March 2004

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https://doi.org/10.15779/Z38XW47V7P

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The Business of Birth:

Obstacles Facing Low-Income Women in Choosing Midwifery Care After the Licensed Midwifery Practice Act of 1993

Sara K. Hayden†

I. INTRODUCTION

Despite a popular perception of California as the homeland of alternative living, women in this state could not legally choose to have a homebirth attended by a lay midwife until 1993. The California Supreme Court ruled in 1976 that the "right of privacy had never been interpreted so broadly as to protect a woman's choice of the manner and circumstances in which her baby is born." Thus, in order to protect the state's interest in the health of its citizens, including its unborn citizens, the Legislature could "require that those who may assist in childbirth have valid licenses." Yet, California had not licensed lay midwives since 1949. By requiring that midwives have valid licenses in order to assist in

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† J.D. Candidate, Boalt Hall School of Law, University of California at Berkeley. The author would like to thank Kathy Roberts and Helga Hakimi for their enduring support—editorial and otherwise. Thanks to Stephanie Pham-Quang for her editorial assistance. Finally, thanks to the members of the Berkeley Women's Law Journal for the opportunity to publish this piece.
1. California now licenses two types of midwives: the direct-entry, or lay, midwife and the nurse midwife. CALIFORNIA ASS'N OF MIDWIVES, at http://www.californiamidwives.org/midwifery.html (last visited Feb. 23, 2004). This recent development concerns direct-entry midwives, and will refer to them as direct-entry midwives licensed midwives, or midwives. Certified nurse midwives will be referred to as such.
3. Id.
4. As early as 1917, direct-entry and nurse midwives were required to register with the state. A certification program began in 1937, but stopped in 1949. Though midwifery was not outlawed explicitly, it was illegal to practice midwifery without a license, and no new licenses were granted after 1949. Midwives who were licensed before 1949 were able to renew their licenses after the certification program ended. RAYMOND G. DEVRIES, MAKING MIDWIVES
childbirth, and at the same time denying them the opportunity to become licensed, the state both precluded midwives from legally practicing their art and women from having the legal option to choose midwives as birth attendants.

Finally, the Legislature passed the Licensed Midwifery Practice Act of 1993, which provided midwives a means to become licensed to provide perinatal care to women and their infants and to attend births that primarily occur in birthing women’s homes. Following several failed legislative bills since 1977, the Practice Act finally succeeded in recognizing midwives as professionals who provide healthy women a safe alternative to physician care and hospital births.

In the notes following the Practice Act, the Legislature explained the important role of licensed midwives, especially in providing care to low-income pregnant women. It emphasized the importance of prenatal care to the health of women and their infants, and included international research supporting the vital link between midwifery care and low prenatal mortality rates. Thus, in passing the Practice Act, the Legislature seemed to be actively supporting the health of California citizens.

But the statute also placed conditions on the practice of midwifery, thus restricting the professional autonomy of midwives. Amendments instituted in 2000 partially addressed these restrictions, but midwives continue to practice in a gray zone, where they are legally and effectively subordinate to the medical establishment. Ironically, such legislation reinforces historically inaccurate perceptions of the profession and undermines access to midwifery care. In fact, despite legislative intent, low-income women have been the least able to utilize midwifery care because of the state’s failure to mandate that Medi-Cal and health maintenance organizations (“HMOs”) include midwives as approved providers.

Thus, the Practice Act expanded, albeit incompletely, the scope of legal birth options for women. But the Legislature does not guarantee the availability of all or any state-approved safe options across all communities, so actual access and availability may restrict the exercise of choice. In addition, the Practice Act has no bearing on the women who arguably would benefit the most from the greater range of birth options—low-income women unable to pay for midwifery services.

