



Rural America's OB Deserts Widen in Fallout From Pandemic

RURAL HOSPITALS ELIMINATING OB SERVICES SINCE 2011 TOPS 25%. MORE THAN 60 RURAL HOSPITALS DROPPED OB SERVICES DURING THE PANDEMIC'S PEAK.

As hospital closures and the loss of inpatient care continue to rattle rural communities, many of these communities are now also part of expanding “care deserts”—large swaths of rural America (sometimes covering thousands of square miles) where access to specific services does not exist.¹ This declining access is not driven just by rural hospital closures or conversion to operating models that exclude inpatient care. [Our research](#) has consistently shown that services such as obstetrics (OB) are quickly disappearing even in rural communities where hospitals remain open. A new analysis into the loss of access to OB services reveals the breadth of this rural healthcare crisis. Key findings include:

- 267 rural hospitals ceased providing OB services between 2011 and 2021.
- The loss of 267 rural OB units represents nearly 25% of America's rural hospital OB units.
- 63 rural hospitals dropped OB services during the height of the pandemic (2020 and 2021).
- Nearly 25% of hospitals that eliminated OB services since 2011 were considered “vulnerable to closure.”

As we examine this dramatic loss of access to OB services within rural communities, a new pressure point is also emerging in some states in the wake of the Supreme Court of the United States' ruling on *Dobbs v. Jackson Women's Health* (June 24, 2022). State laws triggered by the ruling and a tense political climate already are beginning to influence rural hospital decisions about the future of their OB units and are forcing OB-GYNs to reconsider the viability of working in a rural community. The ripple effect of these laws appears all but certain to further erode access to OB services in rural America and bears close watching.

Nearly a Quarter of America's Rural Hospitals Have Dropped OB Services

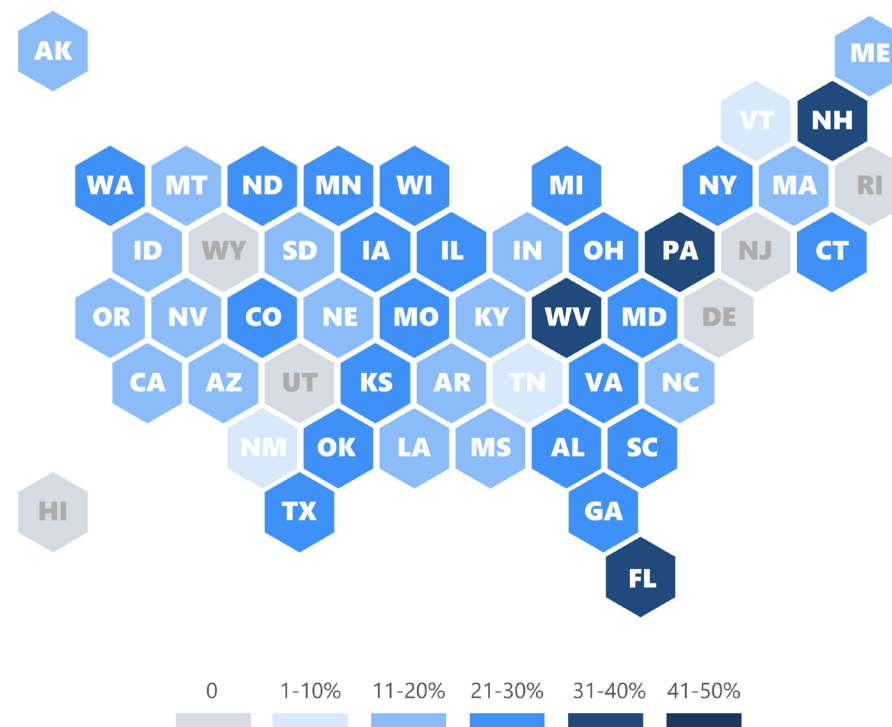
For many facilities, the desire to provide labor and delivery services has been overpowered by the realities of economics and staffing and questions of clinical appropriateness. OB services require skilled, specialized practitioners and nurses, and the ability to deliver care around the clock. Additionally, Medicaid, which pays for approximately 51% of rural births each year in the U.S., not only reimburses hospitals less for this service than commercial payers but often reimburses below the cost of care.²

When we first assessed the availability of OB services in rural communities in 2019, our analysis indicated that access to OB services disappeared in 152 rural communities between 2011 and 2018. Our latest analysis reveals a dramatic escalation over the past several years, especially at the height of the pandemic. Today, nearly 25% of America's rural hospitals have ceased to provide OB services since 2011. This loss encompasses 267 rural communities and spans 44 of the 48 states that have at least 1 rural hospital.

