birth rates fall short of the Healthy People 2010 goals.[3] The APHA has publicly supported the use of innovative strategies to improve birth outcomes and decrease maternal and newborn morbidity and mortality.[4-13] These documents do not, however, address access to midwifery services.

In summary, the World Health Organization (WHO) defines a midwife as a competent care giver in midwifery graduated from an education program recognized by the government that licenses the midwife to practice. As the standard of care for uncomplicated pregnancies throughout much of the world,[14] midwives are the main providers of care in 75% of all European births.[15] Conversely, in the U.S. midwives participate in fewer than 10% of all births.[16] In terms of quality, satisfaction, and costs, the midwifery model for pregnancy and maternity care has been found to be beneficial to women and families, resulting in good outcomes and cost savings.[17] A collaborative approach between midwife and physician utilizes the expertise of both professions, which is key to ensuring optimal outcomes for women and infants. With its focus on pregnancy as a normal life event and health promotion for women of all ages, the midwifery model of care is an appropriate alternative or complement to the medical approach to childbirth.[18]

In exploring the use of interrelated health providers within managed care and other staffing configurations, the Health Services Resource Administration (HRSA), Bureau of Health Professions' project, Use and Impact of Alternative or Complementary Providers, is developing methods designed to forecast the need for alternative and/or complementary providers and document their impact on physician supply and demand.[19] For example, the project examines the integrated use of obstetrician/gynecologists with certified nurse-midwives, anesthesiologists with nurse-anesthetists, and the use of non-traditional providers in managed care. Through the project, the National Center for Health Workforce Information & Analysis will develop recommendations for health professions' training that will reflect current and projected "real world" use of alternative and complementary providers to increase access to health care.[20]

III. The Status of Midwifery in the United States

Women comprise 52% of our nation's population and 46% of the workforce. In general, women live longer than men, suffer more from chronic illnesses, are more frequent users of health services, and account for nearly two of every three health care dollars spent. Additionally, women make three out of four of all household health care decisions.[19] It is well documented that midwives contribute substantially to the health care services of diverse populations of women and their babies. In particular, studies have demonstrated that 7 of 10 visits to certified nurse-midwives (CNMs) were by women vulnerable to poor outcomes.[21] CNMs attended 7% of the approximately 4 million births in 1997 and "other" midwives attended 0.4%.[22] However, during 1995 and 1996 respectively, in the U.S. only 6.7% of CNMs and 6% of homebirth midwives in the U.S. were non-white, indicating that the racial and ethnic diversity of midwives does not reflect that of the nation's population.[23] Nationally, the midwifery profession has demonstrated an increased commitment for diversity within its ranks, especially given midwives' historic commitment to the care of vulnerable women, children, and families.[24,25]

Midwives in the United States with national certification generally fall into three categories: certified nurse-midwives (CNMs), who number over 7,000[3] and who meet the educational criteria of the American College of Nurse Midwives (ACNM), and are certified by the American College of Nurse-Midwives Certification Council (ACC); certified midwives (CMs), who number fewer than 20,[2] a relatively new category of 'direct-entry' midwives who are non-nurses educated within ACNM accredited educational programs and certified by the ACC; and certified professional midwives (CPMs), another category of direct-entry midwife who number approximately 1,000 and are certified by the North American Registry of Midwives (NARM).[26] (Note: direct-entry midwifery, which included CPMs and CMs, is a term used to refer to midwives whose education did not require a nursing background). It should be noted that there is small number of other midwives who have not attained these credentials. Most though not all recognized midwifery educational pathways are accredited by agencies recognized by the U.S. Department of Education, which assures the quality and content of midwifery education programs.