This recent development explores the effects of the Practice Act on a woman’s choice of circumstances in which her baby is born. Specifically, this

6. Perinatal means the period from the establishment of pregnancy to one month following delivery. CAL. WELF. & INST. CODE § 14134.5(b) (West 2003).
8. CAL. BUS. & PROF. CODE § 2505, Historical and Statutory Notes.
9. Id.
10. Id. § 2507 (requiring licensed physician or surgeon supervision).
11. Id. §§ 2505-21.
piece will consider the Practice Act’s effects on low-income women in California and their birth choices. In so doing, this piece will focus on the role of economics in the midwives’ battle for legal recognition, and in low-income women’s access to midwifery care. It will ultimately show that the state has failed to honor its recognized interest in the health of its citizens above the economic interests of the medical establishment. Specifically, the state both has prevented midwives from practicing without unnecessary obstacles and has failed to mandate that all insurance providers and health programs, including HMOs and Medi-Cal, expand their coverage to include licensed midwives.

The first section will provide a brief history of American midwives, including the legal, political, and societal tensions that still exist today. The second section will describe the specific legal status of midwives in California and the legal and practical implications of the Practice Act on their profession. The third section will evaluate the effects of the Practice Act on low-income women in California, both as citizens and as consumers, and will highlight the obstacles that prevent them from choosing midwives as birth attendants. Finally, the last section will address this issue within the scope of reproductive rights and will argue that the State’s interest in the health of its citizens will best be served by fully legitimizing licensed midwifery. To accomplish this, the State must enact policies that support the independent practice of midwifery and a woman’s ability to access and pay for midwives.

II. THE HISTORY OF AMERICAN MIDWIFERY

In the late nineteenth century, the predominantly male medical profession began to dominate birth rooms, which had long been the untouchable domain of female attendants. A shift in birth settings—from the home to the hospital—accompanied this shift in birth attendants. In 1900, midwives attended about 50% of births, while over 95% of women gave birth at home. At this time, Americans began to perceive obstetricians, hospital births, and medical interventions as modern advancements and safer alternatives to home births with midwives. Today, physicians attend 95% of births, while 99% of births occur in hospitals.

To distinguish themselves from midwives and legitimize their profession, physicians realized that pregnant women would have to voluntarily choose to

13. Id. at 133; see also Jessica Mitford, The American Way of Birth 166 (1992).
14. Wertz & Wertz, supra note 12, at 133.
pay higher fees for their services.17 While it is true that physicians provided medical technology that benefited women with difficult births, they did not restrict their practice to high-risk births. Rather, physicians began to represent every birth as a “potential disaster.”18 “In order to triumph over [female] modesty, medicine had to convince the public that childbirth was inherently pathological and unsafe, a dangerous condition that required the attention of the more highly valued male birth attendants.”19

Yet evidence did not support the perceived safety benefits of obstetrics over midwifery. In 1933, the White House Conference on Child Health and Protection issued a report declaring that the maternal mortality rate had not decreased between 1915 and 1930 despite the “increase in hospital delivery, the introduction of prenatal care, and more use of aseptic techniques.”20 In fact, the infant mortality rate increased by 40% to 50% from 1915 to 1929.21 The report attributed the increase to lack of adequate prenatal care and to “excessive intervention, often improperly performed.”22 Still, hospital births became the norm. Accordingly, the locus of power in birth shifted—women, for the sake of safety, became passive participants as the physicians became the experts.23 Physicians were able to provide drugs to women that partially or completely eradicated the pain of childbirth. Typically, such relief rendered a woman completely unconscious and unable to participate actively in pushing her infant out.24

Physicians strongly lobbied state legislatures to regulate midwifery, which they cast as an illegitimate practice of uneducated and unsanitary women.25 Because of the generally low economic and political status of women at this time, midwives were not able to compete against the powerful force of these lobbyists. States responded by strictly regulating or completely outlawing midwives. Though the demand for midwives decreased, regulations also restricted the supply of midwives.26 Women practically lost a way of giving birth, and midwives almost lost their profession.27 Despite legal and societal hostility over the past

