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A Look at Swedish Maternity Care with Medicaid in Mind

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Health Management Associates (HMA) works with state and federal agencies, providers of health and human services, and community-based organizations to ensure access to the full spectrum of reproductive healthcare, including interventions to reduce high rates of maternal and infant mortality and morbidity and address deep and persistent disparities in birth outcomes and the inequities that drive them. This work includes evaluating and supporting implementation of models of enhanced perinatal care, supporting states to address drivers of health that influence birth outcomes, addressing access barriers to reproductive health services and coverage policies in Medicaid, and supporting state work to establish doula benefits in Medicaid.

As states increasingly work to enact and implement health coverage expansions with a focus on the postpartum period and to address factors upstream of the healthcare system in their efforts to reduce disparities in birth outcomes, it may be helpful to look at international examples.

To inform this work, the author, an associate principal at HMA, interviewed Swedish researchers who are OB/GYNs, midwives, and epidemiologists, as well as a leader of a doula organization, to better understand the country's approach to universal, publicly funded maternity and reproductive healthcare. We also exchanged information about Medicaid's role in the US and emerging strategies and issues.

Swedish researchers estimate that three to four maternal deaths occur in Sweden annually. Because the maternal mortality rate is so low, providers and researchers conduct a root cause analysis of each incident. Sweden ranks among the top three of 11 high-income countries in healthcare equity. Of course, Sweden has its own health care challenges and shares some with the US, but to American eyes, the baseline of healthcare services, experiences, and expectations is dramatically different. Several lessons from Sweden could be considered as part of efforts to improve birth outcomes for people with Medicaid. Examples include:

- Universal health care and more generous socioeconomic supports contribute to better health over the life course, as well as better birth outcomes. Swedish interviewees underscored the importance of these benefits in closing gaps in birth outcomes.

BIRTH OUTCOMES IN SWEDEN VERSUS THE UNITED STATES

The United States has the highest rates of maternal and infant mortality among wealthy countries. Racial disparities in birth outcomes are deep and in some cases worsening, despite the highest health care spending. Sweden has among the best birth outcomes in the world. In 2020 its maternal mortality rate was seven per 100,000, compared with 23.8 overall in the United States and 55.3 for Black women. In 2021, the US rate worsened to 32.9 overall and 69.9 for Black women. In fact, 1,205 American women died giving birth—a higher maternal mortality rate than in the entire European Union (population 447 million). Because Medicaid finances 41 percent of births in the United States and covers a significant percentage of people who are most at risk of negative birth outcomes, it is critical to addressing this challenge.

- The collaborative team-based perinatal care approach that incorporates a central role for midwifery and can include “kulturdoula” services in Sweden may be of interest to states, health plans, and health care providers seeking to improve perinatal care and wraparound supports, as well as fund and support access to doula services.
- Sweden’s midwifery and collaborative care model enable resource navigation, referrals with follow-up, and relationship-building that strengthen perinatal care. This approach recognizes different domains of expertise for OB/GYNs, midwives, nurses, and doulas with a consensus-based decision-making approach that provides substantial time to work with each patient on health and social needs during both the prenatal and postpartum periods.
- Kulturdoula pilot programs match women who are new to Sweden with culturally and linguistically aligned doulas to support them through pregnancy, delivery, and the postpartum period. In addition, a culturally and linguistically aligned “emergency” doula can be called in to support birthing people during delivery, even if they have not worked with one during pregnancy, at no cost to the patient.
- Programs, services, and supports to which team members make referrals are generally available in a timely manner, and neither substance use nor pregnancy outcomes are criminalized, facilitating trust in provider-patient relationships, and supporting better outcomes.
- A centralized perinatal data system updated in near real-time enables quality improvement and research, including large-scale research with a rapid turnaround to address emerging issues.
- Like the US, Sweden is grappling with health care provider shortages in rural areas and, more broadly, a lack of behavioral health providers and overall aging of the health care workforce.

Impact of Robust Universal Healthcare and Social Benefits

Swedish interviewees highlighted the importance of universal, lifelong health benefits and a relatively robust social safety net as contributing factors to the country’s better birth outcomes. They also noted that because most care is provided free of charge or at a very low cost (cost-sharing for most services is limited) people have greater access to care and more trust in the heavily public system. No cost or administrative barriers prevent people from initiating prenatal care, though travel times and rural provider scarcity are challenges.

Sweden provides generous paid parental leave and early childhood education is universal. Referrals for needs such as housing, food, domestic violence services and shelter, and mental health services generally readily available (e.g., a housing or behavioral health services needs could be met within the course of a pregnancy without a long waiting list). The most significant disparities in birth outcomes are between people born in Sweden and recent immigrants. Efforts to address those through public policy and health care system-level programs include pilot programs to offer linguistically and culturally aligned doulas to provide perinatal support and resource linkages.