CNMs are educated in the fields of nursing and midwifery. CMs are educated in midwifery alongside CNMs, and thus have comparable competencies and skills although they are not nurses. This training differs from the professional preparation of CPMs certified by NARM focuses on competent entry-level midwives who will practice in predominantly out-of-hospital settings.[23] CNMs, CMs, and CPMs must pass a national certification examination to use their respective titles. These categories of midwives are not interchangeable, and important differences exist in education and certification mechanisms, scope of practice authority, and practice settings.[2,27,28]

State laws and national certification regulate the practice of midwifery and legislation differs from state to state relative to credentialing and scope of practice. Nurse-midwifery practice has been legal in all states for over 20 years.[23] As of January 2000, 17 states regulated non-nurse midwifery practice and in 14 states, non-nurse midwifery is legal but unregulated. In nine states non-nurse midwifery practice is legally prohibited and in six states the practice is effectively prohibited, as there is no legal way to gain legal authority to practice. Regulatory provisions are unclear in five states. Of those states regulating non-nurse midwifery practice, 14 states have widely varying regulatory mechanisms regarding the scope, qualifications, and requirements for supervision, consultation, and referral.[2,26] Whichever professional entry is chosen, the common connection for all midwives is their philosophical adherence to the midwifery model of care.[23]

With the exception of birth registration which captures only a portion of midwifery practice and excludes ambulatory care entirely,[29] there is no current national or state process for collecting data on services provided by midwives.[23] Thus, documentation of the practice of midwifery in the U.S. is incomplete and varies widely between CNMs and direct-entry midwives. Since 1928, more than 20 peer-reviewed journals have reported outcome studies of care by CNM's.[30] To date, nine peer-reviewed studies have been published addressing outcomes of care by direct-entry midwives. These studies have primarily reported homebirth outcomes with homebirth being the predominant site of birth for direct-entry midwives.[30] While a number of publications and reports exist about process and outcomes for all categories of midwives, this literature is difficult to compare to studies about other women's health providers (especially direct-entry midwives). This is due in part to the lack of inclusion of midwives in systematic national data collection.[23,25,30]

In 1998 the University of California at San Francisco Center for Health Professions charged a National Taskforce on Midwifery with examining the current status of midwifery in the United States. Participants of the Taskforce, who represented all levels of entry into the midwifery profession in terms of education, training, and practice, generated a comprehensive report which is the most current description of midwifery in the United States. As charged, the Taskforce also made specific recommendations for practice, regulation, credentialing, education, research, and policy.[23,25] The Taskforce on Midwifery report, endorsed by the PEW Health Professions Commission, presents a multifaceted approach to improving access to health care for women, children, and their families as well as increasing the diversity of the health care work force. These recommendations provide for a grounded approach to examining the field of midwifery and increasing an accountable provider pool with quality, high standards and sensitivity to the cultural needs of the clientele (Appendix).

IV. Actions Desired and Methods

The APHA should:

1. Communicate in writing with the major professional organizations whose members provide health care to women encouraging them to recognize nationally certified midwives as independent and collaborative practitioners

2. Recommend through correspondence to and meetings with members of the health care systems that enrollees be assured access to midwives and the midwifery model of care.

3. Urge all state legislatures to legalize the practice of midwifery and promulgate regulations, including specification of minimal educational standards and assurance to access to appropriate liability insurance in order to assure the safety of the public's health as it relates to midwifery practice.

4. Recommend that states consider in their regulations regarding midwives that the basis for entry-to-practice standards should include: suc-

cessful completion of a recognized midwifery education process, and successful completion of the appropriate national midwifery certifying examination.

5. Recommend that federal and state agencies broaden systematic data collection in birth certificates, death certificates, out patient data sets, the National Ambulatory Medical Care Survey, and other data collection activities that include visits or contacts made by midwives for the care of women or newborns, to include midwifery and midwives.

6. Recommend that the Bureau of Health Professions strengthen federal grants and traineeships to minority midwifery students.

7. Encourage entities including the Institute of Medicine, National Institutes of Health, Centers for Disease Control and Prevention, and the Health Resources and Services Administration to develop a research agenda addressing midwifery practice, outcomes and cost-effectiveness.