18. WERTZ & WERTZ, supra note 12, at 136.
20. WERTZ & WERTZ, supra note 12, at 161.
21. Id.
22. Id. Today, maternal and infant mortality rates are lower than they were in the early twentieth century. ANN OAKLEY, THE CAPTURED WOMB 86-115 (1984). Scholars today attribute the gradual decrease in mortality that was to follow for both midwife- and physician-attended births, to sanitation, better nutrition, and public health. Gibson, supra note 15, at 285.
23. WERTZ & WERTZ, supra note 12, at 136.
24. Id. at 150-54.
25. Id. at 213-14.
27. Peizer, supra note 19, at 141.
century, midwives have continued to practice their art, even outside the law.28

Modern Midwifery

Modern midwifery care is antithetical to the highly interventionist American medical model of birth that typically places the woman in a role subordinate to the physician.29 It is an attentive, women-centric model of care that provides continuous assistance to women throughout labor.30 Midwives are holistic practitioners who approach childbirth as an emotionally, socially, culturally, and spiritually meaningful life experience that can empower women.31

Midwives are experts in normal pregnancies.32 Physicians are experts in pathology trained to approach each birth as a potential emergency.33 According to the current midwifery standard, such an approach is appropriate and necessary only with high-risk pregnant women who have recognized diseases or serious complications.34 Yet, though at least seventy percent of childbearing women are healthy throughout their pregnancies and have normal childbirths, physicians attend 95% of births.35

III. THE LICENSED MIDWIFERY PRACTICE ACT OF 1993

Before 1993, midwives in California existed in a legal gray zone and could be prosecuted under California’s Medical Practice Act, which prohibited the practice of medicine without a license.36 Despite the possibility of prosecution, by the late seventies, there were an estimated 400 midwives practicing without a license in California.37 Since the passage of the Practice Act, midwives can obtain licenses, but conditions of licensure and insurance policies still restrict their ability to practice fully.38

The Practice Act was finally adopted in part because the California Medical Association approved the bill instead of lobbying against it.39 But the Medical Board’s support was contingent on midwives replacing their wording of the bill with the Medical Board’s language, which largely duplicated the language of

28. DEVRIES, supra note 4, at 71-87.
29. Id.
31. Id.
32. Id.
33. Id.
34. Id.
36. DEVRIES, supra note 4, at 48.
37. Id. at 73.
the statute that provided for licensed nurse midwives in 1974, including a physician supervision requirement. As currently written, the statute compromises the professional autonomy of midwives.

The supervision requirement both fails to recognize midwives as autonomous professionals and imposes an obstacle on midwives, preventing them from fully complying with the law. As noted above, midwives train outside of the "normal" medical system and abide by a different model of care. They recognize the important role that physicians, as colleagues, have in complicated high-risk pregnancies, but do not consider them to be authority figures in normal births.

Proponents of the supervision requirement point out that midwives do not have adequate medical training and that physicians are needed to provide safe care to women and infants. Under the Practice Act, a midwife must satisfy educational and experience requirements before she can take the licensing examination. As the legislature recognized in the 2000 amendment, the midwifery model of care includes "identifying and referring women who require obstetrical attention." Midwives themselves recognize the importance of modern obstetrics in a comprehensive health care system. A consultative relationship between midwives and physicians would allow both sets of professionals to do what they do best—the former, providing attentive care to healthy women with normal pregnancies, and the latter, providing expertise in emergencies and difficult births.

In addition to dealing with the constraints on their professional independence, midwives have had great difficulty in finding physicians who are willing to supervise. Even in instances when a physician may choose to supervise a midwife and provide emergency backup, insurance restrictions likely will prevent her from doing so: "Subsequent to the [Practice] Act, almost all medical malpractice insurance carriers included provisions in their policies that either discontinued coverage or dramatically increased premiums when physicians began to supervise midwives." Without physician supervision, a licensed midwife exposes herself to the risk of legal prosecution and compromises her ability to procure liability insurance.

