Disparities in Home Birth: The Status of Home Birth in the US

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Abstract

This paper highlights the state of home birth disparities in the United States. It seeks to explore the reasons that home birth is not as main stream as evidence suggests that it could be among women who have low-risk pregnancies. The paper focuses on 5 key issues in home birth, each with a resounding need for change. Considering the culture of birth in the US, socioeconomic disparities among home birthers, insurance coverage gaps, issues with public policy and current legal struggles within the US maternity system as a starting point for change, this paper outlines several recommendations to alleviate the disparities that are currently impeding the progress towards safer home birth in the US. Inherent in the US maternity system, as it exists today, there is a fuming war between physicians and midwives; hospitals and home birthers, and all sides are dead set in their convictions for their way of birthing. This paper aims to bring forth yet another reason to find common ground when it comes to birth; the people for whom this debate is having the greatest impact, pregnant women and their babies.

Keywords: Home Birth, Midwives, Maternal Health, Culture, SES, Insurance, Law & Policy, United States

Introduction

Since the beginning of mammalian colonization of the earth, human women have given birth at their most frequent place of rest: their home. With the modernization of medicine at the end of the 19th century, childbirth inevitably followed the migration of healthcare out of the home and into the hospital. This movement was advantageous at first; many babies who otherwise would have had a mortal birth outcome were able to receive the medical intervention they needed. However, this movement has led to the almost complete abandonment of the practice of giving birth at home. As a result, childbirth in the United States has been unnecessarily medicalized, private and public policies are often unfavorable to home birth, and women who do seek out a home birth option are often self-selected to be older and more educated, as well as have many other advantages that are unrepresentative of the general population. In this composition, we will seek to establish that the medicalization of childbirth has led to serious consequences such as unnecessary interventions and a perception that childbirth is a dangerous sickness. We will explore the policies of both private and public institutions that sanction practitioners for attending home births, such as denial of admitting privileges to the extreme of criminal prosecutions in some states. Finally, we will look at the demographics of women who choose home birth, specifically the disproportionately low number of minority women of lower socioeconomic status choosing this method of childbirth when it would be beneficial and is actually covered by public health insurance programs.

Literature Review

US Birth Culture & Home Birth:

At the turn of the 20th century, 95% of childbirths occurred primarily at home, and by 1955, this number was down to fewer than 1% of all births in the US (Shepherd, 2011). In this 50-year period, several very significant things happened. First, was the slander and criminalization of midwives, the primary attendants of home birth (Wagner, 2009). Second, the propagation of the belief that the

only “safe place to give birth” was in a hospital (ACOG Committee on OB Practice, 2011). Lastly, the introduction of interventions such as forceps, fetal monitors, vacuum extractors, epidurals and pitocin which helped shape the idea of childbirth as an illness that needs to be treated in a controlled hospital environment as opposed to a natural process (Gibson, 2011).

Since the 1970’s, the desire to give birth naturally, and without intervention, has been gaining popularity in American culture. Yet in the hospital, where almost 98% of US women give birth, the use of protocols that are antithetical to the normal physiological birth process continues (Wagner, 2009). In the hospital, a woman’s body is seen as a “defective machine,” and there is a universal premise that if a laboring woman is monitored with better “diagnostic machines” then birth will be safer (Davis-Floyd, et al., 1996). Doctors, Midwives and Nurses in hospital settings spend the majority of their time interpreting the line graphs that are continuously running from fetal monitors despite countless studies which have proven that continuous fetal monitoring does not result in improved birth outcomes. Providers also routinely employ practices and procedures which the Coalition for Improving Maternity Services (CIMS) has outlined as unsupported by scientific evidence (CIMS, 1996). By routinely inserting IV’s for all labor & delivery admissions, asking women to lie on their backs when they are pushing out their babies (Davis-Floyd, 1990 & 1994) and not allowing women the choice to labor and birth submerged in water (Cluett, et al. 2004), hospitals and the providers that work in hospitals undermine normal physiological birth. Most women are aggressively monitored, screened and tested throughout pregnancy and childbirth and give birth to their babies hooked up to no less than 7 medical devices (Block, 2008). All of these practices are a part of the routines of many labor & deliver units in the US, which CIMS has shown are out-dated and are due to routinized care rather than mother-centered evidence-based care (Angood, et al., 2010).

