

Testimony  
of  
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DISPARITIES:

The most serious disparities in pregnancy outcomes in the U.S. occur in African-Americans.

Black babies in the U.S. have always been twice as likely to die before their first birthday as white babies but in the last decade these figures have gotten far worse in many states. (Appendix A) In Florida the black/white infant death ratio has gone from 1.9/1.0 in 1970 to 2.6/1.0 in 2005. Last year in Hillsborough County (Tampa) the black infant death rate was 4x that of whites.

Maternal mortality among black women is a serious concern also:

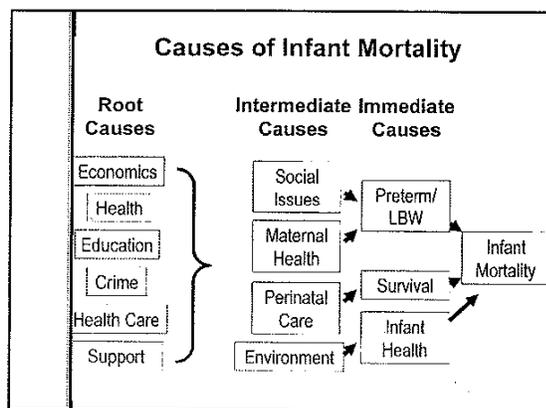
Maternal Mortality – U.S.

<u>1996</u>	<u>2006</u>
Total: 8/100,000	13.3/100,000
Black 20/100,000	33/100,000
White 6/100,000	9.5/100,000

(U.S. goal for 2010 = 4.3/100,000)

Florida has the highest number of black babies born in the U.S. at 56,904 in 2006. (Appendix B)

Many factors enter into causing infant deaths as depicted in the chart below:



Problems with root causes are often more severe in poor black communities in the U.S. However poor white women are often impacted by a different set of root causes, for instance, whites in Appalachia have huge issues with prescription drug abuse with 25% of our pregnant women cared for by the Frontier Nursing Service in Kentucky addicted to oxycodone or similar drugs. The resources to deal with addiction in pregnancy are scarce all over the U.S. and many obstetricians refuse to care for substance abusing pregnant women.

More recent studies of the difficult issue of black infant mortality in the U.S. point to an intergenerational effect – black mothers who themselves were prematurely born are more likely to have premature babies. This effect, called “weathering” by obstetrician Michael Liu at UCLA, seems to defy health care intervention, being so deep-seated in social problems as root causes. Because of this, if the U.S. somehow manages to perfect the delivery of health and health care to black families, it is estimated that, at most, that would impact 30% of the prematurity problem. Adding elective cesareans to the mix (black women in the U.S. have had the highest cesarean rates of any group for over 10 years) only compounds the problem. (Appendix C)

## PUBLIC HEALTH INTERVENTIONS TO REDUCE PREMATURITY

### IMMEDIATE STEPS:

1. Medicaid – stop paying for elective inductions and elective cesareans at any stage of pregnancy – even 39 weeks and above.
2. INFORMED CONSENT – Insist that true informed consent be given to pregnant patients at the beginning of the third trimester to be read and discussed at least 8 weeks before the due date. These should especially highlight the dangers of elective induction and cesarean to the baby. (Appendix D1, D2)
3. Vaginal Birth After Cesarean (VBAC): Put tiered financial incentives for providers in insurance programs to encourage VBAC since babies are healthier after VBAC than repeat cesarean. (Appendix E)  
Proposed scale:            VBAC – \$2,000  
   Vaginal birth – \$1,500  
   C-section - \$1,000

### SHORT TERM (1 YEAR):

4. Encourage new pregnancy provider models:
  - Midwives and doulas do basic primary care on all pregnant women and co-manage high risk women with maternal-fetal medicine specialists. (Appendix F, G, H)
  - Pay midwives full amount paid to obstetricians for managing normal pregnancy. (Equal pay for equal work.)
  - Encourage change to group prenatal care (from individual visits).
  - Stop funding the training of generalist OB/GYN's and invest in the training of maternal-fetal medicine specialists to back up groups of midwives.
  - Move away from hospital birth to out-of-hospital birth centers except for high-risk women. (Appendix I, J)
5. Quality Standards:

MCH Bureau (HRSA), AHRQ, CMS and CDC work with MOD and provider organizations (ACOG, ACNM, AAP, APHA, etc.) to outline quality standards for perinatal care and encourage states to use them to build their own state perinatal quality improvement initiatives. (Ohio, California, North Carolina and Florida have already begun this process.) This should include a list of procedures Medicaid will pay for (medical or OB high risk) and those they will not pay for (elective procedures). (Appendix K, L)
6. Preconception and Interconception Care:

Building on the excellent work of the CDC and MOD the past four years, Medicaid and private insurance companies should develop a panel of pre-pregnancy

interventions (diabetes & HIV testing, folic acid Rx, etc.) that providers can use to be sure the woman and her family are ready for a pregnancy and then advertise so that pre-pregnancy visits become as routine as prenatal care itself.

In the interconception period all women should receive a pregnancy spacing method of their choice and the provider should be paid a fair price for this service. (Not happening now in some states' Medicaid waivers.) Women with chronic diseases (diabetes, hypertension) should be followed closely between pregnancies and not just dropped by insurance after the post-partum visit as they are now in many parts of the country.

7. COST SAVINGS:

Pregnancy is the number one diagnosis for hospital admissions in the U.S. and cesarean is the number one operation performed.

Maternal and newborn charges – U.S.

2005 - \$79B

2006 - \$86B

More than \$2.5B was spent on unnecessary cesareans. Eliminating elective inductions and cesareans would also save hundreds of millions of dollars in unnecessary NICU admissions but untold amounts in the long term expenses of late preterm birth (special education, etc.) due to lack of brain development. (Appendix M, N, O, P)

Conclusion:

Elective induction and cesarean and the resulting late preterm births are serious public health problems in the U.S. – and quickly preventable. (Appendix PP)

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Addendum: DeClercq numbers analysis (appendices Q →FF)