

Natality

In 2014, Oregon recorded **45,557 resident births**, 421 more than in 2013. The **crude birth rate** (the number of babies born divided by the total state population) was 11.5 per 1,000 population (see Table 1-2). Oregon's crude birth rate peaked in 1947 at 25.4 per 1,000 population. From 1975 to 2008, Oregon's rate was consistently in the mid- to low-teens, and has been less than 13.0 for the last five years. Except for the period between 1976 and 1981, Oregon's crude birth rate has remained lower than the national rate for the past 50 years. In 2014, Oregon's rate was 8.0% lower than the national rate (11.5 vs. 12.5; see Figure 2-1).¹

Oregon's **fertility rate** was unchanged from last year at 58.6 per 1,000 women aged 15–44 (see sidebar Table 2-A, Table 2-2). The fertility rate is based on the number of births per 1,000 women aged 15–44. The fertility rate is a more precise measurement of changes in behavioral patterns than crude birth rate. The fertility rate relates only to women of childbearing age, while the crude rate is based on the entire population. Age-specific birth rates decreased among women less than 25 while increasing among all other age groups. The largest percentage decrease was among women aged 15–19 (8.1%), followed by women aged 20–24 (2.9%; see Table 2-2, Figure 2-2).

Oregon's crude birth rate and fertility rate both remain below the national rates

Table 2-A. Fertility rates per 1,000 females 15-44, Oregon and U.S.		
Year	Oregon	U.S.
1980	69.3	68.4
1985	62.2	66.3
1990	65.1	70.9
1991	63.7	69.3
1992	62.5	68.4
1993	61.1	67.0
1994	61.0	65.9
1995	62.3	64.6
1996	63.2	64.1
1997	63.0	63.6
1998	64.2	64.3
1999	64.2	64.4
2000	62.9	65.9
2001	61.6	65.3
2002	60.9	64.8
2003	61.2	66.1
2004	60.0	66.3
2005	62.2	66.7
2006	65.5	68.5
2007	66.0	69.2
2008	64.6	68.6
2009	62.0	66.7
2010	60.0	66.7
2011	59.3	63.2
2012	58.8	63.0
2013	58.6	62.5
2014	58.6	62.9

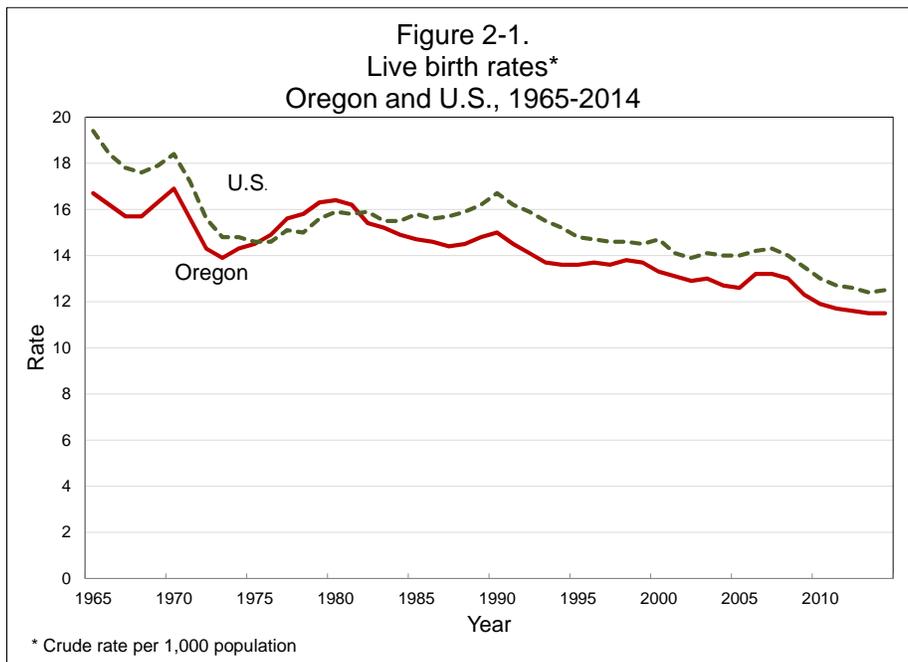
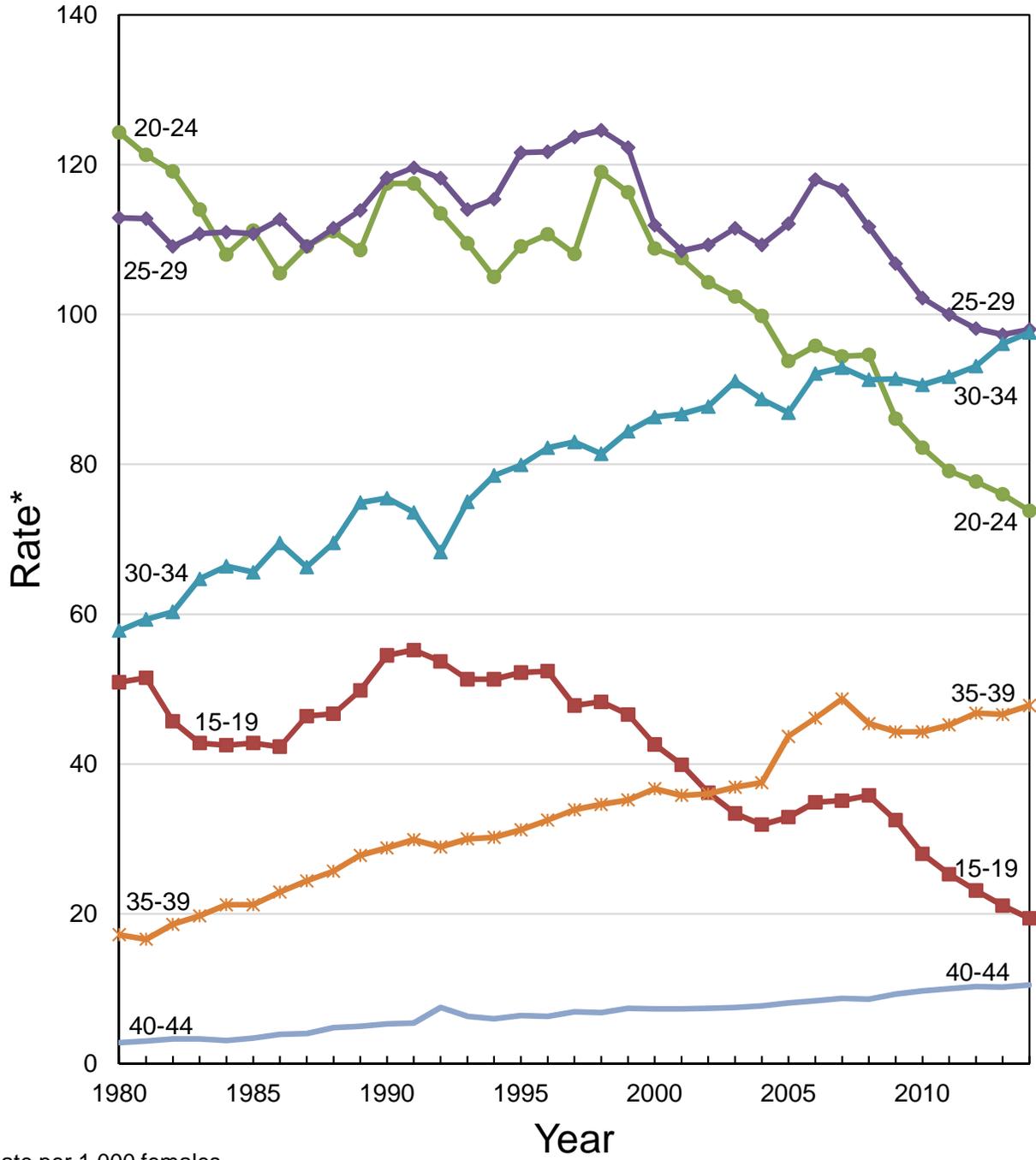