Given that some states (such as Texas and Kansas) have a large number of rural hospitals, it is important to first look at OB service loss as a percentage of rural hospitals in a state to better understand where access was limited to begin with. West Virginia has the highest percentage: nearly half (46%) of the rural hospitals that offered OB services have eliminated them during our review period. Close behind are Florida (43%), Pennsylvania (41%), and New Hampshire (40%). In West Virginia, Florida, and New Hampshire, the number of rural hospitals left in the state offering OB services is fewer than 10.

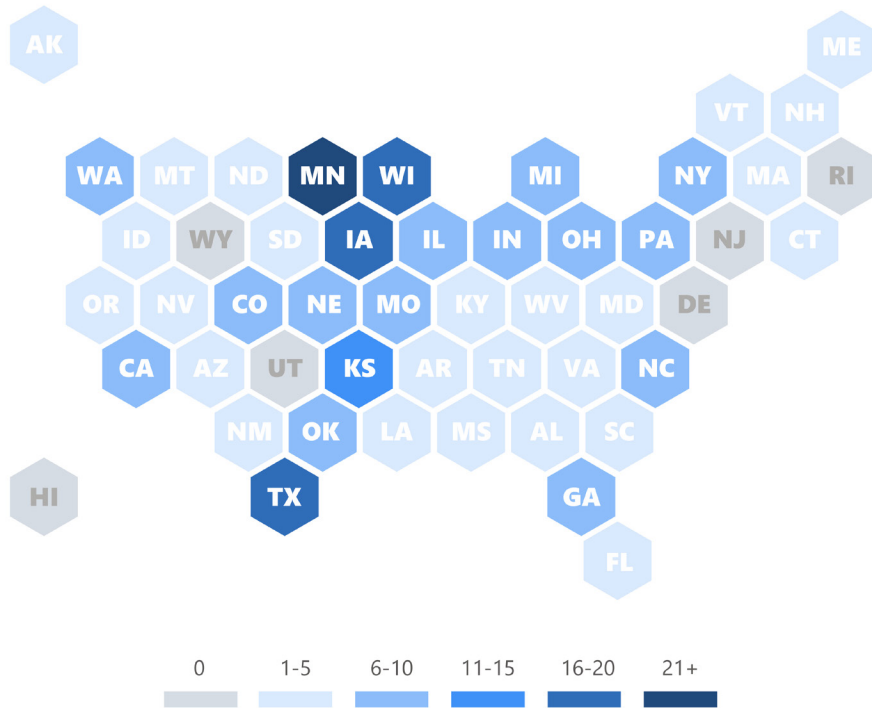
From the standpoint of greatest loss of rural OB units, we found a different collection of states but a similar level of concern. States suffering the greatest loss of OB services in rural communities over this 10-year period include Minnesota (22), Iowa (20), Texas (17), Wisconsin (16), and Kansas (14). States such as Utah and Wyoming (with 20 and 16 rural hospitals offering OB services, respectively) have yet to lose any rural OB units.

Fig. 1: Percentage of Rural Hospitals That Stopped Offering OB Services between 2011 and 2021



The percentage of rural hospitals dropping OB during our review period was highest in Florida, New Hampshire, Pennsylvania, and West Virginia. West Virginia saw the highest percentage loss in the nation at 46%.

Fig. 2: Number of Rural Hospitals That Stopped Offering OB Services Between 2011 and 2021



States suffering the greatest loss of rural OB units during our review period were Minnesota, Iowa, Texas, Wisconsin, and Kansas.

Pandemic Drives OB Closures Upward

While rural hospital closures slowed noticeably during the pandemic due to financial relief programs, the same cannot be said of rural OB units. Our analysis shows that during the peak years of the pandemic (2020 and 2021), 63 rural hospitals ceased to provide OB services. Among the states that lost the most access to OB services during this period are Wisconsin (6), Minnesota (5), California (4), Iowa (4), Ohio (4), and Texas (4).