In a healthy population, normal labor that respects the physiological process of birth without interventions is a single contiguous biological process that is not dominated by an air of anxiety (Gibson

2011). Are pregnant women submitting themselves to a presumably oppressive and dehumanizing obstetric care system (Tanassi, 2004)? With a full range of choices available to women, it appears as though there is a gap between the authoritative knowledge of the provider and the intuition of the pregnant mother that is detrimental to providing quality care to laboring women. In fact, many women in the US acquiesce to their providers requests to use biomedical interventions to facilitate successful delivery of their babies (Browner, 1996) and hence the obstetrical rituals of power and self-interest that pose a major barrier to quality childbirth care continue with no end to these practices on the horizon (Reiger, 2011). And hence, women are turning to home birth.

There are many driving factors for the women and families who are choosing home birth outside of the hospital, and a desire to give birth without medical interventions or pain medications is right at the top of that list (Mayo Clinic Staff, 2011). Since Obstetricians attend 90% of all births in the US, compared to 75% midwifery attendance in all other industrialized countries (Wagner, 2009), it's not coincidental that women have to look outside of the hospital to find midwives to attend their births. The American College of Nurse Midwives (ACNM Board of Directors, 2005) and the American Public Health Association (APHA, 2001) have policy statements supporting the practice of planned out-of-hospital birth in select populations of women. One study in 2005 even showed that planned home birth had similar intrapartum and neonatal mortality rates as low-risk hospital birth (Johnson, 2005). Yet still the social stigma associated with home birthers can be seen as the reason for the disparity within the community (Gibson, 2011).

Home Birth SES Disparities:

Prior to 1976, African American women and White women experienced childbirth in vastly different ways due to segregation in the south creating separate labor & delivery wards for pregnant women; African American women giving birth had better outcomes than White women because they were supported through physiological childbirth (Gibson, 2011). However, by 1976 hospitals began

using the medical model of care on all labor & delivery patients regardless of race, and ever since then the maternal mortality rate has been going up, especially in women of color (Amnesty, 2010). Socioeconomic status (SES) has had a direct impact on women of color and low-income women. SES originally impacted access to hospital birth, because women of color and low-income women couldn't afford to pay for it (Pérez, 2011), but today the opposite is true.

Hospital birth is wide spread among women of lower SES, due to changes in Medicaid covered services, while home birth access is virtually unavailable in most cases due to financial constraints and little to no insurance coverage for home birth. As it turns out, 1 in 98 White women are giving birth at home; compared to 1 in 357 black women and 1 in 500 Hispanic women (Shepherd, 2011). Those women who do chose home birth are typically older at the time of pregnancy, have the means to pay out-of-pocket for their midwives and tend to have attained higher levels education (Pérez, 2009).

Insurance Coverage for Home Birth:

Home birth services generally are not covered by insurance, except where required by law. In the states where services are covered, practitioners and patients alike often find themselves fighting with adjusters who try every excuse possible to avoid following through with their financial obligations (Piard et al., 2011). In states where coverage is not legislated, families who opt for a home birth are required to cover the midwives' fee entirely on their own. According to the website *What It Costs*, the average fee for a home birth with a midwife is $4,400. Here in northern California, the average is $4,200 (Barcelo, 2011). Obviously, the lack of will of our current insurance system to pay for home birth plays a big part in the SES of women self-selecting into home birth.

Lack of insurance coverage both drives women towards home birth and bars them from it. According to the editorial Parturition: Places and Priorities, in 1984, about 25% of all home births in the United States occurred in Texas, "with state sources reporting these as mainly births to Mexican nationals or immigrants attended by lay midwives" (Pearse, 1987). Some states require that women

have a signed proof from a doctor that they are pregnant before the woman is eligible to have her prenatal services covered through their state Medicaid program (Amnesty, 2010). Both of these situations can result in a woman giving birth at home, most likely with an unskilled or poorly skilled attendant. In states that provide presumptive eligibility Medicaid to women suspected of being pregnant, a woman who desires a home birth often cannot find a home birth provider that Medicaid will reimburse.

Another factor affecting women's access to home birth is the policy of most insurers. Those who cover childbirth, typically only reimburse certain healthcare professionals for childbirth services; those covered are usually either a physician, or a Certified Nurse Midwife (CNM). Since most of these professionals work primarily in hospitals, women are once again financially pushed towards a hospital delivery.