Figure 2-2. Age-specific birth rates, Oregon residents, 1980-2014



The youngest female to give birth in 2014 was 13 years old and the oldest was 53. Mother's median age for all births was 29 and the mean age was 28.8. The median age at first birth was 27 and the mean age was 26.8. The **rate of first birth** decreased slightly from the previous year to 23.0 first births per 1,000 women aged 15–44, slightly lower than the 2014 national rate of 24.6.¹ The proportion of first births among total births has been stable for the past decade. In 2000, 40.1% of births were first births; in 2014, 39.3% were first births.

Father's mean age for births was 31.4 years and the median age was 31. The **birth rate per 1,000 men** aged 15–54 was 57.5 in 2014 for Oregon resident births. Information on the father was missing from 8.7% of birth certificates. Unknown father age was distributed in the same manner as national data (see Appendix B: “Technical notes — definitions”). The national birth rate for men was 45.8 per 1,000 men in 2013 (the most recent data available).²

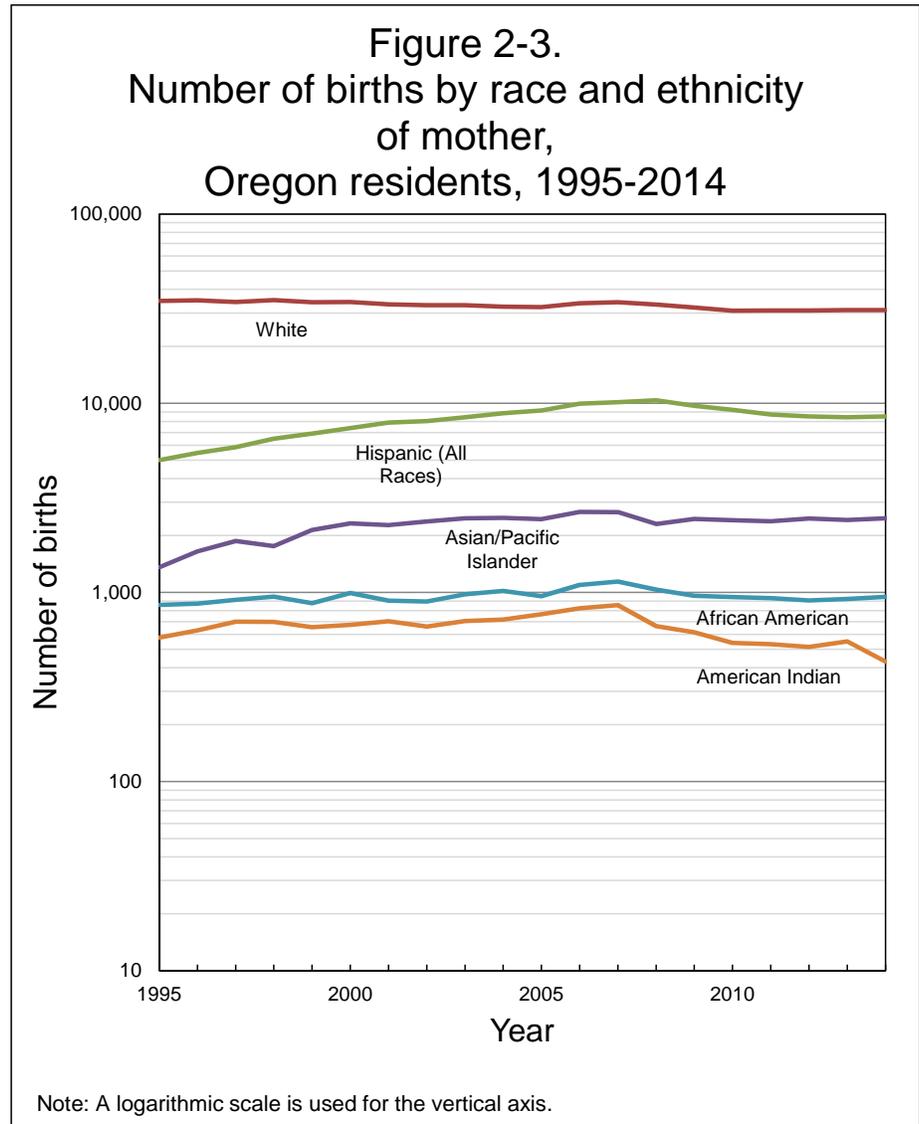
Demographics

Maternal race/ethnicity

Birth rates for racial and ethnic groups are not calculated in this report because precise population data by racial and ethnic groups are available only for census years. Instead, this report focuses on the race and ethnicity of women that gave birth as a proportion of total births.

Since 1990, the number of births to women of Hispanic ethnicity has almost tripled to 18.7% of total births (see Table 2-7, Figure 2-3). The method for reporting the Hispanic category has changed in Oregon over the years. From 1981 to 1988, “Hispanic” was a race category on the birth certificate. From 1989 to 2007, information regarding Hispanic ethnicity was reported separately from race. Starting in 2008, an individual could choose multiple race/ethnicity responses (see Appendix B: “Technical notes — methodology”). Persons of Hispanic ethnicity may belong to any race category (or categories). This change addressed the complexity of race and ethnicity and increased self-reporting accuracy for Oregon.

Perinatal differences by race and ethnicity of mother persist. These differences are noted within the topic areas discussed in the remainder of this chapter.



Marital status of mother

Unmarried women as a group have historically poorer birth outcomes than married women. They generally have a greater proportion of babies with lower birthweight and lower Apgar scores than do their married counterparts. Infants born to unmarried mothers are more likely to require neonatal intensive care, have congenital anomalies or die before the age of 1. In Oregon, the ratio of births to unmarried mothers in 2014 was 3.5 times higher than in 1975, and 5.7 times higher than in 1965 (see Table 1-2, Figure 2-4). While there has not been a matching increase in low birthweight rates and other indicators of poor health, the disparity in prenatal care, tobacco use and race/ethnicity between married and unmarried women continues.

Among women giving birth in 2013, the percentage of women that were unmarried varied widely by ethnic and racial group (see sidebar Table 2-B). Non-Hispanic American Indian women had the highest percentage of non-marital births (65.6%), followed by non-Hispanic African American women (58.5%) and Hispanic women (49.2%). Non-Hispanic Asian women had the lowest percentage of unmarried mothers (13.4%). (See Table 2-13.)

In 2014, 36.0% of all Oregon births were to unmarried women, a slight increase from the previous year (see Table 1-2). Oregon has consistently had a lower percentage of births to unmarried women than the United States. Oregon’s rate in 2014 was 10.7% lower than the national rate (see Figure 2-4).¹

Among women giving birth in 2014, the percentage of women that were unmarried varied widely by ethnic and racial group (see sidebar Table 2-B). Non-Hispanic American Indian women had the highest percentage of non-marital births (61.9%), followed by non-Hispanic African American women (54.1%) and women of multiple races (51.4%). Non-Hispanic Asian women had the lowest percentage of unmarried mothers (13.2%; see Table 2-13).

Mothers less than age 17 are likely to be unmarried, primarily because persons younger than age 17 cannot legally marry in Oregon. More than four-fifths of teens aged 15–19 that gave birth in 2014 were unmarried (86.2%),

