# ACNM WORKFORCE STUDY

Executive Summary

The American College of Nurse-Midwives conducted a two-year study of the midwifery workforce. The workforce study generated information on the supply of Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) in the United States. These data are critical to better understand midwifery workforce needs and to inform the policy work needed to increase access to advanced practice midwives and improve maternal mortality and morbidity rates nationwide. Data from the Workforce Study are available on ACNM's website, https://www.midwife.org/midwifery-workforce.

Assessing the viability of the current midwifery workforce is integral to planning expansion of midwifery. Existing workforce data for CNMs and CMs is not easily accessible, and the Workforce Study presented ACNM with an opportunity to do the research necessary to gather this information. ACNM used publicly available data along with data from the national certifying body for CNMs and CMs, the American Midwifery Certification Board, to create a more accurate picture of the location and density of midwives than has been available in the past. The workforce findings required a deep dive into state policy structures, which led to the development of an advocacy toolkit for midwives which provides a road map for developing strategies to increase access to midwives and midwifery-led care models and to grow the midwifery workforce. The national and state data in this toolkit inform these initiatives.

## *PROBLEM:*

> **Midwifery is associated with a host of good outcomes for childbearing individuals, yet most people in the United States do not have access to midwives.**

According to the World Health Organization (WHO), midwives could be providing 90% of sexual and reproductive care in the United States but the predominant structure of the healthcare system is not set up to support midwives or midwifery-led care models. Midwives, incorporated fully into US health care systems, could reduce perinatal health disparities, and help address provider workforce shortages. The barriers that midwives face to grow keep people from accessing midwifery-led care. For instance, many midwives across the country are reimbursed less for providing care than physicians by both private and public insurers. This creates problems for access: practices don't want to hire midwives if the midwives generate less income than doctors.

Another barrier is the restriction of autonomous practice by state laws and regulations that treat the work of midwives as an extension of physician work. Medicine and midwifery are complimentary professions, but they are not the same thing. Restrictions of midwifery autonomy and scope of practice make it difficult for midwives to practice the midwifery model of care. Midwives often are relegated to the role of physician extenders which deprives consumers of the benefits of the midwifery model and the potential benefits of midwifery care, and renders midwifery invisible in health system data. In addition – in 48 states, midwives may not be able to admit their own patients to hospitals, which is the primary location of birth for most people in the United States. Worse than that is that hospitals can exclude midwives all together and choose not to offer midwifery. Midwifery care in hospitals should be available to consumers in the same way that pediatrics, family practice, or other health care specialties are.

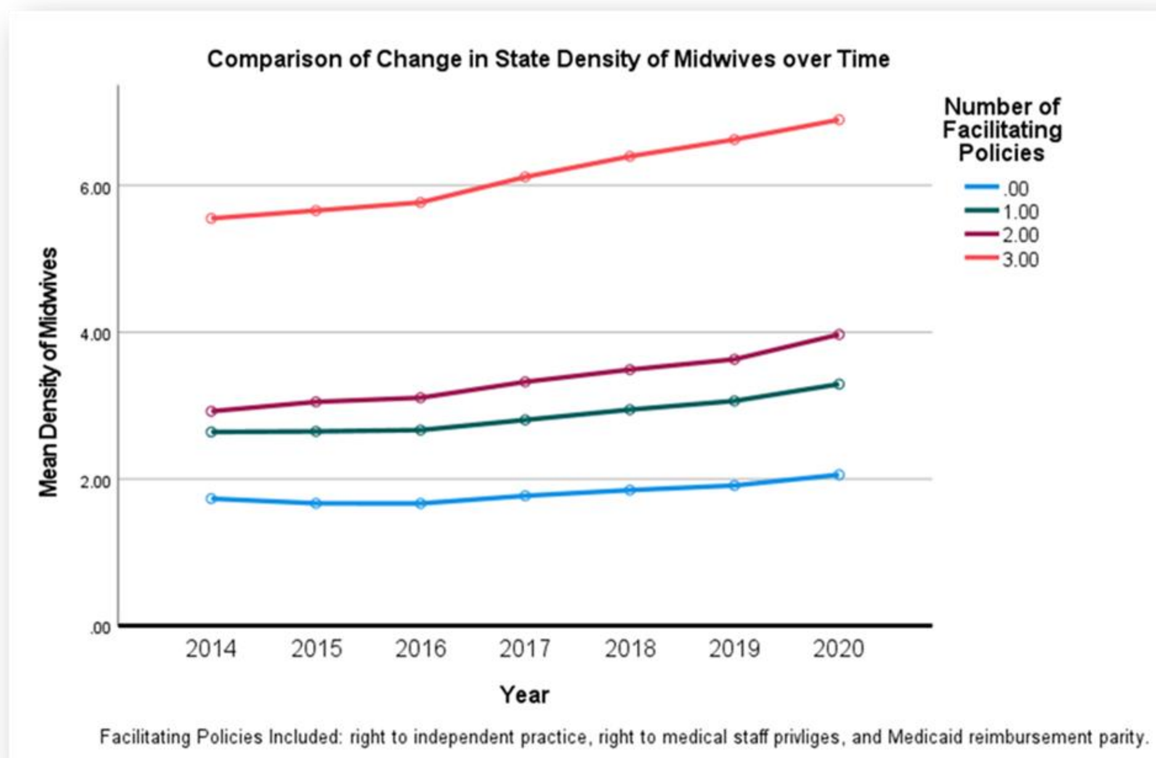
# Selected FINDINGS:

## Midwifery Independence and Workforce Size

States have three policies that act as facilitators of midwifery practice:

1. Licensing midwives for full independent practice, including prescribing all essential medications
2. Reimbursing midwives the full Medicaid physician fee for services
3. Ensuring midwives can admit their clients to the hospital independently

States that adopt all three policies have a larger midwifery workforce, and experience faster growth of the midwifery workforce, than states that adopt fewer or none of these policies.




Data Sources: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2007-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. American Midwifery Certification Board (AMCB). (2022). Number of CNM & CM by State – August 2022. Available at https://www.amcbmidwife.org/about-amcb/data-and-research

## State variation in percentage of midwifery births:

There is wide variation in the state proportion of births attended by midwives, and it's not explained by variations in population risk. In 2022, the proportion of midwife-attended births for people with no maternal risk factors recorded on the birth certificate varies from less than 1% in Alabama to 32% in Vermont. In 2022, 65% of births had no maternal risk factors recorded on the birth certificate. Midwives attended 13% of these births. Based on these data, the United States has the low-risk birth volume to increase the midwifery workforce to five times its current size.

## Variations in practice ownership:

Most midwife clinical practices are privately owned, or hospital owned. Practice ownership varied by state midwife regulation. In states with independent midwifery practice, most practices are owned by hospitals and equal proportions of practices are owned by midwives and physicians. In states that require a written practice agreement, physicians and hospitals own equal proportions of practices while midwives own the same proportion of practices as community clinics (12.4%, 12.0%). Restricted midwifery practice appears to shift the supply of midwifery practices to physician demand for midwifery colleagues rather than consumer demand for midwifery services.

## Barriers to educating more midwives:

> **A shortage of preceptors is the major bottleneck for midwifery education and the main limitation to expanding the capacity of existing midwifery education programs.**

Not every state has access to a midwifery education program, and the lack of clinical sites and preceptors is a limiting factor in class size. ACNM has been actively working to address the barriers with federal legislation – because the number of programs is growing but not the number of seats. The Midwives for MOMS Act (H.R. 3768/S. 1851) is a bill to address the growing maternity care provider shortage, to improve maternity care outcomes for mothers and babies, and to reduce maternity care costs for families and state/ federal governments, by expanding educational opportunities for midwives. The bill will establish two new funding streams for midwifery education, one in the Title VII Health Professions Training Programs, and one in the Title VIII Nursing Workforce Development Programs. Additionally, the bill will address the significant lack of diversity in the maternity care workforce by prioritizing students from minority or disadvantaged backgrounds. There will also be funding for preceptors, clinical sites, and starting new programs.

**RESOURCES FOR SOLUTIONS:**

ACNM has produced a toolkit for midwives and midwifery advocates to find ways to address state-level barriers so that midwives can practice to the full extent of their education, clinical training, and certification. There are three companion pieces. The first is the National Midwifery Chartbook, which is a slide deck about the current midwifery workforce from a national perspective. The second is a State Chartbook - a slide deck of state-specific facts and identification of areas of policy that could be changed to improve the ability to scale up midwives and increase access to midwifery care. The State Chartbook is available to ACNM members. The third is a publicly available Advocacy Policy Toolkit.

**ACNM's POLICY PRIORITIES:**

**Independent practice:** State licensing is the process by which a state confirms that a health care worker is competent to practice and designates the health care worker as legally able to practice within the state. Requirements for licensing are generally set by state statute, and the

licensing process is overseen by a regulatory authority in the state. In "independent" states, midwifery licensure is based on evidence of education and certification. In "restricted" states, midwives are required to provide evidence of a written contract with a physician to be licensed to provide midwifery care. Removal of the requirement for contractual relationships with physicians is a policy goal.

**Parity in reimbursement:** Parity means midwives receive the same rate of reimbursement as a physician when they are providing the same service, and changing state regulation so that midwives receive 100% of physician fees for Medicaid is a policy goal.

**Independent admitting privileges:** The Medical Staff is a body of healthcare providers authorized by the hospital and state law to provide health care within a specific hospital. Midwives who are part of the Medical Staff can independently admit and discharge patients, and admitting privileges for midwives is a policy goal.