California Health Care Foundation

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Midwives Speak: Integration Challenges in California's Health System

About Midwives

Midwives play a crucial role in the maternity care workforce, providing comprehensive health services during pregnancy, labor, and postpartum, including as the primary birth attendant. In many countries that have better birth outcomes than California and the United States, midwives provide the majority of care for uncomplicated pregnancies and births. The midwifery model of care emphasizes respectful, relationship-based, and person-centered care, supporting the progress of labor and birth with minimal intervention unless necessary. An element of successful midwifery care is appropriate consultation with obstetrician/gynecologists and transfer to physician care if the need arises (e.g., if a patient develops medical complications outside the scope of midwifery care or requires surgery).

California licenses two types of midwives: licensed midwives (LMs) and nurse-midwives (NMs). LMs, regulated by the Medical Board of California, primarily practice in community-based settings, including birth centers and home births. Nationally certified LMs are credentialed as certified professional midwives and are legally recognized in 38 states.[1] NMs are also registered nurses and are regulated by the California Board of Registered Nursing and primarily practice in clinics and hospitals. Nationally certified NMs are credentialed as certified nurse-midwives (CNMs) and are legally recognized in all 50 states. Both LMs and NMs meet international midwifery education standards and provide high-quality care focused on pregnancy, childbirth, and postpartum, including family planning and newborn care, with NMs also offering broader gynecologic services.

About the Survey

To better understand the midwife workforce, the University of California, San Francisco, with funding from the California Health Care Foundation, conducted the Survey of California Nurse Practitioners (NPs) and Nurse-Midwives and the Survey of California Licensed Midwives from July 18, 2022 to March 31, 2023. Of those completing the NM survey, 267 were NMs and 118 were dual-licensed NP-NMs, while 229 LMs completed the LM survey. More details on the study methodology are available in the appendix.

This brief describes the scope of practice and integration of midwives; their relationships with physicians, hospitals, and health plans; and their levels of career satisfaction and burnout.

Midwifery care produces excellent clinical outcomes and positive patient experiences.

National and international research demonstrates that midwifery care is associated with excellent clinical outcomes and positive patient experiences, including an increased likelihood of vaginal birth, vaginal birth after cesarean, and breastfeeding; decreased number of unnecessary medical interventions (e.g., labor induction, episiotomy, cesarean and vaginal births assisted by the use of forceps or a vacuum); decreased health care costs; reduced rates of preterm birth; and reduced maternal morbidity and mortality.[2]

Importantly, midwifery also impacts the way patients experience their care, including an improved sense of connectedness, security, and respect.[3] In the Listening to Mothers in California survey, patients who had midwives reported experiencing greater support for decisionmaking, which increased their sense of agency and satisfaction.[4] Midwives are particularly effective in community-based settings, where they provide care that is culturally sensitive and respectful, reducing the likelihood of mistreatment and improving birth outcomes.[5]

Issue Brief

Midwifery care can address systemic racism in maternal health care.

In California, significant racial/ethnic disparities exist across a variety of maternal quality measures from prenatal visits to preterm births to maternal and infant mortality rates.[6] Across many of these measures, Black mothers/birthing people* and infants experience worse quality than their peers in other racial/ethnic groups. Notably, the pregnancy-related mortality rate for Black birthing people in California has been three to four times higher than rates for other races/ethnicities for many years.

Midwifery care has been recognized by many health policy experts as an important intervention to address racism-based disparities in maternal health care, especially when provided by culturally and racially concordant providers.[7]

Growing shortages of obstetrics providers and settings increase the importance of midwifery care.

In California and nationwide, a growing shortage of obstetrician/gynecologists (ob/gyns) and closures of hospital labor and delivery units have generated urgency for expanding the number of midwives and their scope of practice. In 2023, there were 400,108 births in California, with 86% of those delivered by physicians.[8] Midwives served as the primary attendant in only 14% of births. By 2030, California's demand for ob/gyns is projected to exceed supply by 1,160 full-time equivalents, and the state is losing labor and delivery units faster than the US rate — 56 hospitals have stopped delivering babies since 2012.[9] Midwives could help address the workforce shortage and maternity care access issues that loom large in California's present and future.