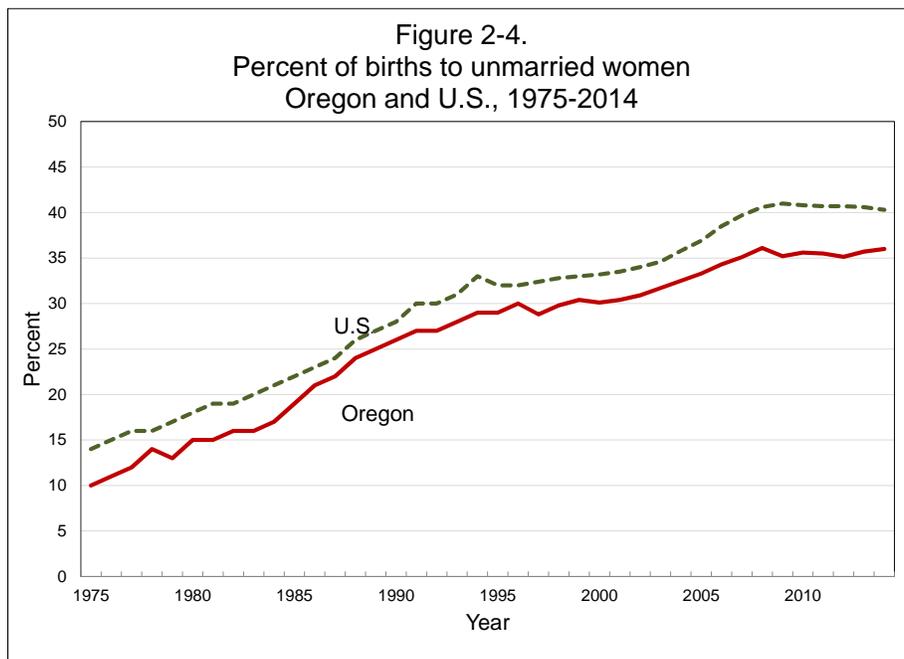


Table 2-B. Percent of unwed mothers by race/ethnicity, Oregon residents, 2014	
Total unmarried	36.0
Non-Hispanic	
African American	54.1
American Indian	61.9
Asian	13.2
Hawaiian/Pacific Islander	50.8
Multiple races	51.4
White	31.5
Hispanic	50.7

compared to 60.6% for women aged 20–24 and 33.4% for women aged 25–29. The percentage of unmarried women was lowest for mothers aged 35–39 (20.0%) and 30–34 (20.4%), while 24.6% of mothers aged 40–44 were unmarried (see Table 2-3). Thirteen of Oregon’s 36 counties had proportions of non-marital births significantly higher than the state average (see Table 2-9). Among counties with statistically significant differences, Jefferson had the highest percentage (54.4%) followed by Lincoln (50.8%) and Douglas (50.7%). (See Appendix B: “Technical notes — formulas” for information on statistical significance). Five Oregon counties had percentages of non-marital births significantly lower than the state average. Benton County had the lowest percentage of non-marital births (23.5%). A county’s non-marital birth proportion should be viewed, in part, as a function of its own specific population mix, especially age and race. Variations in population composition among counties will likely result in significant differences in non-marital births.

Educational attainment

A mother’s level of education was closely related to prenatal care patterns. Women with less than a high school education had the lowest percentages of first trimester prenatal care. As educational attainment increased, so did the percentage of women obtaining first trimester care. Women with a doctorate or professional degree had the highest percentage of first trimester care (see sidebar Table 2-C, Table 2-19).

Table 2-C. Mothers' education and no first trimester care, Oregon residents, 2014	
Education	No first trimester care (%)
8th grade or less	35.2
9th to 12th grade, no diploma	35.6
High school graduate or GED	28.7
Some college, no degree	22.9
Associates degree	18.6
Bachelors degree	13.4
Masters degree	10.1
Doctorate or professional degree	9.1

More than four-fifths of women that gave birth in 2014 had at least a high school diploma or GED (85.5%) and 29.8% had a bachelor’s degree or higher. The race/ethnic groups with the highest percentages of high school completion are non-Hispanic Asian (92.1%) and non-Hispanic White (91.9%) mothers. Hispanic mothers had the lowest percentage of completion of at least 12 years of education (62.1%; see Table 2-13).

Women who smoked had a low birthweight rate of 108.3 per 1,000

Maternal lifestyle and health characteristics

Tobacco

National Healthy People 2020 objective

Percentage of infants whose mothers did not use tobacco during pregnancy (self-reported)

2020 target:	98.6 %
2014:	89.6 %

Women that smoke when pregnant have a far higher incidence of low birthweight babies than nonsmokers. Low birthweight infants are more likely to experience serious health problems, including increased rates of infant mortality. Women that smoked had a low birthweight rate of 108.3 per 1,000 live births, compared to 57.0 per 1,000 among women that did not smoke. Approximately one in 10 mothers (10.4%) reported

Figure 2-5.
Percentage of mothers who smoked during pregnancy by age and marital status, Oregon residents, 2014

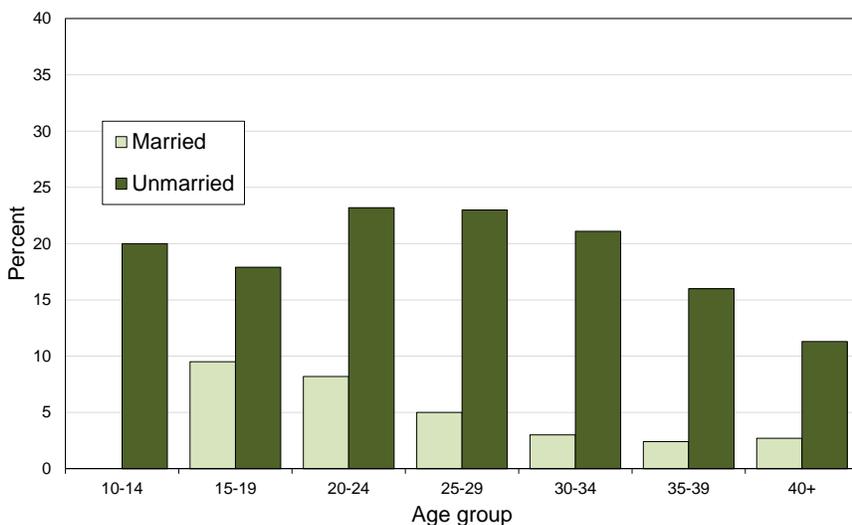


Table 2-D. Percent of maternal tobacco use by year, Oregon residents

1990	22.4
1995	17.9
2000	13.5
2005	12.4
2006	12.3
2007	11.7
2008	11.8
2009	11.3
2010	11.3
2011	10.7
2012	10.6
2013	10.2
2014	10.4

using tobacco during pregnancy, slightly more than the previous year (10.2%) (see sidebar Table 2-D). The percentage of mothers that reported smoking during pregnancy generally decreased with age among married women.