40. Gaskin, supra note 39, at 21; see also CAL. BUS. & PROF. CODE § 2746.5 (West 2004).
41. See generally Suzanne Hope Suarez, Midwifery Is Not the Practice of Medicine, 5 YALE J.L. & FEMINISM 315 (1993).
42. Id.
43. A midwife must successfully complete a Board-accredited three-year postsecondary education program and pass a comprehensive licensing examination developed by the North American Registry of Midwives ("NARM"), MEDICAL BOARD OF CALIFORNIA, LICENSED MIDWIVES at http://www.medbd.ca.gov/Midwives.htm (last visited Feb. 23, 2004).
44. CAL. BUS. & PROF. CODE § 2508, Historical and Statutory Notes.
45. Gibson, supra note 15, at 324.
46. Happe, supra note 26, at 722-23.
47. Id. at 713.
48. Lack of liability insurance is not a legal obstacle to practice, but the 2000 amendment requires that the midwife disclose the fact to her client. CAL. BUS. & PROF. CODE § 2508(a)(2) (West 2003).
In 2000, the amendment to the Practice Act changed the requirement that a licensed midwife needs to disclose to her clients "that a specific physician is being briefed regularly concerning the client's pregnancy" to a requirement that she disclose the specific arrangements in case of an emergency. As submitted to committee, the bill proposed to change the relationship between physician and midwife from one of "supervision" to one that is "consultive." However, the committee rejected this change, and the amendment describes the relationship as "supervising." The amendment is a step toward greater autonomy of practice for the licensed midwife because it does not require her to consult with a physician throughout the care of her client, although it still requires that she have a supervising physician.

Despite the norm of the obstetrical approach to birth, the United States ranks at the bottom in perinatal mortality for the twenty-five industrialized countries. Greater interventions have not translated into the greater health of infants. The California Legislature identified the correlation between midwifery care and infant health in its notes to the Practice Act, stating that the "five nations with the lowest prenatal mortality rates have 70 percent of all births attended by midwives."

Significantly, the California Legislature also recognized in its findings of the 2000 amendment to the Practice Act that:

Numerous studies have associated professional midwifery care with safety, good outcomes, and cost-effectiveness in the United States and other countries. California studies suggest that low-risk women who choose a natural childbirth approach in an out-of-hospital setting will experience as low a perinatal mortality as low-risk women who choose a hospital birth under management of an obstetrician, including unfavorable results for transfer from the home to the hospital.

If midwifery is a safe option, why the continued resistance of physicians, medical associations and the State in allowing midwives to work collaboratively in a health care system that respects their professional authority and autonomy?

Generally, more educated and affluent consumers choose nonphysician health care providers, which is arguably one of the reasons organized medicine fights so strongly against legislative recognition and hospital privileges for alter-
native practitioners. There is a market battle for the consumer's dollars. In fact, the State, in refusing to license midwives, was not defending its interest in the health of its citizens, but was defending the medical establishment's economic monopoly over birth. Birth is big business—it is the "single most common cause for hospitalization, accounting for over 20% of all hospital charges for women." The midwives' fight for licensure was largely about the battle between the medical establishment and midwives for the consumers' money.

The physician supervision requirement in the Practice Act is a typical provision of laws that legitimize some aspect of alternative care. Such provisions assure that physicians still get paid and are able "to retain control by enabling the licensing board dominated by physicians to determine what the alternative providers may or may not do." Alternative care providers, who have been able to show that they wish to serve a "less desirable" consumer group—such as low-income or geographically removed patients—have more readily gained legal recognition through licensure. But the licensure requirements tend to restrict their professional autonomy. Such is the case with the provisions of the Practice Act.

