Rural America's disappearing maternity care

An empty hospital room is seen in the emergency center at Virginia Gay Hospital and Clinics in Vinton on Monday, July 25, 2011. (David Scrivner/The Gazette)

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Life in rural America can be tough, with challenges starting right from birth. Increasingly, rural women lack access to maternity services, jeopardizing their health and that of their newborns at a time when U.S. maternal mortality is rising.

Giving birth is hard enough, but racing 100 miles to the nearest hospital down winding country roads is a particularly harrowing way to experience labor. Evidence confirms what common sense suggests: Drive time affects outcomes. A Canadian study shows that the babies of mothers who travel more than an hour to give birth are more likely to require intensive care or to die within their first year of life.

Anguishing personal stories underlie the aggregate data that signal pervasive problems. For Whitney Brown of rural Tennessee, hospital staff discovered an amniotic fluid embolism too late. She died after childbirth. Courtney Cross, a mother living in rural Alabama, fell into debt in

part because of the cost of her lengthy trips to pregnancy care.

And the challenges for rural mothers are getting worse. A recent study in Health Affairs, co-authored by one of us (Kozhimannil), shows that more than half of rural counties lack obstetric services. A wave of rural obstetric unit closures has increased the distance to maternity and delivery services; the least populated and most remote communities have been hit hardest. What's left are maternity-care deserts in some of the United States' most vulnerable communities.

Because birth is unpredictable, hospitals must have staff and infrastructure in place at all times to offer obstetric services. But sparsely populated areas have few births, making it hard for hospitals to balance their books. In addition, it is difficult for rural areas to recruit and retain maternity clinicians. Many hospitals cut back on their obstetric services. Others close altogether.

The generosity (or lack thereof) of a state's Medicaid program also contributes to maternity deserts. Medicaid pays for more than half of the births at rural hospitals. Rural communities in states where Medicaid covers only the poorest pregnant women are less likely to have in-county obstetric services, compared with states with more generous eligibility criteria.

Wisconsin's Medicaid program, for example, covers pregnant women living at up to 306 percent of the poverty level. There, only one-third of rural counties lack obstetric services. But North Dakota's program covers only those under 152 percent of the poverty level, and 85 percent of the state's rural counties lack obstetric services.

Not all rural communities are equally disadvantaged. Those with more African American and low-income families have suffered more rapid losses of hospital-based obstetric services. Maternal mortality is substantially higher for rural and black women relative to urban and white women, respectively. These disparities are among the most tangible consequences of structural racism and classism in the United States.

Despite these challenges, some rural communities demonstrate extraordinary resilience. Take the case of Clare Shirley, a resident of rural Cook County, Minnesota, whose local hospital — Cook County North Shore Hospital — stopped providing obstetric care in 2015, leaving her more than two hours from a hospital where she could give birth.

Shortly after midnight in May 2016, Shirley's labor progressed quickly. Shirley's mom called her local doctor, Jenny Delfs, who, along with the county sheriff, got in an ambulance and met Shirley on the road. They decided against the two-hour trip to her planned birth hospital, rushing instead to Cook County North Shore Hospital.

There, Delfs and her colleagues from the Sawtooth Mountain Clinic (an adjacent community health center) attended the birth of a healthy baby girl. This good outcome was possible because the clinic and

hospital had maintained competency in emergency birth management through training, simulations and strong local partnerships with county public-health services, emergency medical services and law enforcement.

To achieve more successes like this, policymakers need to offer greater support to rural families and communities. Congress could start by passing legislation that would designate maternity-care shortage areas and expand workforce programs to include maternity services.

States can also play a role by addressing housing and transportation needs of rural residents who give birth far from home. Alaska, for example, finances homes where rural, pregnant women can stay as their due dates approach. The state also funds travel by pregnant women to medical hubs and clinical teams to accompany high-risk cases. Federal or state programs should also provide financial assistance to support emergency birth training, the kind that contributed to a good outcome for Clare Shirley.

Inadequate access to maternity care is yet another way in which some Americans have been left behind. We can — and should — do more to fill the gaps in our frayed maternity-care system, especially in rural America.

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