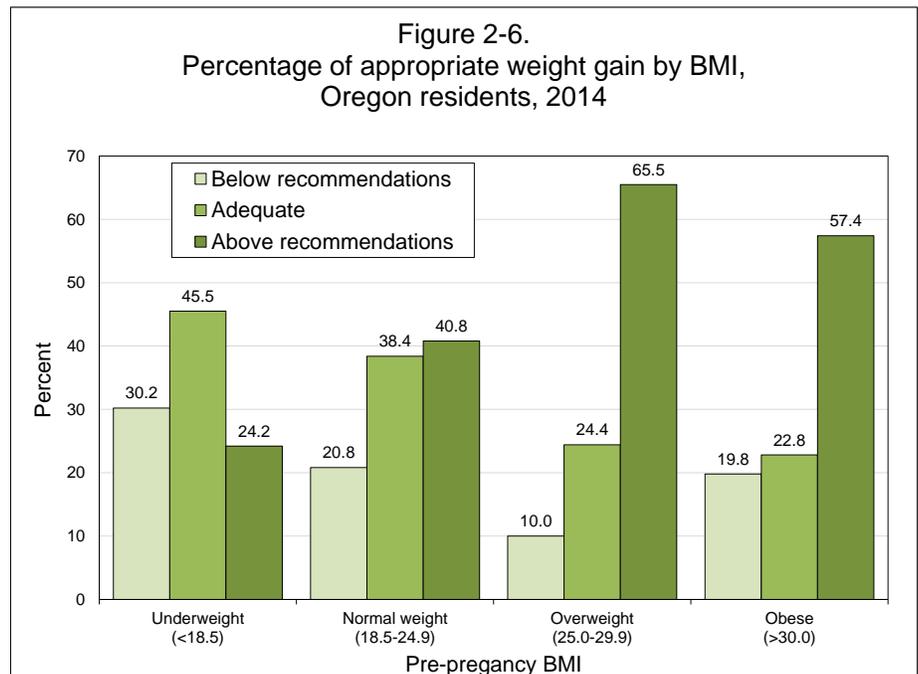
For unmarried women, smoking rates rose and fell with age, peaking in the early 20s. The percentage of tobacco use among unmarried women was more than five times that of married women (21.3% vs. 4.2%). The highest percentage of tobacco use during pregnancy in 2014 was among unmarried mothers aged 20–24 (23.2%) and unmarried mothers aged 25–29 (23.0%). Married mothers aged 35–39 had the lowest percentage of smokers (2.4%), followed by married mothers aged 40 or older (2.7%). For the youngest mothers, aged 10–14, 20.0% reported smoking during pregnancy (see Figure 2.5).

Smoking prevalence as reported on birth certificates also varied among racial and ethnic groups. In 2014, non-Hispanic American Indian women (20.0%) and non-Hispanic women reporting multiple races (17.2%) had the highest reported proportions for smoking during pregnancy, while non-Hispanic Asian women (1.1%) and Hispanic women (3.7%) reported the lowest (see Table 2-25).

Maternal weight and weight gain

Appropriate maternal weight gain has been shown to be positively correlated with infant birthweight. Low maternal

Figure 2-6.
Percentage of appropriate weight gain by BMI, Oregon residents, 2014



weight gain is associated with poor fetal growth, lower birthweight and the chance of a baby being born prematurely. High maternal weight gain is associated with higher infant birthweight and cesarean delivery. Excessive weight during pregnancy is often accompanied by chronic disease and is a health risk factor for both the mother and child.

Pre-pregnancy BMI (kg/m ²)	Weight gain (lbs)
Underweight (<18.5)	28-40
Normal weight (18.5-24.9)	25-35
Overweight (25.0-29.9)	15-25
Obese (>30.0)	11-20

In 2008, Oregon began collecting data on birth certificates about mothers’ pre-pregnancy weight, weight at delivery and height. The availability of this new data allows for the calculation of body mass index (BMI) and provides a better picture of pre-pregnancy BMI and gestational weight gain. In 2009, the Institute of Medicine (IOM) revised its guidelines for weight gain during pregnancy; the guidelines express ideal weight gain in pregnancy as a range for each category of pre-pregnancy BMI (see sidebar Table 2-E). Many Oregon mothers exceeded these recommendations. In 2014, 50.5% of women gained more weight than the IOM guidelines. Additionally, 49.1% of Oregon women entered pregnancy overweight or obese and also had the highest percentage of weight gain above the guidelines (65.5% and 57.4%, respectively; see Figure 2-6). Women starting pregnancy underweight had the highest percentage of weight gain below the IOM recommendations (30.2%) and had the highest percentage of low birthweight infants (9.3%).

Medical risk factors

Maternal medical risk factors influence pregnancy complications and infant health and vary greatly based on the mother’s age, race and ethnicity. In 2014, the most frequently reported medical risk factors were previous cesarean delivery (13.7%), gestational diabetes (7.8%) and pregnancy-associated hypertension (6.5%; see Table 2-23, Table 2-26).