Given all this, it is important to understand the experiences and perspectives of midwives currently practicing in California, especially concerning their scope of practice and working relationships with physicians, hospitals, and health plans.

Many midwives in California experience restrictions to practicing to their full scope of legal authority and to their level of expertise.

California law provides both LMs and NMs with an independent scope of practice, which means that physician oversight is not required. However, the state statutes for LMs and NMs impose a narrower scope of practice than their training allows and require physician oversight in certain situations, undermining their professional autonomy. A higher degree of professional autonomy among midwives is linked to better outcomes such as lower rates of cesarean birth, preterm birth, and low birthweight infants.[10]

Nearly 9 in 10 LMs identify government scope of practice restrictions as a "major" (39%) or "minor" (49%) problem in their practices.[11] Among NMs, 10% consider this a "major problem" and 27% a "minor problem" in their practices.

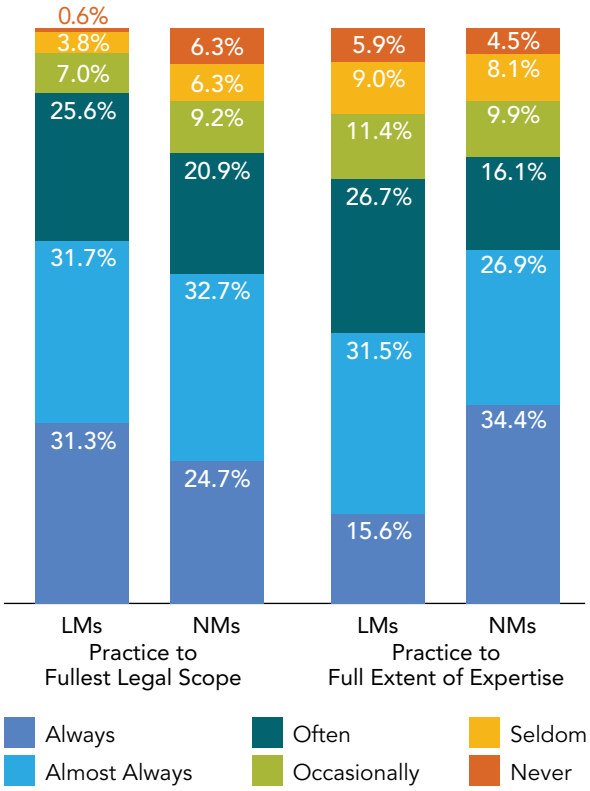
Allowing each member of the maternity care workforce to use all their skills to the maximum extent permitted by their license and knowledge expands the capacity for high-quality patient care. Eleven percent of LMs and 22% of NMs say they "occasionally," "seldom," or "never" feel free to practice to the fullest extent of their legal scope. About one in four LMs (26%) and NMs (23%) report they are "occasionally," "seldom," or "never" allowed to practice to the fullest extent of their expertise (Figure 1).

* We use "birthing people" to recognize that not all people who become pregnant and give birth identify as women or mothers.

Figure 1. Practicing to the Fullest Extent of Scope and Expertise, Licensed Midwives and Nurse-Midwives, California, 2023

Q: Do you feel free to practice to the fullest extent of legal scope?

Q: Are you allowed to practice to the fullest extent of your expertise?



Notes: Number of cases – LMs = 161, NMs = 176. Data are weighted to represent all LMs and NMs with active California licenses. Data reported only for respondents who answered these questions.

Sources: *Survey of California Nurse Practitioners and Nurse-Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023); and *Survey of California Licensed Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023).

Many midwives, especially LMs, identify their lack of integration into the health care system as a problem in their practices.