Such a high number of OB unit closures in this 2-year window is indicative of not only the financial strain created by the pandemic but also the impact of staffing shortages, particularly at the nurse level, on the delivery of care. Nearly 20% of respondents to a [rural hospital leadership survey](#) conducted by Chartis in partnership with the National Rural Health Association in 2022 indicated that nurse staffing shortages had resulted in the suspension of services, and another 13% of survey respondents said their facilities were considering such action.

Future analysis of the OB unit closure data will provide further visibility into service suspension and whether “temporary” truly was for a short period or whether that suspension morphed into the permanent elimination of OB services.

Loss of Access in Communities that Need It Most

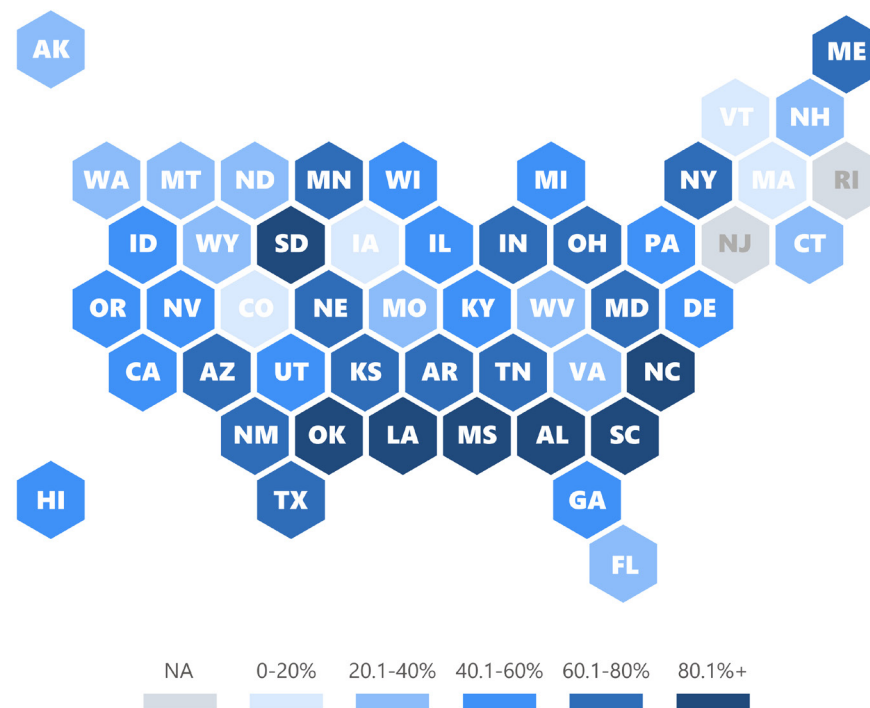
We also examined how the loss of OB services potentially overlapped with infant mortality rates. Our health disparities and safety net research has often yielded interesting insight from how different measures overlap with each other at the state level. Rural infant mortality rates in 26 states are higher than the overall statewide infant mortality rate. Within that group, 7 states also saw 30% or more of their rural hospitals drop OB services during our review period (i.e., Minnesota, New York, Pennsylvania, New Hampshire, Oklahoma, South Carolina, and West Virginia). The intersection of these two data points indicates that some of the rural communities where OB services are disappearing are those who can least afford to lose this access.

On the Brink and Dropping OB Services

Two of the foundational components of our rural health safety net research are rural hospital operating margin and vulnerability to closure. Our latest analysis of rural hospital operating margins indicates that 50% of the country's rural hospitals are operating in the red. Within states yet to expand Medicaid under the Affordable Care Act, the figure rises to 56%.

Among the rural hospitals that have ceased providing OB services, nearly 80% were operating in the red the year in which these services were dropped. For nearly half of these facilities, their operating margin was between -0.1% and -10% in the final year providing OB services. However, these facilities aren't necessarily hospitals one could categorize as on the brink of closure.