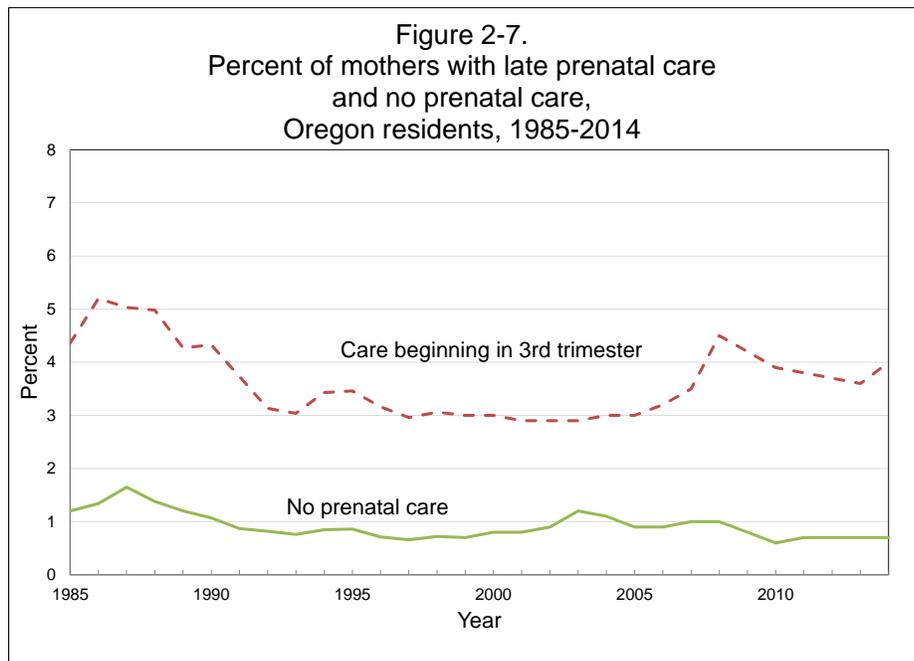
Medical services utilization

Prenatal care

National Healthy People 2020 objective

Percentage of infants whose mothers received prenatal care beginning in the first trimester

2020 target:	77.9 %
2014:	77.5 %



Public health services and private care providers seek to minimize the risk of death and disability to infants. Additionally, they seek reductions in costs associated with low birthweight infants by providing comprehensive prenatal care. The two ways Oregon measures prenatal care are:

- “Inadequate prenatal care,” defined as no care until the third trimester or fewer than five total prenatal visits; or
- “First trimester care,” defined as care beginning in the first 12 weeks of pregnancy, regardless of the number of total prenatal visits.

Overall, 77.5% of women that gave birth during 2014 received early prenatal care, which is 8.4% higher than the 2008 national number of 71.0% (see Table 2-17, Table 1-5). Moreover, this is 0.5% lower than the 2013 rate of 77.8%.

In 2014, 6.0% of women giving birth received inadequate prenatal care and 22.5% received no first trimester care. The percentage of low birthweight infants was much higher for women that received inadequate prenatal care (11.8%) compared to 5.8% of children born to mothers that received adequate prenatal care. The percentage of mothers that received no prenatal care was slightly higher than the previous year (0.8% and 0.7%, respectively). Mothers that initiated care in the third trimester increased from 3.6% in 2013 to 4.0% in 2014 (see Figure 2-7).

Age, marital status, education and race/ethnicity continue to show important differences in accessing prenatal care (see tables 2-17, 2-18, 2-19 and 2-21). For example, the highest percentage of inadequate care is found among non-Hispanic Hawaiian and Pacific Islander women (28.1%) and Hispanic American Indian women (13.3%). White non-Hispanic and Asian non-Hispanic women had the lowest percentages of inadequate care (5.2% and 5.6%, respectively; see Table 2-18).

None of Oregon's 36 counties had first trimester care rates significantly higher than the statewide rate. Two counties had rates significantly lower than the state: Malheur (58.3%) and Marion (73.9%). (See Table 2-20.)

The Adequacy of Prenatal Care Utilization Index

is an alternate measure of prenatal care based on the month prenatal care began and the number of prenatal visits, adjusting for gestational age. Care is determined to be intensive (exceeding recommended care by a ratio of expected visits to actual visits by at least 110%), adequate, intermediate or inadequate (see Table 2-F). As with other measures of prenatal care, more women less than the age of 20 received inadequate prenatal care, while more women aged 40 and older received intensive prenatal care. Women with medical risk factors such as diabetes and hypertension also were more likely to receive intensive prenatal care.