Ninety-one percent of LMs identify "poor integration of midwifery with other health care services" as a "major problem" (58%) or "minor problem" (33%) in their practices; in a list of 20 potential problems they face in practice, poor integration was second only to denial of coverage of care by insurance companies. Among NMs, 13% say this is a "major problem" and 33% a "minor problem" in their practices.[12]

In addition, among LMs not practicing, 62% say "lack of integration of midwifery care in the health care system" is a "very important" or "important" reason they are not practicing. Among NMs not practicing, 29% say "lack of integration of NM care in the health care system" is a "very important" or "important" reason they are not practicing.

Most LMs report challenges working with hospitals.

The vast majority of LMs (86%) report having to transfer at least one patient from a birth center or home birth to a hospital in the last year. Although some transfers may be emergencies, the most common reasons for transfers are a stall in the patient's labor and need for medication to aid progress or to treat pain.[13] More than two-thirds of LMs (68%) say they bypassed the nearest hospital for at least one patient transfer within the past three years (Figure 2). The most common reason for bypassing was "the nearest hospital was hostile to midwifery care."

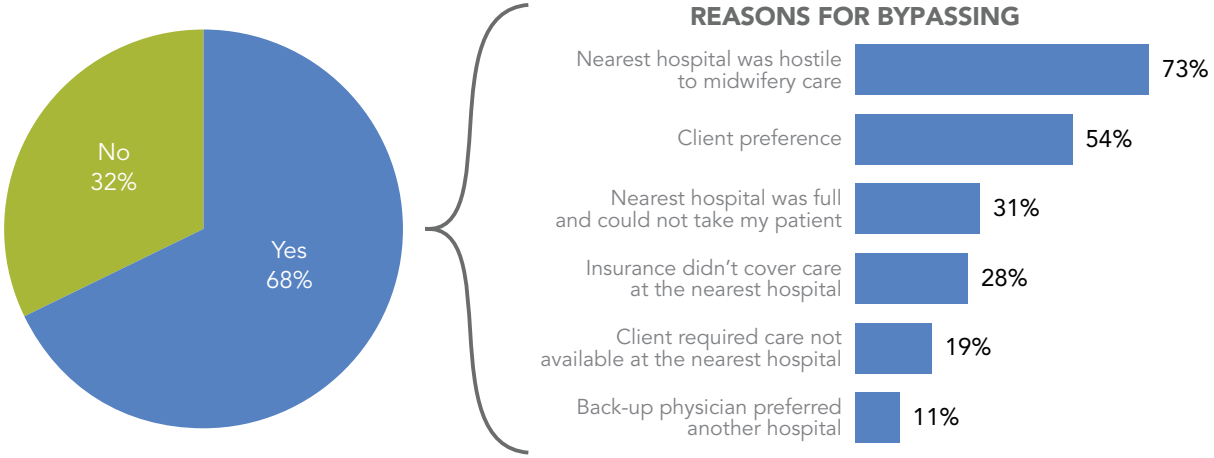
In addition, 44% of LMs identify "concern for clients being treated respectfully during hospital transfers" as a "major problem" and 47% as a "minor problem" in their practices.

During a transfer to a hospital, the transferring midwife ideally remains as the primary caregiver when care is within the midwifery scope of practice. This patient-centered approach supports continuity of care and improved collaboration with physicians, nurses, and other hospital staff.

Figure 2. Bypassing the Nearest Hospital for a Patient Transfer, Licensed Midwives, California, 2023

Q: Have you bypassed the nearest hospital for a transfer in the past 3 years?

Q: Why did you bypass the nearest hospital? Check all that apply.



Notes: Number of cases – whether bypassed = 135, reasons for bypassing = 91. Data are weighted to represent all LMs with active California licenses. Data reported only for respondents who answered these questions. Although NMs were asked these questions, the number of responses (n = 11) was insufficient to report results.

Source: *Survey of California Licensed Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023).

However, the transferring midwife must have hospital privileges to remain the primary caregiver,† and very few LMs report having hospital privileges. Four percent are allowed to admit patients, 2% may assess their patients in a hospital, less than 1% can provide clinical services at a hospital or discharge from a hospital, and 0% can write orders without a physician cosigning. Among those without privileges, 87% cited "hospitals near me won't credential LMs" and 79% cited "lack of physician support to acquire privileges" as "very important" reasons they did not have privileges.