Midwifery Model with Consensus-Driven Decision-Making

Swedish maternity care is delivered through a midwifery model, in which a pregnant woman seeks a midwife from her nearest local public health midwifery agency (or chooses one, if multiple agencies are nearby as is the case in cities). Appointments begin around week nine of pregnancy; the first appointment may last two hours, with any follow-up visits ranging an average of 30−60 minutes based on the individual's need. The antenatal midwife is responsible for prenatal care for common aspects of the pregnancy, while supplemental visits with an OB/GYN = address complications or high-risk aspects of pregnancies. These appointments are in addition to the baseline midwifery appointments. A separate midwife employed by the hospital is present at the birth, along with an OB/GYN if necessary, labor and delivery nurse(s), and potentially a doula and an interpreter if needed. Nearly all births take place in a hospital setting. After delivery, the mother and infant typically have an additional visit four to 16 weeks after delivery with the midwife at a maternity care center, which provides such services as resource navigation, breastfeeding support, and scheduling appointments with a pediatric clinic that will serve as an ongoing medical home for the child.

The roles of the care team are clearly defined, with the standard course of pregnancy viewed as the purview of the midwife and the OB/GYN focused on complications during pregnancy and delivery. As in other facets of Swedish professional life, interviewees emphasized that consensus-based decision making, where all members of the team are consulted, is the norm, which makes the process of managing care somewhat less hierarchical (though they noted that this can have its own challenges). Anecdotally, Swedish colleagues reported an increasing emphasis on continuity of care throughout pregnancy, delivery, and postpartum, which contributes to patient satisfaction and positive outcomes. They highlighted collaboration with US colleagues on enhancing continuity in a team-based care approach and anticipate their findings will resonate with research on continuity of maternity care and its correlation with satisfaction among Medicaid members (such as the Strong Start for Mothers and Newborns Initiative evaluation that HMA and other organizations conducted).

US midwifery and doula models—which originated in Black and Native American communities—are underused in general and in Medicaid given their potential positive impact on outcomes and satisfaction with care. They enable time early in pregnancy for pregnant people and providers to build relationships, identify needs, and connect with necessary resources, and may reduce fragmentation that can occur when screening and referrals are done by under-resourced staff who are not well-integrated into a maternity care team. This time and relationship development came up often as an important advantage of a system that incorporates midwifery services and offers midwives and doulas flexibility in determining how much time they spend with clients, allowing more time for women who need additional support.

Kulturdoulas: Providing Support for Women Who are New to Sweden

As in Medicaid programs, the value of doula services is increasingly recognized as a strategy to address inequities in birth outcomes. Women born outside Sweden experience the largest disparities, although the Swedish Pregnancy Register, which monitors quality of care, does not track race or ethnicity data for women born in Sweden. In Gothenburg and Stockholm, publicly funded pilot programs pay for doula care for women who are recent immigrants and may not speak Swedish or may be more comfortable speaking another language. An interpreter is also present and support services are offered by a doula who speaks the client's preferred language, ensuring that the doula can have an explicit focus on cultural concordance and cultural interpretation between the rest of the health care team and the client.

Doula training is similar to major curricula used in the US and internationally, and, like community doulas in the US, these providers play an important role in resource navigation and linking women to social benefits. Midwives contact a participating doula organization to identify the right person and can also request that an emergency doula come to the hospital for a delivery if needed. This strategy may be of interest to the Medicaid programs and health plans with which HMA is working to develop and implement doula benefits.

The doulas track their time using an app and are paid an hourly rate. Four visits are typical, but more can be arranged. Payment rates and caseloads are not yet sufficient to support doulas to make this work a career, so workforce development and sustainability are challenges in Sweden, as they are in the United States. Doula organizations are exploring medical interpreter certification for doulas as a potentially valuable credential that would create additional professional opportunities. Doulas have been received extremely well, including during COVID-19 pandemic-related restrictions. Hospitals welcomed them even when other visitors were restricted because they recognized the value of their support in helping make maternity care safer. Antenatal clinics and midwives value the doulas' ability to help identify issues and challenges. Swedish colleagues working to incorporate doula care into their system are interested in learning about the work of US doula organizations, particularly with respect to reducing disparities in birth outcomes.

Human Rights and Reproductive Healthcare

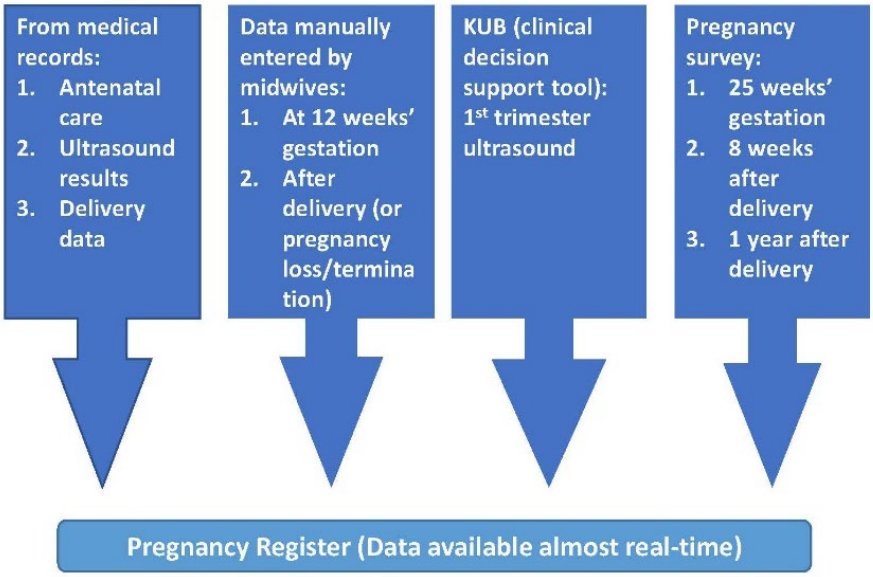
Pregnancy outcomes are not criminalized in Sweden, nor would disclosure of a substance use disorder to a health care provider lead to law enforcement involvement. Timely induction of treatment and the well-being of the pregnant person are generally prioritized. One role of both the midwife and the doula is to inform pregnant people of their rights and available benefits. Maternity care is available to asylum seekers and undocumented