**Table 2-F. Adequacy of Prenatal Care Utilization Index
Oregon 2009-2014**

Year	Intensive	Adequate	Intermediate	Inadequate
2009	32.4	40.1	12.5	14.1
2010	35.5	40.1	10.9	12.9
2011	34.8	41.3	11.8	12.2
2012	33.6	40.9	13.6	12.0
2013	32.5	41.7	13.5	12.3
2014	32.5	42.7	12.0	12.1

Birth attendant and place of delivery

Hospital births. Hospitals were the most frequent place of birth with 95.9% of Oregon occurrence births. Most in-hospital births were planned to occur in the hospital (99.3%); 323 out-of-hospital births were planned at the onset of labor and subsequently delivered in the hospital. Medical doctors or osteopathic doctors delivered the majority (81.6%) of planned hospital births; certified nurse midwives delivered 18.1%, and other licensed medical

Year	Deliveries	Rate ¹
1985	1,772	43.5
1986	1,520	37.9
1987	1,361	34.0
1988	1,217	29.4
1989	1,117	26.2
1990	1,077	24.2
1991	979	22.2
1992	996	22.8
1993	936	21.6
1994	979	22.5
1995	967	21.7
1996	979	21.4
1997	970	21.5
1998	914	19.8
1999	948	20.6
2000	1,047	22.4
2001	1,007	21.7
2002	947	20.6
2003	1,000	21.3
2004	1,003	21.6
2005	1,058	22.6
2006	1,134	23.1
2007	1,267	25.4
2008	1,431	29.0
2009	1,404	29.4
2010	1,574	34.3
2011	1,680	36.9
2012	1,739	38.2
2013	1,702	37.3
2014	1,878	40.7

¹ Rate per 1,000 births

professionals delivered 0.4% (see Table 2-38).

Out-of-hospital births. In 2014, 4.1% of Oregon births occurred out-of-hospital. As in past years, the majority of out-of-hospital births occurred in the mother's home (60.5%). Of those home births, 93.5% were planned home births, while the remaining 6.5% were not intended to occur at home. Freestanding birthing centers accounted for more than one-third, or 694, of out-of-hospital births.

In 2011, the Oregon Legislature passed House Bill 2380, which required the Oregon Public Health Division to add two questions to the Oregon Birth Certificate to determine planned place of birth and birth attendant. Every mother that delivered in the hospital was asked if she planned to deliver at a private home or a freestanding birthing center and the planned primary attendant type at the time she went into labor. Overall, 2,076 births were planned out-of-hospital (4.5%). Of these, 323 (15.6%) planned out-of-hospital births ultimately delivered in-hospital. Neonatal transfers were slightly more likely among women that planned out-of-hospital births (2.0% versus 1.2%; see Table 2-40). Women that planned out-of-hospital births tended to be 30 or older (56.5%), White non-Hispanic (84.8%), married (81.3%) and college-educated (44.3%). (See Table 2-39.)

Women that planned out-of-hospital births generally experienced fewer medical interventions than those women that planned hospital births. Medical intervention rates among planned out-of-hospital births included induction and augmentation of labor (9.8%), epidural or spinal anesthesia (9.1%), operative vaginal birth (1.2%) and cesarean section (5.1%). A woman planning on delivering in-hospital was nearly three times more likely to have a primary cesarean section than a woman planning on delivering out-of-hospital (16.8% vs. 4.2%). In 2014, 35.0% of women planning out-of-hospital births did not have a Group B streptococcal test compared to 4.0% for women planning a hospital birth (see Table 2-40).

Outcomes generally have been positive for out-of-hospital births. Women that planned out-of-hospital births were more likely to deliver term infants (obstetric estimate of gestation of 37 completed weeks or more) and less likely to deliver low birthweight infants.

Birth attendant. There are three different types of midwives in Oregon: certified nurse midwives (CNM), licensed direct entry midwives (LDM), and direct entry midwives (DEM). CNMs have completed an accredited, university-affiliated nurse-midwifery program, and have an active nurse practitioner license. They may attend deliveries in hospitals, freestanding birth centers and homes. LDMs are direct entry midwives that have volunteered for state licensure through the Oregon Health Licensing Agency. They must meet qualifications and adhere to Oregon regulations. Other midwives are lay midwives that are not licensed in Oregon but are registered with the Center for Health Statistics to certify births.

A major shift during the past few decades has been the increasing prevalence of births attended by certified nurse midwives (CNMs). In 2014, 18.1% of planned hospital deliveries were CNM-attended. Women that planned out-of-hospital births reported the following planned attendants: CNMs (26.6%), LDMs (47.6%), naturopathic physicians (13.9%) and other midwives (9.0%). Non-medical attendants delivered 170 babies in total, including 8.6% of out-of-hospital births (see Table 2-38).

Year	Deliveries		
	Total	In-hospital	Out-of-hospital
1985	2,022	1,661	390
1986	1,984	1,607	400
1987	1,843	1,483	385
1988	2,345	2,133	259
1989	2,886	2,706	244
1990	3,660	3,539	226
1991	4,262	4,096	166
1992	4,498	4,319	179
1993	4,784	4,618	173
1994	4,931	4,772	159
1995	5,601	5,441	160
1996	6,019	5,871	148
1997	5,853	5,734	119
1998	6,152	6,004	148
1999	6,357	6,193	164
2000	6,740	6,591	149
2001	6,848	6,721	127
2002	6,837	6,747	90
2003	6,838	6,721	117
2004	6,586	6,472	114
2005	6,487	6,386	101
2006	7,102	6,996	106
2007	7,631	7,507	124
2008	8,004	7,820	184
2009	7,711	7,579	132
2010	7,476	7,257	219
2011	7,496	7,245	251
2012	7,454	7,156	298
2013	8,279	7,929	350
2014	8,456	8,059	397

Method of delivery

In 2014, the rate of cesarean delivery was 27.4%, well below the 2014 national rate of 32.2%.¹ The rate for vaginal delivery after a previous cesarean was only 2.5%, while the repeat cesarean rate was 11.2%. The majority of births (70.1%) continued to be vaginal deliveries without prior cesarean (see Table 2-37). The number of vaginal deliveries (without prior cesarean) increased slightly (1.6%) from 2013. Cesarean rates have declined slightly each year since their peak, in 2009, of 29.4%. The rate for 2014 is 2.1% lower than the previous year (28.0%) and 6.8% lower than 2009.