In contrast, most NMs have formal relationships with hospitals and report having hospital privileges: 79% can round at a hospital,‡ 74% can discharge from a hospital, 74% can write orders without a physician co-signature, and 64% can admit patients. This difference reflects the greater degree of integration of nurse-midwives into the hospital systems where they work, in part due to the long history of registered nurses being integral care providers within hospitals.[14]

† Hospital privileges are permissions granted to medical providers, including midwives and physicians, to practice patient care at a specific hospital.
‡ "Hospital rounding" refers to the provider assessing their patients in the hospital and creating care plans.

Midwives report varying levels of understanding and respect from physicians.

Most NMs at least "somewhat agree" that physicians, especially their backup physicians, understand and advocate for the midwifery model of care. In contrast, most LMs disagree that local physicians understand and advocate for the midwifery model of care. Slightly more than half of LMs (51%) agree that local physicians who collaborate or accept their transfers understand and support the midwifery model of care (Figure 3).

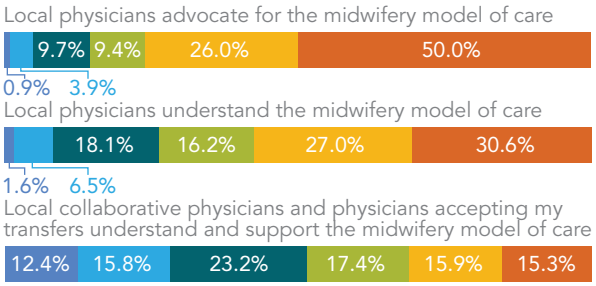
Many NMs agree that they feel valued and supported by physicians they work with:§

- 94% "strongly agree" or "agree" with the statement "physicians support my patient care decisions."
- 93% "strongly agree" or "agree" with the statement "physicians in my practice setting trust my patient care decisions."
- 87% "strongly agree" or "agree" with the statement "I feel valued by my physician colleagues."

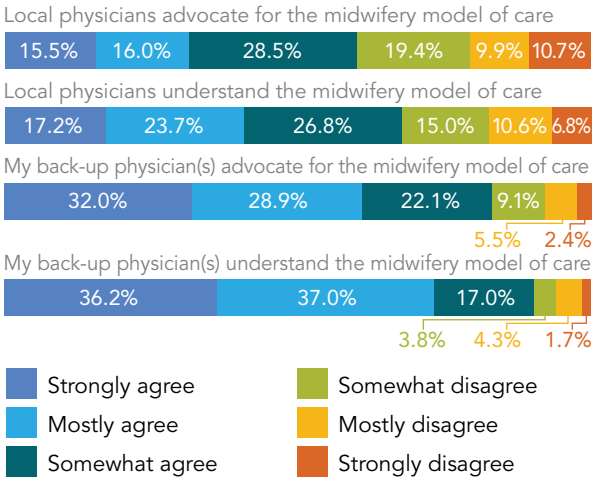
§ LMs were not asked these questions.

Figure 3. Physician Understanding and Advocacy for Midwifery Care, Licensed Midwives and Nurse-Midwives, California, 2023

Q (LM): Please rate the degree of your agreement with these statements.



Q (NM): Please rate the degree of your agreement with these statements regarding your principal NM position.



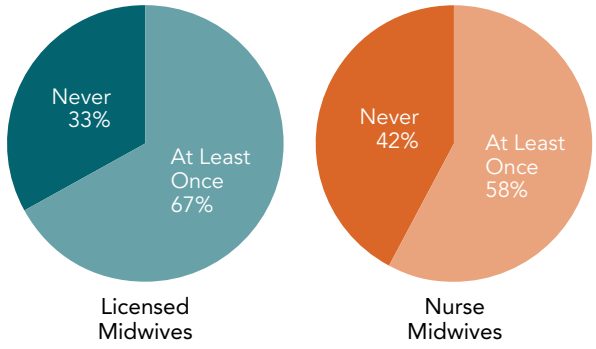
Notes: Number of cases – LMs = 161, NMs = 173. Data are weighted to represent all LMs and NMs with active California licenses. Data reported only for respondents who answered these questions.