Most home births are attended by midwives who have one of the other three midwifery designations as a Certified Professional Midwife (CPM), a Lay Midwife (LM), or a Certified Midwife (CM). Unfortunately, neither Medicaid nor private insurance will pay for the services of any other midwife except those designated as a CNM (Pérez, 2011), those who have additional training as nurses on top of their midwifery training.

Policy Issues in Home Birth:

It is no secret to anyone who has worked in healthcare that the "birth center", or labor & delivery unit, of a hospital is one of their largest income generators. According to the documentary, "Pregnant in America", about 66% of hospital revenues come from childbirth services, making the hospital birth the largest moneymaker for hospital corporations (Buonagurio, 2008).

One tactic that hospitals use to limit the practice of home birth is by threatening to revoke the admitting privileges of childbirth practitioners who attend home births (Annas, 1988). Such practices are still endemic in our current hospital system. Interviews with practitioners who are associated with Alta

Bates Regional Medical Center report being required to sign an agreement not to attend home births, lest they lose their admitting privileges. According to George Annas, lawyer and public health expert, such agreements have dubious legal grounding:

> "It has nothing directly to do with in-hospital care and therefore can make no pretext about being for the safety of hospital patients. As to non-hospital patients, the hospital has no legitimate concern with their free exercise of the legal option of home birth. The only interest it seems to have is economic; and if the attempt is to join in a conspiracy to restrain trade in home births, the activity might also be challenged under anti-trust laws. Finally, the promulgating authority seems ambiguous... and summary revocation of privileges is inconsistent with the doctrine that staff qualifications must not only be 'reasonably related to the operation of the hospital,' but also 'fairly administered'."

In the event that a transfer to a hospital is needed for a planned home birth, the attitudes of the hospital staff can vary depending on hospital policies, the staff's experience with home birth transfers, and the culture of the hospital work environment. According to a feed on the website www.allnurses.com, nurses themselves even find great variation. One feed participant, using the screen name 'motherwise', describes her various experiences as a practitioner in the maternity care system. Now a labor and delivery nurse, she was once a licensed midwife in Washington State and had experiences that represented both spectra of handling by hospital staff, including one where the attitudes of the emergency room staff obstructed appropriate care for a patient:

> "She [the mother] started to push at which time I made a comment to the doctor that she was going to deliver quickly. She [the doctor] gave me a dirty look and turned away. At just that time the woman pushed and baby fell into the garbage...The staff spoke poorly of me and my abilities even though I had made a quick decision to

transport and they had dropped the baby" (Motherwise, 2007).

Of course it is hard to ignore the institutional bias for medicalized childbirth. In the documentary, *Pregnant in America*, the documentarian, Steve Buonagurio, conducts a parking lot interview with a young anesthesiologist outside the hospital to discuss the use of painkillers and epidurals during childbirth. When Steve mentions that he and his wife were not only planning a natural childbirth, but a home birth, the negative, visceral reaction from the anesthesiologist was almost palatable. "Home birth is dangerous." says the anesthesiologist. When asked why, the doctor responds with the typical claim that birth is unpredictable, and can go badly very quickly. He does not mention that most complications start hours before they become critical, and a well-trained home birth midwife will catch the problem and take steps to remedy it or transfer to a hospital (Wickham, 1999).

Home Birth's Legal Struggles:

According to the Midwives Alliance of North American (MANA), CNM's are the only midwives that are allowed to attend home births in every state in the union. CPM's, CM's, and LM's are criminalized in ten states, and unregulated in fifteen states (MANA, 2011). Since most CNM's work in hospitals, it can be difficult to find a home birth provider in states where lay midwives are criminalized. This criminalization of home birth midwives has driven many parents and practitioners underground in their attempt to avoid a hospital birth. This underground status of home birth in these states only serves to make the practice dangerous in such states as it discourages practitioners from calling for help if a complication arises that needs medical intervention.

Although the American Medical Association (AMA) and American College of Obstetrics and Gynecology (ACOG) both formally discourage home birth, not all physicians subscribe to such thinking, and there even those who would readily back up midwives performing home births, or even perform home births themselves if the barriers weren't so great. "Unfortunately, many midwives who perform home births are not able to procure the required supervisory physician. This is because insurance

companies are hesitant to provide coverage to doctors who agree to back-up or supervise midwives for home births" (Harmon, 2001).