The notes of the Practice Act emphasize that low-income women in California were not getting the adequate prenatal care "that reduce[d] the incidence of low-birth weights." Thus, as part of a cost-effective approach to better health care, licensed midwives could provide "prenatal, delivery and necessary followup care to families." Yet, in defiance of its own intent, the Legislature continues to impede women, especially low-income women, from accessing midwifery care and choosing home births.

IV. WOMEN—CITIZENS AND CONSUMERS

Pregnant women may not realize that there are options other than a physician-attended hospital birth, especially within a birthing culture defined by medical and insurance systems that prescribe "the American way of birth"—the obstetrical model. But many women who do choose midwives, now the alternative providers, want greater control over one of the most important and intimate

59. Id.
60. PEW REPORT, supra note 55, at 1.
63. Id.
65. Id.
66. CAL. BUS. & PROF. CODE § 2505, Historical and Statutory Notes.
67. Id.
experiences of their lives. These women object to routine obstetric practices as well as to impersonal and isolated hospital settings. Feminism has played a role in developing “a new consciousness among women in which good health and reproductive freedom are key issues.”

Similar to other healthcare issues within America today, access to midwifery services is often spoken of in terms of cost effectiveness. Supporters of the first defeated predecessor to the Practice Act emphasized the cost effectiveness of midwifery services relative to obstetric care. They added that an insufficient number of obstetricians accepted patients with Medi-Cal, just one of the reasons only 27% of the state’s pregnant women were receiving adequate prenatal care. The emphasis on the cost-effectiveness backfired because “representatives of minorities had assumed that cheaper care meant inferior care and that the state was trying to save money at the expense of the poor.”

Nearly twenty years later, the same sell worked. The Practice Act’s sponsor, State Senator Lucy Killea of San Diego, offered that midwives could be crucial in getting prenatal care to low-income women and thus perhaps lowering the number of low-birth-weight babies and the infant mortality rate. The Historical and Statutory Notes of the Practice Act emphasize both the cost savings of licensed midwifery services to the state and the lack of physicians available to serve low-income women. Despite these concerns for low-income mothers, the Legislature did not at that time substantiate its intent by expanding Medi-Cal coverage to include licensed midwives.

A woman’s right as a citizen within a community to choose a homebirth attended by a midwife is dependent upon her power as a consumer. Low-income women have been the least able to access midwifery care. Insurance and other forms of health care coverage, including Medi-Cal, are a huge factor in this disparity.

Currently, California law requires that disability insurance providers that cover perinatal services “shall contain a provision for direct reimbursement to licensed midwives for perinatal services rendered under terms and conditions as may be agreed upon between the policyholder and the insurer.” Pregnant women with disability insurance can use this law as a basis to negotiate with their insurers to be reimbursed for midwifery expenses. At any socioeconomic

68. See Andrews, supra note 58.
69. Charles Wolfson, Midwives and Home Birth: Social, Medical, and Legal Perspectives, 37 HASTINGS L.J. 909, 918-23 (1986).
70. Peizer, supra note 19, at 153.
71. DEVRIES, supra note 4, at 72-74. The bill was A.B. 1896, the Midwifery Practice Act of 1978. Id.
72. Id.
73. Id. at 75.
74. Gaskin, supra note 39.
75. CAL. BUS. & PROF. CODE § 2505(f) (West 2003).
77. CAL. INS. CODE. § 10354(a)(1) (West 2003).
level, women who have such coverage often find that the insurance carrier will not directly reimburse a licensed midwife, forcing women to pay up front for midwives' services and then seek reimbursement from the carrier.\textsuperscript{78} For those women "who cannot afford to pay the midwife out of their own pockets while they wait to get reimbursed, midwife-assisted births would not be economically feasible."\textsuperscript{79}

Women with disability health insurance are still in a better position than women who qualify for Medi-Cal, the State's version of Medicare, since there are no statutory requirements that Medi-Cal reimburse licensed midwives.\textsuperscript{80} Medi-Cal provides free, or nearly free, perinatal care to low-income women in the state.\textsuperscript{81} Fifteen percent of Californians are covered by Medi-Cal,\textsuperscript{82} which draws over $13 billion in federal funds a year.\textsuperscript{83} Currently, Medi-Cal does not cover licensed midwifery services, though it does cover certified nurse midwifery services.\textsuperscript{84}