Sources: *Survey of California Nurse Practitioners and Nurse-Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023); and *Survey of California Licensed Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023).

Most midwives have experienced unprofessional or hostile behavior from physicians. Two-thirds of LMs (67%) and 58% of NMs report having experienced unprofessional or hostile behavior from a physician in relationship to their roles as midwives at least once in the past three years (Figure 4). Among those who had such experiences, LMs reported an average of 6.8 incidents, and NMs had an average of 6.2 incidents in the past three years.

Figure 4. Unprofessional or Hostile Experiences with Physicians in the Past Three Years, Licensed Midwives and Nurse-Midwives, California, 2023

Q: How many times in the past 3 years have you experienced unprofessional or hostile behavior from a physician in relationship to your role as a midwife?



Notes: Number of cases – LMs = 180, NMs = 182. Data are weighted to represent all LMs and NMs with active California licenses. Data reported only for respondents who answered these questions.

Sources: *Survey of California Nurse Practitioners and Nurse-Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023); and *Survey of California Licensed Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023).

LMs face significant challenges contracting with and billing health plans, including Medi-Cal.

The ability to contract with and receive adequate reimbursement from insurers, including Medi-Cal, is critical to serving as a maternity care provider. In California, 41% of births are paid by Medi-Cal and 53% by private insurers.[15] Although only 2% of all births in California are self-paid, practicing LMs report that over half of the care they provided (54%) was self-paid, with no anticipated insurance reimbursement.

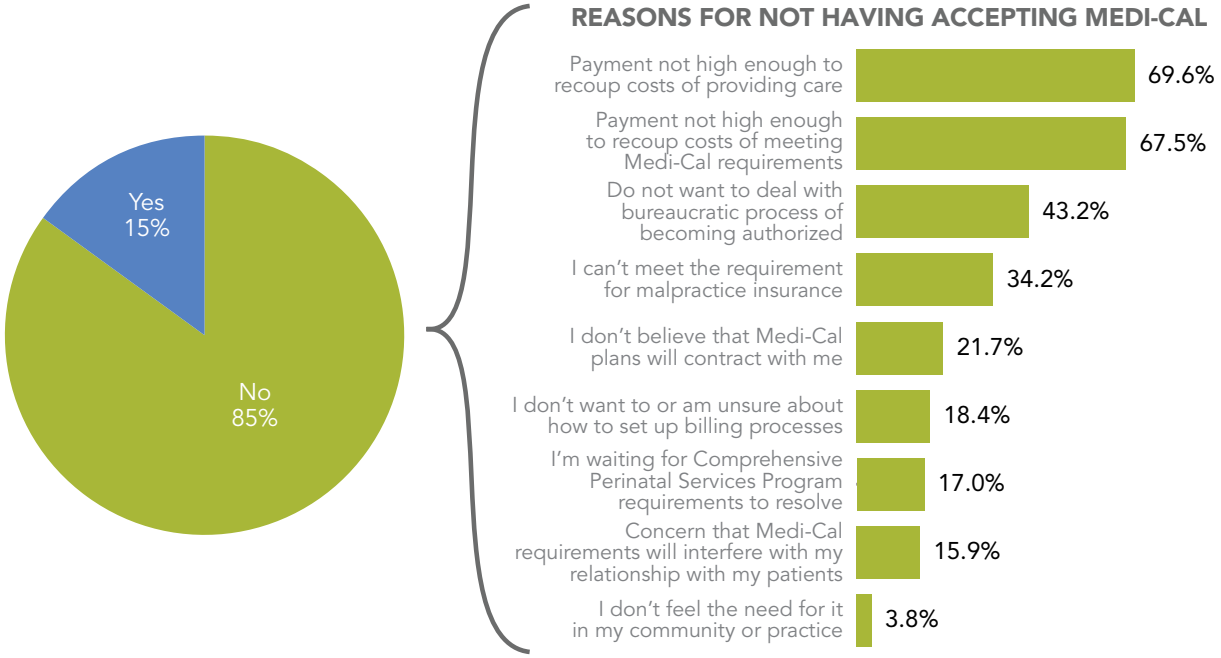
Eighty-five percent of LMs do not accept Medi-Cal insurance, with 70% of LMs reporting the lack of adequate Medi-Cal reimbursement and 43% citing the bureaucratic challenges of provider enrollment among the top reasons for not accepting Medi-Cal (Figure 5).