Since it is such a challenge for midwives to find a physician who is willing to sign on as a backup, midwife organizations in states that have this requirement have been fighting to change state law. In 2000, midwife organizations successfully lobbied the California legislature to sign SB-1479, an Amendment to the Licensed Midwifery Practice Act of 1993. This bill removed the previous physician-supervisor requirement for midwives in California, allowing them to be care providers in their own right (Harmon, 2001).

Despite the oftentimes contentious relationship between physicians and midwives, the truth about the midwife model of maternity care is that it does not work without successful and respectful collaboration between midwives and physicians. ""Public health experts and researchers are recognizing that midwifery will not disturb the system of obstetrics. Instead, international research indicates that the two professions are compatible, complementary, and necessary to each other for an efficient and cost-effective system of care" (Harmon, 2001).

Discussion

With all of the interventions occurring in US hospitals, it's no wonder that there is a group of pregnant women who wish to stop giving birth in hospitals. Trust and respect of birth as a physiological process is very difficult to find amongst providers who attend birth in the hospital setting. Coincidentally, it is also hard to find providers in the hospital who are supportive of, or have seen many, normal physiological births that are without interventions and occur spontaneously without the disturbance of the medical system. Our current medical model dictates relieving symptoms and providing treatments for any conditions that deviate from the patient's baseline. Trying to fit pregnancy and childbirth into the medical model is like trying to fit a round peg into a square hole. Birth is a natural process, and for a model used exclusively to treat disease, birth is a conundrum. There is an inherent risk

in life, and birth is one of those risks. But it is a risk that a woman's body is naturally prepared for.

One reason for choosing home birth that is prevalent among the community is the desire to have informed consent and egalitarianism between the family and their care provider, which is diametrically opposite to the informed persuasion and authoritarianism of the hospital and its doctors. In hospitals, broad consent documents, including anesthesia and c-section consent forms, are commonly signed as soon as you are admitted to labor & delivery. In home birth settings the midwife comes to the family's home, and thus, egalitarianism is set-up from the beginning of the client-provider relationship; the midwife has birth-specific information to share with the mother and family to help guide their decisions and the mother is treated as the expert on her body and pregnancy from the intuitive perspective. Informed consent in home birth doesn't merely include the benefits and risk, but also the alternatives, the mother's intuition and the option of doing nothing and waiting for nature to take its course as long as the mother and baby's safety are not in question. The ladder is almost universally unacceptable in hospital birth settings. In fact, some home birthers have had previous traumatic birth experiences at hospitals attended by doctors and wish to give birth guided by their intuition with midwives. Home birth midwives spend time with their clients and are not influenced by the policies of the hospitals, and they do not use medical interventions to hurry the labor process along. Even hospital midwifes or "medwifes," as Marsden Wagner, MD has coined them, are more likely to use interventions to aide in the facilitation of childbirth in the hospital than are midwives attending home births. In home birth, pregnancy, labor and delivery are not the disease that the medical model sees them as.

Home birth is the subject of ongoing controversy. Most families who chose to birth at home are treated like outsiders by their peers. Home birthers do not see birth as a medical event like the 98% of women who are giving birth in hospitals in the US. Home birthers question the authority that doctors purport to have over nature. And in the US, women have a lot of reasons to believe that home birth is not the rebellious choice that the maternity system makes it out to be. "Home births attended by lay

midwives can be accomplished as safely as, and with less intervention than, physician-attended hospital deliveries" (Duran, 1992). Just look at the Netherlands, they are a developed country with a much higher rate of home birth than the US. About 30% of women give birth at home in the Netherlands, attended by a midwife, and their maternal and infant mortality rates are lower than in the US (Declerq, et al., 2011). A 2009 study concluded that in a group of 529,688 low-risk labor & delivery patients, over 60% of whom planned to give birth at home, "planning a home birth does not increase the risk of perinatal mortality and severe perinatal morbidity (de Jonge, et al., 2009)." This was a nationwide study. If home birth is this safe in the Netherlands, then what is propelling US women into the hospital to birth their babies? The answer is almost always socioeconomic status.

On the surface, self-selection appears to be playing a huge role into or out of home birth. However, home birthers are not only a self-selecting population of women, but a population of woman who can afford the price tag. With the cost of a home birth midwife averaging at around $4,200 in the California, SES further isolates women of color and low-income women from being able to exercise this birth option safely. Regardless of race, women who chose home birth in the US must have the means to pay for a midwife to attend their birth or birth unassisted because insurance simply doesn't pay for home birth at rates that make it accessible to women of lower SES. This is not the only disparity that appears in home birth.