residents of Sweden free of charge. Abortion is available without restriction up to 18 weeks of pregnancy and the cost is equivalent to a physician visit. Contraceptives are accessed through local maternity and youth health clinics rather than primary care providers, and though offered at subsidized or no cost, prescription birth control does require a separate visit. The expectation of low- or no-cost care and an emphasis on the rights and well-being of the pregnant person, as well as lack of risk of law enforcement involvement, helps reduce barriers to timely prenatal care.

Using Data from the Swedish Pregnancy Register to Monitor and Improve Quality of Care

Another area of potential interest to health plans and states monitoring the quality of maternity care is the Swedish Pregnancy Register, a certified national database initiated in 2013 to support quality improvement, clinical decision making, and health care research. Patient data are de-identified and can only be accessed with identifying information after going through a rigorous national-level review process. Participation in the registry is voluntary and people can opt out, but participation is approximately 99 percent. The register does not collect ethnicity data for women born in Sweden, which is a limitation in studying disparities.

Figure 1. Data Flow into the Pregnancy Register



Source: Adapted from a diagram by Michaela Granfors, Swedish Pregnancy Register; Department of Medicine, Solna, Clinical Epidemiology Unit, Karolinska Institutet, Stockholm, Sweden

The pregnancy survey administered at 25 weeks' gestation, eight weeks postpartum, and one year postpartum includes both outcomes and experience-related questions and is translated into 8 languages. The overall response rate in 2020−2022 was 53.7 percent, and researchers are working to increase participation further. Register data flow into more than 60 publicly available dashboards on topics including:

- Maternity/antenatal care
- Ultrasound results
- Delivery/birth outcomes
- Pregnancy survey results[1]

Clinicians also can access personal reports to track outcomes and trends among their own patient population. They can only view their own outcomes data, not those of other providers.

[1] Data provided by Michaela Granfors, Swedish Pregnancy Register; Department of Medicine, Solna, Clinical Epidemiology Unit, Karolinska Institutet, Stockholm, Sweden

Figure 2. C-Section Dashboard by Hospital

Enhet	Förlossningar	Kejsarsnitt	Andel
Solna Karolinska Universitetssjukhuset	1821	487	26.7 %
Eskilstuna Mälarsjukhuset	923	223	24.2 %
Lycksele lasarett	148	34	23.0 %
Karlskrona Blekingesjukhuset	708	162	22.9 %
Sundsvall Länssjukhuset	751	170	22.6 %
Huddinge Karolinska Universitetssjukhuset	2323	524	22.6 %
Danderyds sjukhus	2998	671	22.4 %
Umeå Norrlands Universitetssjukhus	880	191	21.7 %
Karlstad Centralsjukhuset	1291	279	21.6 %
Norrköping Vrinnevisjukhuset	1047	223	21.3 %
Malmö Skånes Universitetssjukhus	2418	507	21.0 %
Stockholm Södersjukhuset	3270	684	20.9 %
Göteborg Sahlgrenska Universitetssjukhuset	4600	944	20.5 %
Visby lasarett	239	48	20.1 %
Gällivare sjukhus	221	44	19.9 %
Borås Södra Älvsborgs Sjukhus	1551	305	19.7 %
Gävle sjukhus	810	156	19.3 %
Total	**51260**	**9745**	**19.0 %**

Source: Michaela Granfors, Swedish Pregnancy Register; Department of Medicine, Solna, Clinical Epidemiology Unit, Karolinska Institutet, Stockholm, Sweden

The registry enables quick-turnaround research, allowing researchers to rapidly examine outcomes for pregnant women with COVID-19 in 2020, for example.

Though the costs, structure, and accessibility of reproductive health care in Sweden are dramatically different from the overall US healthcare system, some common threads emerged with regard to Medicaid, including:

- Shared interests in quality improvement tools and addressing regional and other inequities
- Increasing attention to the use of doulas with a particular emphasis on cultural and linguistic concordance
- Shared challenges with rural access to care, behavioral health, and clinical workforce shortages

Swedish colleagues welcome collaboration and exchange of ideas to address disparities in birth outcomes and further improve experiences of care and outcomes for all.

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About the Author

Diana Rodin has more than 15 years of experience conducting policy analysis, program evaluation, and technical assistance related to public health and safety net healthcare systems, with a particular focus on reproductive health. Read more about Diana.