A majority of LMs identify billing and reimbursement from insurance plans as problems in their practices, especially denial of coverage/care decisions by insurance companies, with 62% reporting that as a "major" and 27% as a "minor" problem. Fewer NMs identify billing and reimbursement as problems interfering with the care they provide (Figure 6).

The different experiences of LMs and NMs is likely due to the differences in their practice settings; most NMs are employed by health care organizations that handle health plan contracting and billing, while most LMs are solo or small-business owners.[16]

Figure 5. Medi-Cal Accepted at Licensed Midwife Practices, California, 2023

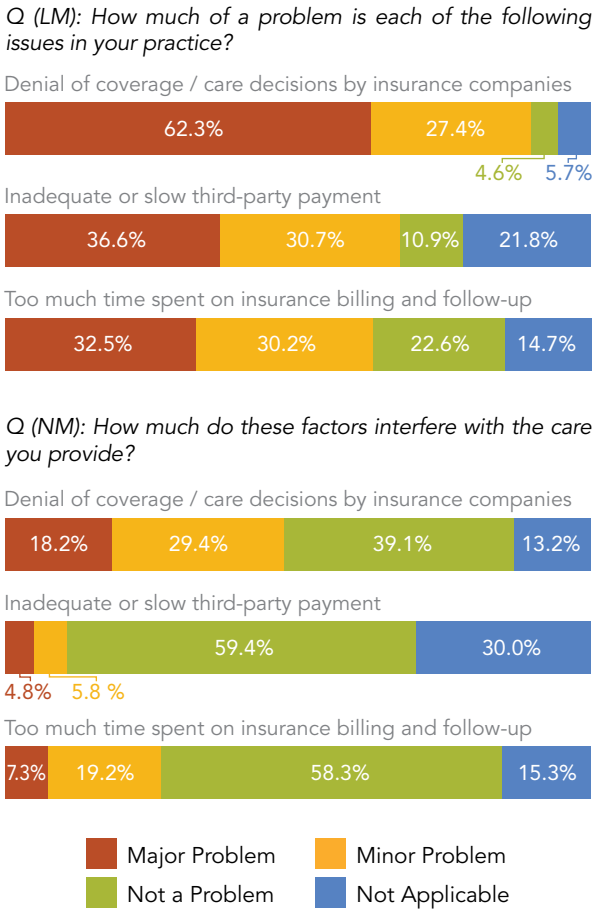
Q: Do you accept Medi-Cal payment, individually or through the practice in which you provide midwifery care? If no, why not? Check all that apply.



Notes: Number of cases – accept Medi-Cal = 156, reasons for not accepting = 132. Data are weighted to reflect the full statewide population of LMs with active California licenses. Data reported only for respondents who answered this question. Other not shown.

Source: *Survey of California Licensed Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023).