The reality is that over the course of over a hundred years midwives were hunted like witches and forced to practice midwifery underground. Hospitals took the reins of labor & delivery and asserted themselves as the safest place to give birth, with doctors at the helm. First hospital birth was only available to white women. Then women of color could give birth in the hospital, but weren't allowed to use pain medication or even labor on the same floor as the white women (Gibson, 2011). It was during this time that the last of the higher proportion of good birth outcomes for African American women were probably recorded. As soon as 'all persons were being treated equal without regard to race,'

maternal and infant mortality rates started going up. This was in 1972. African American women now had the right to use pain medication and use it they did. Who could blame them? But the atmosphere of support of physiological labor went away as quick as the pain medications for labor took hold. When Medicaid began covering labor & delivery and other pregnancy related services, the fate of "where" women of color and low-income women would give birth was sealed: they would birth in the hospital.

To make a change in the "where" women of color and low-income women give birth will take a substantial effort, especially when considering the numbers. For each African American woman that gives birth at home 3.5 white women give birth at home. For each Hispanic woman that gives birth at home 5 times as many white women give birth at home (the statistics of other ethnic groups were not available). This phenomenon does not happen because only white women know about home birth; there are a multitude of factors in play here. Can women of lower SES afford home birth? No. Does insurance cover home birth? Not really. Are women of lower SES respected in their healthcare decisions regarding pregnancy? Not usually. Does the medical system who put women of color and low-income women in the hospital to birth their babies think that they should be having babies in their "economic situation?" Most of these things never come up in the debate about home birth, but they are at the crux of the matter.

It is always a challenge to convince medical insurance companies to pay for services that they have previously excluded, but reimbursement for home birth has been an especially difficult one. Currently, insurers only cover home birth in states where they are legislated to do so, and most will only cover home births attended by a CNM (Piard et al., 2011). Given that CNM's generally practice in hospitals (Harmon, 2001); this often results in a financial conundrum and a legal one as well. The Patient Protection and Affordable Care Act of 2010, while expanding Medicaid coverage to millions of Americans, fell short by only extending coverage of midwife services to those births occurring in birth centers run by licensed midwives (Pérez, 2011). When pushed about denying payment of services for

home birth, most insurers will cite the economically motivated guidelines of ACOG that recommend the hospital as the safest place to give birth, as well as studies from Washington state and Australia that show “a higher risk of births that occur at home for women who have had complicated pregnancies” (Piard, et al., 2011). However, insurers will conveniently ignore that these same studies find home birth a suitable option for *un*complicated pregnancies (Piard, et al., 2011). The driving force behind the United States for-profit health insurance industry is their bottom line. The theme that stood out the most from our review of the literature is that home birth is a safe, cost-effective alternative for women presenting with a low-risk pregnancy. While data and dollars pile up, politicians and insurance CEO’s will be looking for ways to cut costs in healthcare, and policies will eventually come into line with the known safety, quality, and affordability of the midwife model of maternity care.

While insurers drag their feet on paying for home birth, the archaic policies of our birthing institutions also play a pivotal role in women’s access to home birth providers. Hospitals often refuse admitting privileges to lay midwives, and we have discovered that some hospitals even go so far as to require their in-house nurse midwives to sign agreements not to attend home births, lest they lose their own admitting privileges. “The ACOG and the AMA policies prohibit physicians from collaborating with CPM’s, which contributes to the hostility, and which may in fact contribute to a birth outcome that's worse than if a woman's choice had been supported and the midwife and physician had been encouraged to collaborate” (Block, 2009). It is institutional policies such as these that block women from seeking home birth, and limit providers available for home birth. However, the literature makes legal arguments for challenging such policies. One such argument is that a hospital has no right to try and control their staff’s interactions with non-hospital patients (Annas, 1988).

Currently, ten states criminalize the practice of midwifery, except for CNM’s (MANA, 2011). Such laws drive the practice underground in those states, endangering the lives of the women and babies who chose to deliver at home. Although politicians uphold such laws based on the inaccurate

assumption that home birth is unsafe, the simple existence of such laws create risk and unsafe situations for pregnant women. In the states where lay midwifery is legal, there is no regulation in thirteen states (MANA, 2011). This also puts women choosing home birth at risk as it doesn't allow women to be fully informed about their chosen lay midwife, and her official history in those states. Through our research, it has been overwhelmingly clear that laws that outlaw midwifery outright are dangerous and do nothing but harm women who seek the best environment for *them* to deliver their babies. In places that it is unregulated, midwifery can be a legal gray area that can still present some dangerous situations. Midwifes operate best where they are integrated with the local healthcare system. For example, in Washington State, CPM's are covered by the Medicaid system, and home deliveries are twice the national average (Pérez, 2011).