The Legislature in the Practice Act's notes emphasizes the cost effectiveness of midwifery care. It states that "research has shown for every dollar society might spend to reduce the number of underweight births, three dollars ($3) in medical-care costs could be saved."\textsuperscript{85} It further explains that an "increasing state budget deficit limits the amounts of state funds available to subsidize public health care."\textsuperscript{86} Given the Legislature's emphasis on the cost effectiveness of midwifery care and the recognized safety of midwifery care, why does Medi-Cal not reimburse licensed midwives?

Physicians and medical boards are powerful political forces. In order to benefit from the cost effectiveness of midwifery care, the State needs to recognize licensed midwives as legitimate providers of perinatal care, not just as lesser physician substitutes. Medi-Cal reimbursement is an example of such recognition. If the State were to recognize midwives as independent practitioners, and not subordinate to physicians, more people might choose to become midwives,\textsuperscript{87} and more women would have the ability to choose midwives. The result would be greater market competition for physicians, and not just within the Medi-Cal demographic. Currently, women who choose midwives and homebirths are

\textsuperscript{78} Happe, supra note 26, at 730.
\textsuperscript{79} Id.
\textsuperscript{80} CAL. WELF. & INST. CODE § 51051 (West 2003).
\textsuperscript{81} Each of California's fifty-eight counties is given near total discretion in the implementation of its health insurance programs. CALIFORNIA HEALTHCARE FOUNDATION, MEDI-CAL GUIDELINES, available at http://www.chcf.org/topics/medi-cal/index.cfm (last visited Feb. 23, 2004).
\textsuperscript{82} Id.
\textsuperscript{83} Id.
\textsuperscript{84} CAL. BUS. & PROF. CODE § 51051 (West 2003).
\textsuperscript{85} Id. § 2505, Historical and Statutory Notes.
\textsuperscript{86} Id.
\textsuperscript{87} Since the licensure program began, over one hundred forty midwife licenses have been issued. There are over a thousand nurse midwives in California. MEDICAL BOARD OF CALIFORNIA, supra note 43.
more likely to be married, white, and more educated when compared to the general United States childbearing population. 88 This is the very demographic group that the medical establishment is interested in keeping as clients. Denying Medi-Cal reimbursement to midwives keeps them out of the mainstream.

Without Medi-Cal reimbursement for midwives, it is not more cost effective for low-income women to choose a midwife over a physician. Though the dollar-for-dollar figure is less for a licensed midwife-attended home birth than for a physician-attended hospital birth, this apparent cost effectiveness is undermined by the fact that Medi-Cal does not cover licensed midwifery services, but will completely pay for a hospital birth. Thus, a home birth is actually more expensive for a pregnant woman who qualifies for Medi-Cal. Though licensed midwives have been promoted as being able to provide cost effective perinatal care to low-income women, ironically, these women are not able to access licensed midwifery care unless they are able to pay out-of-pocket.

V. REPRODUCTIVE RIGHTS AND THE STATE

Reproductive rights encompass a woman’s decision to continue pregnancy and its consequences, including prenatal care and birthing options. “A woman’s interest in controlling her body during childbirth involves not only direct physical control of her body but also exercise of that bodily control as an expression of her identity.” 89 A woman’s ability to choose among birthing options depends on the actual availability of these options, including a midwife’s ability to practice.

The 2000 amendment to the Practice Act recognized that “every woman has a right to choose her birth setting from the full range of safe options available in her community,” 90 and that the midwifery model of care “should be a choice made available to all women who are appropriate for and interested in home birth.” 91 There is an optimistic interpretation that this language “negates [the] decision which stated the legislature has never recognized the right of child-bearing women to have control over ‘the manner and circumstances of childbirth.’” 92 But a woman is still restricted to choose among the “safe options available in her community,” 93 which are determined by the State and legitimized through licensure. Thus, a woman is not free to choose an option that has not been State approved.