Figure 6. Barriers Related to Contracting with and Billing Health Plans, Licensed Midwives and Nurse-Midwives, California, 2023



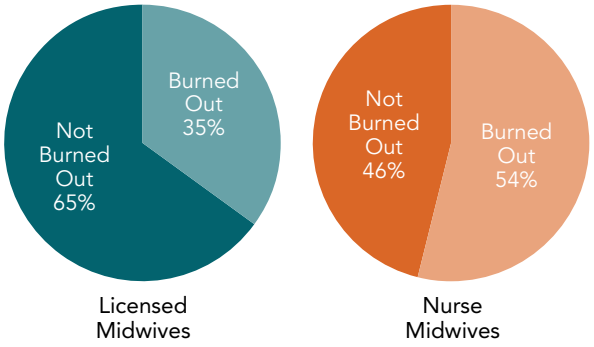
Notes: Number of cases – LMs = 156, NMs = 169. Data are weighted to represent all LMs and NMs with active California licenses. Data reported only for respondents who answered these questions.

Sources: *Survey of California Nurse Practitioners and Nurse-Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023); and *Survey of California Licensed Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023).

Despite high levels of career satisfaction, many midwives report feeling burned out.

Most practicing midwives report high levels of career satisfaction: two in three LMs (66%) and three in four NMs (76%) say they are "very satisfied" or "satisfied" with their midwifery careers. Thirty-five percent of LMs and 54% of NMs reported feeling burned out, based on a validated composite measure of nine statements related to emotional exhaustion (Figure 7).[17]

Figure 7. Burnout, Licensed Midwives and Nurse-Midwives, California, 2023



Notes: Number of cases – LMs = 155, NMs = 168. Data are weighted to represent all LMs and NMs with active California licenses. Data reported only for respondents who answered these questions. Midwives were asked a series of questions to ascertain the extent to which they were experiencing burnout, which was measured using the 9-item Emotional Exhaustion subscale of the Maslach Burnout Inventory Human Services Survey. Burnout was defined by a cut-off of ≥ 27 on the emotional exhaustion scale.

Sources: *Survey of California Nurse Practitioners and Nurse-Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023); *Survey of California Licensed Midwives* conducted by UCSF (July 18, 2022 to March 31, 2023); and Christina Maslach & Susan E. Jackson, MBI - Human Services Survey for Medical Personnel: Copyright ©1981 (Mind Garden, Inc., 2016).

THE TAKEAWAY

Research shows that midwives deliver high-quality clinical outcomes and high levels of patient satisfaction. Today, midwives in California, especially LMs, are often restricted from practicing to the full extent of their license or expertise and frequently experience challenging relationships with hospitals, physicians, and health plans. Truly integrating midwives into maternity care in California requires ensuring access to midwives who have professional autonomy, respectful inclusion as members of the health care team, and broad insurance coverage of midwifery services in both hospital and community settings.

Appendix. Survey Methodology

The Survey of California Nurse Practitioners and Nurse-Midwives and the Survey of California Licensed Midwives were conducted by the University of California San Francisco (UCSF) from July 18, 2022 to March 31, 2023.

UCSF worked with an advisory group of stakeholders to develop the survey questionnaires. The nurse practitioners / nurse-midwives (NP/NM) survey development included reviewing the 2017 California Board of Registered Nursing Survey of Nurse Practitioners, the Nurse Practitioner Primary Care Organizational Climate Questionnaire, and the 2018 National Sample Survey of Registered Nurses and consulting staff at the California Nurse-Midwives Association. The licensed midwives (LM) survey development included reviewing the NP/NM questionnaire for relevant questions to include and consulting staff at the California Association of Licensed Midwives.

The NP/NM survey was sent to 700 NMs (400 licensed NMs and 300 dual-licensed NP/NMs) with active NM licenses and addresses in California. The NP/NM survey was also sent to 3,300 licensed NPs, but their responses were not included in this report. The sample of NMs was selected from the publicly available mailing list of NMs obtained from the Board of Registered Nursing (BRN), which included names and addresses. The NM survey sample was stratified by region to ensure adequate numbers in each region for regional analyses.

The LM survey was sent to all 437 LMs with active LM licenses and addresses in California. The list of LMs was obtained from a publicly available mailing list maintained by the Medical Board of California, which included names and addresses. All LMs with active licenses and addresses in California were included in the LM survey sample.

