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COMMENTARY

Not-So-Simple Solutions for Improving Maternal Morbidity in Maternity Care Deserts

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In May 2023, I visited South Central Virginia as part of a conference series. When our group toured a community hospital, I learned that two of the three hospitals along the nearby Virginia-North Carolina border no longer provided perinatal care.[1,2] The two labor and delivery (L&D) units closed within 18 months of one another, leaving three counties, 144,000 people, and more than 2,100 square miles with only one delivery location. A pregnant person in Southern Virginia may drive more than an hour, in labor, to deliver a baby.

Hospital closure of L&D units is not uncommon. Rural L&D units are closing across the United States,[3] creating *maternity care deserts* (MCDs), which the March of Dimes defines as counties that have no hospitals providing obstetric care and no practicing obstetricians/gynecologists or certified nurse midwives.[4] MCDs have expanded in the past decade, exacerbated by rural hospital L&D unit closures. Only 51% of rural community hospitals had L&D services in 2021.[5,6] As MCDs expand, the absence of community-based L&D units potentially leaves individuals with long drives, inequitable access, and risk of increased morbidity and mortality.[7]

The March of Dimes does not consider family physicians in its MCD definition. But family physicians provide both prenatal and delivery care. In fact, family physicians are the sole perinatal care clinicians in 16% of MCDs.[8] While family physicians help fill the gap in MCDs, only a small proportion of family physicians provide perinatal care. Upon leaving residency, graduates report readiness to provide perinatal care, and nearly a quarter of family medicine residency graduates intend to practice obstetrics.[9] However, fewer than 10% of family physicians go on to practice obstetrics.[9,10] The barriers that are most cited include lack of job opportunities with obstetrics included, difficulty with hospital credentialing, and concerns about work-life balance.[11]

Hospital L&D closures and expanding MCDs necessitate the question, *How do clinicians and health care systems solve the lack of equitable obstetric care?* The solution is not simple and requires a multistep process with multiple collaborators. The following specific challenges need to be overcome:

- The current workforce is too small and inadequately distributed to meet the needs of every community.
- Training pathways that lead to a clinician practicing general obstetric care can be limited and/or restricted.
- Hospitals continue to close L&D units due to high cost and/or low volume of deliveries.

Solutions to improve equity of perinatal and delivery care include purposeful recruitment, clear training to practice pathways, and sustained funding for hospitals to secure L&D services.

Currently, too few clinicians provide perinatal and delivery care for the population. Physicians tend to cluster in urban areas, leaving rural communities without qualified physicians. To strategically retain physicians across the United States, evidence has demonstrated the effectiveness of recruiting potential physicians well before college and from rural areas.[12,13] While many barriers exist to practicing in rural and underserved areas, lack of ties to the region may contribute; recruitment of clinicians from MCDs may improve return to these areas. Recruitment for obstetrics and family medicine physicians alone will not sustain full scope perinatal care. Allied

health professionals are essential to a functional team and should also intentionally be recruited from MCDs.

Training and credentialing of physicians to provide perinatal care is essential to safe and continuous care. Support for general obstetricians to practice in L&D should continue. Approximately 20% of obstetrics and gynecology residents subspecialize and may not provide perinatal and delivery care.[14] Importantly, family physicians should be counted as perinatal and delivery providers for MCD definitions. The difference in the number of family medicine residency graduates who are interested in providing perinatal care and the number of active family physicians who include perinatal care in their practice is dramatic. The break in the pathway from training to practice could be alleviated by increased opportunities from hospital systems and practices in obstetric care for family physicians, ease of the credentialing process with hospitals, and increased malpractice and monetary support from hospital systems and practices for those family physicians interested in providing delivery services. Importantly, in addition to gaining perinatal care providers, these communities would benefit from having a family physician providing continuous, lifelong care to residents.

Finally, hospital systems must identify and address cost barriers and volume necessary for fiscally sound L&D units. Many hospital systems report that the total cost of L&D, including staffing, surpasses the income costs from the volume of deliveries.[15] For hospitals that may not reach the volume threshold, financial incentives are necessary to ensure L&D unit viability. This goal can be accomplished based on the currently completed community needs assessment. Using data on the reproductive age population and MCDs, and in collaboration with surrounding hospital systems, hospitals and practices should identify counties that have geographic need for L&D, even with low volumes. In these instances, federal support is indicated to sustain L&D through financial incentive programs and staffing incentives.

Notably, some counties in the United States are unlikely to have full perinatal care due to a small reproductive age population. For example, King County, Texas (an MCD) has a population of approximately 225 people and a low number of births annually. The surrounding counties are also MCDs. To best support King County, the adjacent counties with higher populations should have operational L&D units.

Equitable access to perinatal care is crucial to improving the health of the United States by reducing maternal mortality and ensuring that future generations begin life with a healthy start. The solution will not be free; it will take investment from hospital systems, the federal government, and medical schools and residencies. Organizations must support sustainable L&D units in MCDs. The United States continues to carry the worst maternal morbidity outcomes of any developed nation, and the only way to better outcomes is to provide access and continuity of care.[16]

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