Fig. 3: State-level Median Infant Mortality Rate Percentiles Across Rural Hospitals



Operating Margin in Last Year of Offering OB is

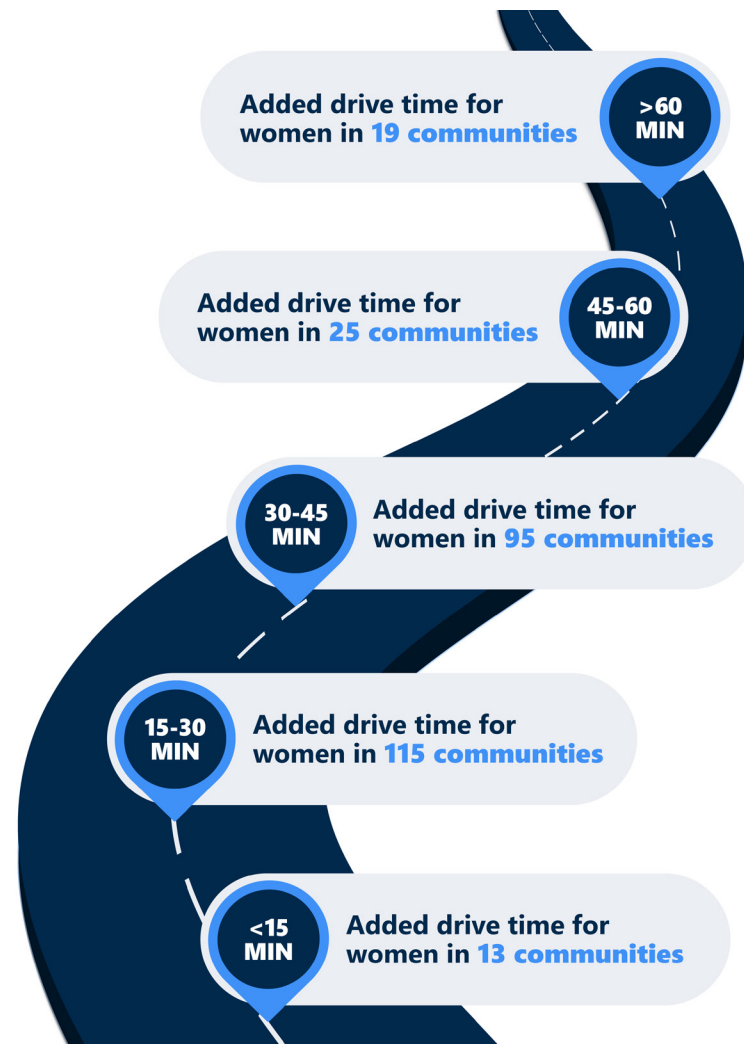
-0.1% to **-10%**

Our [rural hospital vulnerability study](#) identified 453 rural hospitals vulnerable to closure. Comparing that data to this new OB analysis shows that 24% (63) of the 267 hospitals with OB closures since 2011 vulnerable to closure. During the height of the pandemic, we found a similar percentage—22% (14 of 63)—that were previously identified as vulnerable to closure dropping OB services. These 2 findings illustrate how high OB is on the list of potential cuts when rural hospitals are urgently trying to remain viable.

Longer Drive Times Impede Care and Increase Risk

As expecting mothers are forced to travel further for OB care, the risk to mother and baby increases, especially in the event of an emergency. In maternity care deserts, the concern is so worrying that some opt to move in with relatives who live closer to OB care³ or book hotel accommodation to avoid expected severe weather on the day of a planned C-section.⁴ Our analysis of drive times in these OB deserts validates the concern and measures families are taking.