The survey was administered both online and via a paper survey mailed to NMs and LMs to maximize the response rate. The survey was sent by email to 162 NMs (102 NMs and 60 dual-licensed NP/NMs) and 287 LMs. A paper version of the survey was mailed to all NMs and LMs who did not already complete the online version. The survey packet included information on how to complete the survey, the survey instrument, a postage-paid return envelope, and a link and instructions for accessing the online version of the survey. Approximately 52.4% of NMs completed the NP/NM survey online, and 78.2% of LMs completed the LM survey online. Upon survey completion, respondents received a $5 gift card.

A total of 267 NMs (149 NMs and 118 dual-licensed NP/NMs) completed the survey, for a 39.5% response rate for the eligible population. A total of 24 cases were determined to be ineligible due to the survey packet being returned for lack of a current mailing address.

A total of 229 LMs completed the survey, for a 56.4% response rate for the eligible population. A total of 31 cases were determined to be ineligible due to the survey packet being returned for lack of a current mailing address.

To address differential response rates by age group and region, and to account for the stratification of the sample design, weights were used to ensure that all analyses reflected the full statewide population of NMs with active California licenses. The responses were weighted per the sample design (regional stratification) and then the weights were raked to match the age distribution of each of NM and NP/NM based on BRN reports. The sample size and weighting ensure that the data presented in this report are representative of the statewide population of NPs.

To address differential response rates by region, and to account for the stratification of the sample design, weights were used for the LM survey data to ensure that all analyses reflected the full statewide population of LMs with active California licenses.

The sample sizes and weighting ensure that the data presented in this report are representative of the statewide population of NMs and LMs. Unweighted tables based on the full data sets of 267 NMs and 229 LMs with active licenses may vary from the true population values by +/-3.05 percentage points from the values presented, with 95% confidence. The use of weights improves the accuracy and representativeness of the reported tabulations and means presented in this report.

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About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. "Feeling Pushy?," The Big Push for Midwives Campaign, 2024. There is a third national midwifery credential, "certified midwife." The CM credential is not legally recognized in California but is recognized in 11 other states and the District of Columbia. The CM has the same scope of practice and competencies as the CNM but without the requirement to be an RN.
2. Molly R. Altman et al., "The Cost of Nurse-Midwifery: Use of Interventions, Resources, and Associated Costs in the Hospital Setting," Women's Health Issues 27, no. 4 (July-August 2017): 434–40; Laura Attanasio and Katy B. Kozhimannel, "Relationship Between Hospital-Level Percentage of Midwife-Attended Births and Obstetric Procedure Utilization," Journal of Midwifery & Women's Health 63, no. 1 (January 2018): 14–22; Mary J. Renfrew et al., "Midwifery and Quality Care: Findings from a New Evidence-Informed Framework for Maternal and Newborn Care," Lancet 384, no. 9948 (September 20, 2014): 1129–45; Jane Sandall et al., "Midwife Continuity of Care Models Versus Other Models of Care for Childbearing Women," Cochrane Database of Systematic Reviews 4 (2024); and Petra ten Hoope-Bender et al., "Improvement of Maternal and Newborn Health Through Midwifery," Lancet 384, no. 9949 (September 27, 2014): 1226–35.
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5. Lisa Dubay et al., "Improving Birth Outcomes and Lowering Costs for Women on Medicaid: Impacts of 'Strong Start for Mothers and Newborns,'" Health Affairs 39, no. 6 (2020): 1042–50.
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8. "Natality Information: Live Births" (2007–2023), CDC WONDER Database, US Centers for Disease Control and Prevention, accessed December 6, 2024.
9. Projections of Supply and Demand for Women's Health Service Providers: 2018–2030 (PDF), US Department of Health and Human Services, March 2021; and Kristen Hwang, Erica Yee, and Ana B. Ibarra, "California's Maternity Care Crisis Is Worsening as Newsom Decides on Bills to Slow Closures," CalMatters, September 16, 2024.
10. Y. Tony Yang, Laura B. Attanasio, and Katy B. Kozhimannil, "State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes," Women's Health Issues 26, no. 3 (May-June 2016): 262–67.
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