Recommendations

Changing the culture of birth in the US is one of the fundamental recommendations that have come to the forefront. In order to even begin to make a dent in the number of hospital vs. home births we must educate people about normal physiological birth. A good start is to encourage media networks to portray birth on current TV, film and related media in a realistic light with consultation from midwives. Portrayals of birth in the media need to include both home and hospital birth so as to show women in the US all the options from a very young age. As well, news media outlets should be regulated to cover home birth with a representative ratio of good outcomes to emergency transfers as continuing to propagate that home birth is dangerous is disingenuous and slanderous.

Changing the way we educate women with regards to childbirth is another recommendation that must be implemented in order to bring about change in US birth culture. Currently, childbirth education, while occasionally offered for free at the local hospital, is an out-of-pocket expense for women that is not covered by insurance. We suggest that insurance coverage for thorough childbirth education provided *outside* of the hospital by a certified childbirth educator be mandated. This will

increase the knowledge base of pregnant women in the US and will aid in the re-building of an oral-tradition in childbirth, which has long-since been replaced by birth horror stories. In addition to mandated insurance coverage for education, we acknowledge the need for mandated insurance coverage for doula/childbirth support services and lactation support. With coverage for these key support services, US women will build confidence over time to birth outside of the hospital and eventually at home.

While the US is transitioning towards having a home birth rate closer to that of the Netherlands 30%, women will still be birthing in the hospital. Therefore, more research into the efficacy of water birth in the hospital is needed and we suggest that this might be one area of childbirth that a randomized controlled trial might prove ethical. Incentives for midwifery education that are equal to those available to physicians are also needed. Not just for CNM's, but for all types of entry into the field of midwifery. While women can birth with a midwife in the hospital, the majority, about 90%, still birth with physicians and some hospital do not even have midwives on staff. As such, broad consent forms in labor & delivery units must be eliminated to encourage informed consent between patient and provider for every intervention suggested. Hospitals would also do well to hire doulas to work on their labor & delivery units in order to provide the much needed support that is required for normal physiological labor.

In order for women to call forth their power to birth in a normal physiological manner, childbirth education must start before women are pregnant or capable of becoming pregnant. This goes back to the media's portrayal of pregnancy and childbirth as something "easy" or "scary," and also as an over-medicalized event in a woman's life. Childbirth can be both of those things, but it's not that way for everyone or for every situation. For this reason, we recommend challenging these "cultural norms" as early as middle school and high school by mandating childbirth education provided as a part of sex education by a certified childbirth educator. If this education is provided at these critical ages in public

schools and includes detailed education regarding home birth and home birth practices as the new "cultural norm," this education will become a powerful tool for women of lower SES to empower themselves to demand change in the system that keeps them from birthing at home in the first place.

The recommendation for more education programs for young mothers about home birth must be coupled with legislation to prevent physicians from maintaining their dominant control over the population of women who are on Medicaid in the US. The federal governments should therefore make changes to the Medicaid law to mandate that all low risk pregnant women be assigned to a midwife during pregnancy. In addition to this, Medicaid should restrict claim payments to doctors whose low risk patients have not seen a midwife during their pregnancy. These two actions will send a message to the US maternity system; enough is enough. No longer will physicians be handed an entire population of already marginalized women to treat; these women will instead be cared for by midwives and only transfer to a physicians care if their pregnancy becomes high risk.

Once American society catches onto the safety and affordability of home birth, the next barrier in the way will be insurance. Finding the money to pay for home birth will continue to affect women of lower SES so long as the insurance industry is allowed to deny claims for home birth. Since private insurance usually follows suit after government insurance programs start paying for a service, the first step in this arena would be to mandate that Medicaid cover home birth services the same way that they cover hospital birth services. This would also help to eliminate the perception of home birth as an "outsiders" choice.