But California has recognized that midwifery care is a safe option. Even as

90. CAL. BUS. & PROF. CODE § 2508, Historical and Statutory Notes.
91. Id.
92. Gibson, supra note 15, at 321; Happe, supra note 26, at 731.
93. CAL. BUS. & PROF. CODE § 2508, Historical and Statutory Notes.
licensed midwives are gaining ground in their battle for legal recognition and professional autonomy, low-income women in California have been left out. It is in the interests of both the State and women in California to make midwives more accessible. Low-income women do not receive adequate prenatal care to foster their health or that of their infants.\textsuperscript{94} Despite the strong legislative intent of the Practice Act, a woman’s ability to choose a licensed midwife and a home birth is directly linked to her socio economic class. Medi-Cal does not reimburse licensed midwives, and other insurance restrictions further impede midwives from accepting certain clients. A woman’s recognized right of choice as a citizen is meaningless if her economic status prevents its actual exercise.

A significant study has emphasized that “the midwifery model of care is an essential element of comprehensive health care for women and their families that should be embraced by, and incorporated into, the health care system and made available to all women.”\textsuperscript{95} To that end, this study—a joint report of the Pew Health Professions Commission and the University of California, San Francisco Center for the Health Professions—made recommendations, including the following:

Midwives should be recognized as independent and collaborative practitioners with the rights and responsibilities regarding scope of practice authority and accountability that all independent professionals share.

Every health care system should integrate midwifery services into the continuum of care for women by contracting with or employing midwives and informing women of their options.

Hospitals, health systems, and public programs, including Medicare and Medicaid, should ensure that enrollees have access to midwives and the midwifery model of care by eliminating barriers to access and inequitable reimbursement rates that discriminate against midwives.\textsuperscript{96}

Currently, a woman’s eligibility for Medi-Cal does not guarantee her access to a physician who will accept it, especially as the number of doctors who serve low-income women decreases.\textsuperscript{97} Likewise, if Medi-Cal reimbursed licensed midwives, there would be no guarantee that all midwives would decide to accept Medi-Cal patients. To address this problem, and in accordance with the findings that low-income women are receiving inadequate prenatal care and that midwifery care is not just a safe, but perhaps preferable, alternative to physician care, the State needs to implement programs and incentives to have licensed midwives provide care to this demographic group.

\textsuperscript{94} Id. § 2505, Historical and Statutory Notes.
\textsuperscript{95} PEw REPORT, supra note 55, at i.
\textsuperscript{96} Id. at ii-iii.
\textsuperscript{97} CAL. BUS. & PROF. CODE § 2505, Historical and Statutory Notes.
At the heart of this struggle is the medical establishment's fear that midwives, if allowed to practice fully, will compete for the consumer's dollar. Purported safety concerns are unfounded, as the Legislature itself recognized the quality of licensed midwifery care and the deplorable mortality rate in the United States despite the predominance of "more advanced" obstetrical care. In fact, women's health is being compromised in the current system that does not fully value or support midwifery care. Low-income women and their children disproportionately suffer the consequences.

As the "consumers" in this business of birth, women of all socio-economic levels need to stay outside of the framework of fear that paints each birth as a pathological event, and make informed and educated choices about the manner and circumstances of their births. By wielding this collective power, both as consumers and as citizens, women can refocus on the true priorities of their health and the health of infants. Midwives are crucial in this. Obstetrics has saved the lives of some mothers and infants, but its monopoly in birthing rooms has compromised the physical and spiritual health of many others. A health care system that incorporates the best of the obstetrical and midwifery models of care is in the best interests of women as individuals and the State as protector of its constituents' health.