Fig. 4: Added Drive Times for Expecting Mothers in Communities That Lost OB Services



Abortion Access Collides with OB Services

The Supreme Court of the United States' ruling on *Dobbs v. Jackson Women's Health* set in motion a series of trigger law(s) that effectively banned abortion in 14 states. These bans are creating a new pressure point as reports are now emerging that practicing OB-GYNs are opting to leave these states entirely⁵ and new, graduating OB-GYNs are more likely to pursue practicing in states that protect abortion rights.⁶

Idaho, for example, has emerged as a focal point for understanding the ripple effect of the *Dobbs* decision on access to OB services in rural communities. Bonner General Hospital, a Critical Access Hospital in Sandpoint, Idaho, for example, publicly cited a changing political climate as one of the reasons behind the decision to close its OB unit earlier this year.⁷ According to a published report, Bonner General's OB unit delivered "nearly 300 babies last year, with more than a dozen 'code stork' deliveries, in which the baby's life, the mother's, or both are at risk, leaving just 30 minutes for the staff to get them into the operating room for an emergency cesarean delivery."⁸ Without access to Bonner General—previously the county's only OB unit—expecting mothers now must travel 40 to 55 minutes to the nearest facilities.

Considering Clinical Appropriateness

For individual rural hospitals and those among the nearly 60% that are affiliated with a health system, the clinical appropriateness analysis that drives OB closure decisions often involves careful consideration of a facility's ability to deliver safe and reliable care.

Through Chartis' work in [quality, safety and high reliability](#), we have seen how common it is in rural communities, for example, to find fewer OB-GYNs or facilities lacking the necessary infrastructure to support emergency birth scenarios (e.g., neonatal intensive care). Many of these conditions also hinder efforts by hospitals and health systems to recruit providers in rural settings.

▶ "Hybrid models can bridge geographical and programmatic gaps, creating programs that might enable prenatal care closer to home but centralize deliveries at larger hospitals."

—Andrew Resnick, MD,
Chartis Chief Medical and Quality Officer

While quality of care can be a driver in the decision-making process, staffing gaps and lack of requisite OB-related training often tip the balance of a risk profile in favor of closure—especially when alternative OB venues exist. A more hybrid approach may not mean retaining labor and delivery in a rural hospital, but it does offer a pathway for maintaining connectivity between expecting mothers and healthcare providers.

Given the long-established challenges rural providers face recruiting and retaining healthcare professionals—more than 60% of Healthcare Professional Shortage Areas (HPSAs) are in rural locations—the impact of abortion bans and restrictions bears watching closely. Many of the states that have banned abortion (e.g., Alabama, Arkansas, Idaho, Indiana, Mississippi, and South Dakota) lost OB services in rural communities during our data review period.⁹ In most instances, OB services disappeared from 3 to 6 rural hospitals, while states such as Oklahoma (10) and Texas (17) incurred much higher losses.

The hospital closure crisis has been driven in part by the unintended consequences of policy decisions, and a similar scenario with OB services and state-level bans on abortion may be about to unfold. This issue seems likely to further chip away at access to OB services and maternal care in these states, many of which have been hardest hit by rural health safety net instability. These states may also see a broader impact on general practice decisions, given the polarizing nature of abortion rights.

Finding a Way Forward to Preserve Access to OB Services

As we consider what is next for OB services in rural communities, we must also recognize that declining access is no longer exclusive to rural healthcare. Reports of hospitals and health systems shuttering OB units at urban hospitals are on the rise. Suburban or urban hospitals in Massachusetts, Maine, North Carolina, and Alabama, for example, all have announced plans to close their OB units this fall.¹⁰

Recent legislative efforts on Capitol Hill, such as the Healthy Moms and Babies Act (H.R. 4605/S. 948) and the CARE for Moms Act (H.R. 5568), are promising. If passed, these bills could be positive steps forward, relieving some pressure by expanding the maternal care workforce through increased use of telehealth and grants for mobile OB units. Similarly, the American College of Obstetricians and Gynecologists has been active in advocating for a series of initiatives and recommended actions aimed at improving maternal and infant healthcare in rural communities to the Centers for Medicare and Medicaid Services (CMS).¹¹ Beyond Capitol Hill legislative and advocacy efforts, the development of hybrid models, such as those that bridge gaps in geography by focusing on prenatal care locally and delivery in a more urban setting, may provide viable avenues for some rural hospitals and health systems with rural affiliates. But the complexity of this issue will most certainly require additional innovation and new ideas among those advocating for rural healthcare in the months ahead.



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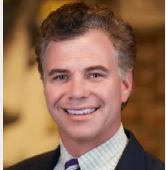
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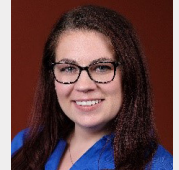
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