We have known for quite a while that the reimbursement system in this country for medical services rendered needs to be fixed. In no other place is this more pervasive than in birth care. In our current pay-for-service system, doctors are reimbursed more for deliveries via c-section than they are for vaginal deliveries. Since c-sections are more predictable and offer physicians more control (and money!), it is no wonder that our cesarean section rate is around 30%. Our recommendation in fixing

this issue is to change the pay-for-service system, and offer providers one lump sum for maternity care, regardless of the birth ends up at home or in the hospital. If the birth does end up in the hospital, the midwife should be given reimbursement for the prenatal care and labor support provided before hospital transfer.

Currently, only CNM's, and CPM's in some states, are able to take insurance, especially Medicaid. This disparity is a key factor in the accessibility of home birth, especially to poor women and women of color. By requiring all midwives, including lay midwives, be paid by insurers, we would be able to greatly expand the accessibility of badly needed prenatal and postpartum care. Such a change would start to work towards bringing the demographics of women choosing home birth more in line with that of the general population.

One aspect of home birth that is essential to it being a safe alternative for low-risk women is its integration into the local healthcare system. Our current hospital system often reacts with outright hostility towards home birth midwives, including refusing to give formal backup to home birth midwives. Such policies are yet another hindrance towards preserving the continuity of care for home birth patients who find they need to transfer to a hospital. After the transfer to a hospital, currently patients suddenly find that their midwife is no longer the practitioner helping her make decisions. In some instances, hospitals will not allow a home birth midwife to accompany her transfer into the hospital. Such restrictions only lead to more distress and harm for the mother and baby. It would be wise to include lay midwives in the continued care of home birth transfers.

One tactic that we have explored that hospitals have tried to use to stamp out home birth is that of requiring the CNM's and physicians employed by them sign an agreement not to attend home births lest they lose their hospital admitting privileges. While such an agreement has been deemed to be of dubious legal grounding, a legislative mandate solidifying the illegality of such a requirement would strengthen the home birth movement.

The most obvious legal change to increase home birth would be to legalize all midwifery in all fifty states and set up national standards and licensing. Such a mandate would bring more trust and credibility to the profession. As it stands right now, most midwives cannot afford the price of malpractice insurance. In fact, most lay midwives cannot even get a policy. To remedy this problem, it would be necessary to require that the underwriters of malpractice insurance follow the risk/benefit analysis when writing policies for midwives, as multiple studies show that for low-risk women home and hospital births are equally safe options. Another aspect of the malpractice insurance field that needs to be reformed is the practice of blocking physicians from providing back up to home birth midwives. This is usually achieved through threatening to cancel the malpractice insurance policy or sharply increasing the rates. It is time for this to stop as it neither improves patient safety nor reflects the true risks of home birth.

Another recommendation is that the federal government recognizes midwifery and physician obstetrical practice as independent professions; as opposed to the physician-supervisory model we have today. The midwifery model of care works best when midwives and physicians work in collaboration with one another, freely referring patients to each other's practices. As doctors refer healthy, low-risk pregnancies to midwives and midwives refer risky pregnancies to physicians a delicate balance can be achieved. Such a model of care would foster egalitarianism between physicians and midwives as well as bring stream-lined efficiency (cost effectiveness!) to maternity care.

Summary

Home birth is a part of healthcare that has been ridiculed and seriously dismantled by the medical establishment over the last 100 years. As a result, childbirth in the United States has been unnecessarily medicalized, but thanks to a backlash against this trend in childbirth, home birth is once again seeing resurgence in modern US birth culture as a safe, cost-effective, holistic birthing option. There are many cultural, institutional and economic obstacles in front of women desiring a home birth,

making this birth choice less accessible to women of lower SES. Many women on public health insurance programs, as well as those with private insurance, are not thoroughly informed of their birthing choices. This makes home birthers appear to be an unrepresentative population of older and more educated women who may also have many other advantages that are unrepresentative of the general population. The truth is that private and public policies are often unfavorable to home birth, and women who do not seek out a home birth are simply doing what they are expected to do and fall in line with the US cultural norms with regards to childbirth.

Changes in the payment structure and reimbursement policies of public and private insurance would help increase all women's access to home birth. However, the powerful and wealthy hospital lobby sees home birth practitioners as competitors for a share of the birthing market, and often employs policy practices that aim to reassure their 98% share of the market is protected. As home birth midwives make headway in legislation and policy, their importance to the health of our maternity system will become more apparent, and more women will chose their services. With traction growing in all these areas home birth can again be a mainstream choice in US birth culture.

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