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Appendix: Recommendations for "The Future of Midwifery"

Practice

Midwives should be recognized as independent and collaborative practitioners with the rights and responsibilities regarding scope of practice authority and accountability that all independent professionals share.

Every health care system should integrate midwifery services into the continuum of care for women by contracting with or employing midwives and informing women of their options.

When integrating midwifery services, health care organizations should use productivity standards based on the midwifery model of care and measure the overall financial benefits of such care.

Midwives and physicians should ensure that their systems of consultation, collaboration and referral provide integrated and uninterrupted care to women. This requires active engagement and participation by members of both professions.

Regulation and Credentialing

State legislatures should enact laws that base entry-to-practice standards on successful completion of accredited education programs, or the equivalent, and national certification; do not require midwives to be directed or supervised by other health care practitioners; and allow midwives to own or co-own health care practices.

Hospitals, health systems, and public programs, including Medicare and Medicaid, should ensure that enrollees have access to midwives and the midwifery model of care by eliminating barriers to access and inequitable reimbursement rates that discriminate against midwives.

Health care systems should develop hospital privileging and credentialing mechanisms for midwives that are consistent with the profession's standards, recognize midwifery as distinct from other professions, and recognize established processes that permit midwives to build upon their entry-level competencies within their statutory scope of practice.

Education

Education programs should provide opportunities for inter-professional education and training experiences and allow for multiple points at which midwifery education can be entered. This requires proactive intra- and interprofessional collaboration between colleges, universities and education programs to develop affiliations and complementary curriculum pathways.

Midwifery education programs should include training in practice management and the impact of health care policy on midwifery practice, with special attention to managed care.

The profession should recognize and acknowledge the benefits of teaching the midwifery model of care in a variety of education programs and affirm the value of competency-based education in all midwifery programs.

The midwifery profession should identify, develop and implement mechanisms to recruit student populations that more closely reflect the US population and include cultural competence concepts in basic and continuing education programs.

Research

Midwifery research should be strengthened and funded in the following areas:

- Demand for maternity care, demand for midwifery care, and numbers and distribution of midwives;
- Analyses of how midwives complement and broaden the woman's choice of provider, setting, and model of care;
- Cost benefit, cost-effectiveness, and cost-utility analyses, including the relationship between knowledge of economic/cost analyses and provider practices;
- Midwifery practice and benchmarking data (among midwives) with a goal of developing appropriate productivity standards;
- Descriptions and outcome analyses of midwifery methods and processes;
- Analysis of midwifery practice outcomes, from pre-conception through infancy, using an evidence-based perspective;
- Normal pregnancy, normal labor and birth, healthy parent-infant relationships, and breastfeeding; and
- Satisfaction with maternity and midwifery care.

Federal and state agencies should broaden systematic data collection, which has traditionally focused on medicine and physicians, to include midwifery and midwives.

Policy

A research and policy body, such as the Institute of Medicine, should be requested to study and offer guidance on significant aspects of the midwifery profession including:

- Workforce supply and demand;
- Coordination of regulation by the states;
- Funding of research, education and training; and
- Coordination among the federal agencies whose policies affect affect the practice of midwifery.

Source: Dower CM, Miller JE, O'Neil EH and the Taskforce on Midwifery. Charting A Course for the 21st Century: The Future of Midwifery. San Francisco, CA: Pew Health Professions Commission and the UCSF Center for the Health Professions; April 1999.

20005: Effective Interventions for Reducing Racial and Ethnic Disparities in Health

The American Public Health Association,

Knowing that many ethnic* minorities in the United States suffer substantially and disproportionately from adverse health conditions and inadequate access to quality health care services as described in detail in "Healthy People 2010";[1] and

Recognizing that over the years in the United States there have been efforts in the United States to reduce ethnic disparities in health through national health policy (e.g., "Healthy People 2000");[2] and

Understanding that some of these efforts to reduce ethnic disparities in health outcome may have also successfully improved the nation's health during the 20th century as evidenced by overall reductions in deaths from coronary heart disease and stroke, an increase in the number of healthy mothers and babies (e.g., in 1997 an all-time low infant mortality rate of 7.2 deaths per 1,000 live births), and elimination or near elimination of a number of vaccine-preventable diseases of childhood (e.g., in 1996, 90% of young children were vaccinated with most critical vaccines);[1,3-6] and

Further understanding that the 20th century has also given rise to other great public health achievements, including improved motor-vehicle safety, safer workplaces, control of infectious diseases, safer and healthier foods, fluoridation of drinking water, and recognition of tobacco use as a health hazard;[3,7-13] and

Realizing that these 20th century achievements resulted from efforts to reach all Americans through a variety of policies that focused on legislation, regulation, research, and education; a voluntary change in personal lifestyles; and population-wide policies and programs that also targeted high-risk groups, including racial/ethnic minority populations;[3-13] and

Recognizing that the public health community needs to understand and replicate interventions that have already demonstrated success in reducing or eliminating ethnic disparities in health; and

Further recognizing that lessons learned from 20th century achievements, particularly childhood immunizations, suggest that the following eight activities, especially if taken together as a strategy, would be effective in eliminating certain disparities in health: setting a national priority, adopting not only long-term goals but interim goals (e.g., annual or biennial), providing of sufficient funding for effective programs that is tied to accountability, regularly monitoring and evaluating progress toward goals at all levels of government and the community, providing financial incentives for achievement of goals, engaging the community by forming community partnership and encouraging participation, expanding access to quality health care services, and optimizing health care services through performance monitoring, evaluation, and feedback;[1,3-22] and

Understanding that, while the overall health of Americans improved during the 20th century, persistent and often increasing disparities in the burden of illness and death have been experienced by ethnic minorities, particularly by African Americans (e.g., hypertension, infant mortality, adult immunizations;)[1] and

Recognizing that the persistent problem of ethnic disparities in health led to President Clinton's announcement in 1998 of a goal to eliminate health disparities in six areas as part of his Initiative on Race and that elimination of disparities in health has become a national health goal for the 21st century (Healthy People 2010) and a priority issue for the American Public Health Association;[1,23] and

Realizing that the previously mentioned eight activities, taken together as a strategy, have demonstrated success in addressing some ethnic disparities and can be applied to the six areas that President Clinton has targeted for elimination of disparities (infant mortality, cancer screening and management, diabetes, cardiovascular disease, HIV infection and AIDS, and immunization), and all other national health objectives of 2010 in which ethnic minorities have a 25% or more difference in outcome;[1] and

Recognizing that the sum of four hundred million dollars was initially appropriated to the initiative for prevention, outreach, and education in the six priority areas; and

Further recognizing that the action plan of the Department of Health and Human Services (DHHS) includes providing leadership in research, expanding and improving programs to purchase or deliver quality health care services, reducing poverty and providing children with healthy environments, and expanding prevention efforts;[24] and

Realizing that a first step of the action plan of the DHHS is to review existing programs to identify and implement strategies that work, our support in promoting effective interventions is timely; therefore, APHA

1. Reaffirms the recent joint announcement of APHA and DHHS as partners in a national campaign to eliminate racial and ethnic health disparities;
2. Supports the action plan of the DHHS for eliminating ethnic disparities in health, particularly activities to identify existing interventions/programs effective in eliminating health disparities and the community-based demonstration projects that are identifying new strategies by expanding our knowledge of intervenable risk factors for eliminating disparities (i.e., REACH 2010 projects);
3. Urges the DHHS and Congress to ensure that the current plan for targeting specific priority areas for elimination be continued, particularly in future administrations, and to expand funding to fully implement effective interventions for first eliminating disparities in the six priority areas, and then to the focus areas specified in Healthy People 2010 in which ethnic minorities experience a 25% or more difference in health outcome;