Infant health characteristics

Period of gestation

Preterm births (infants born prior to completion of 37 weeks gestation) comprised 7.7% of total births in 2014, lower than the national rate in 2013 (9.6%; see Table 2-25). Similar to national trends, proportions of preterm births are higher for non-Hispanic African Americans (10.3%) and non-Hispanic Hawaiian and Pacific Islanders (11.2%). Non-Hispanic Asian

women had the lowest proportions of preterm births (7.1%; see Table 2-25).

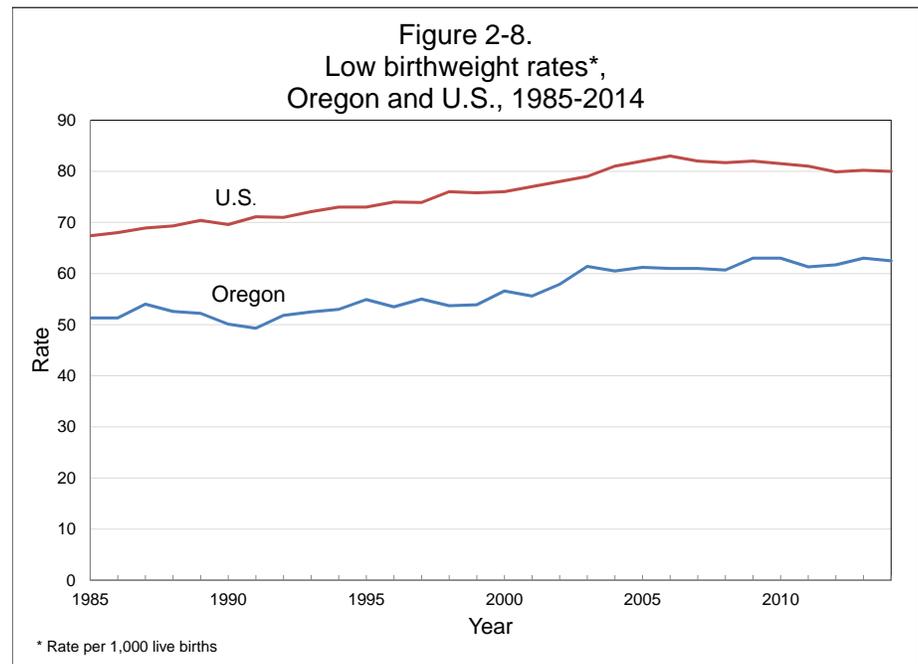
Low birthweight

National Healthy People 2020 objective

Percentage of live births resulting in low birthweight infant

2020 target:	7.8 %
2014:	6.3%

Of the thousands of infants born each year, not all thrive and become healthy adults. Low birthweight is the major predictor of infant death, which is a fundamental measure of the health of a population. Infants with low birthweight are more likely to need extensive medical treatment and to have lifelong disabling conditions. (For more information, see “Oregon Vital Statistics Annual Report 2014, Volume 2: Mortality Fetal and Infant Mortality.”) The low birthweight rate is the proportion of infants that weigh less than 2,500 grams (5 pounds, 8 ounces) at birth. In 2014, there were 2,847 low birthweight babies born to Oregon mothers (see Table 2-27). One of the National Healthy People 2020 objectives is to reduce the percentage of low birthweight infants nationwide to 7.8%. In 2014, the percentage of low birthweight births in Oregon remained well below this objective at 6.3%, or 63.0 per 1,000 live births. This rate is unchanged from the previous year. While annual changes have been small in the last 20 years, there has been a slight upward



trend in low birthweight infants (see Table 1-5, Figure 2-8). Nevertheless, Oregon’s low birthweight rates are typically 25% lower than national rates and in 2014, Oregon’s rate was 21.9% lower than the 2014 national rate (62.5 vs. 80.0 per 1,000 births).¹

High birthweight

Birthweight is an important factor in the health of a newborn. Excessive birthweight, or fetal macrosomia, is a health risk factor for both the mother and child and is commonly defined as birthweight greater than 4,000 grams (8 pounds, 13 ounces).

Among Oregon residents in 2014, the prevalence of fetal macrosomia at 4,000 grams was 10.7% (see tables 2-24 and 2-25). As maternal age increases, the risk of fetal macrosomia also tends to increase (see Table 2-24). The percentage of infants born weighing more than 4,000 grams is 6.9% greater than the state average for women 35 and older (11.4%), and 58.3% higher than among women less than 20 years of age (7.2%; see Table 2-27).

In 2014, the prevalence of macrosomia was highest among non-Hispanic American Indian women (11.8%; see Table 2-25). The lowest rates of macrosomia were found in Asian women (5.0%) and Hawaiian/Pacific Islander women (7.6%).

Apgar scores

The Apgar score is composed of measurements of five infant characteristics: heart rate, respiratory effort, muscle tone, reflex irritability and color. Each characteristic is rated 0–2 and the scores totaled. Total scores below 7, five minutes after birth, indicate poor to intermediate health at birth. In Oregon during 2014, 2.6% of infants had Apgar scores below 7 (see tables 2-24 and 2-25).

Abnormal conditions and congenital anomalies

The most frequently reported conditions on birth certificates were admission to the neonatal intensive care unit, assisted ventilation immediately after delivery and antibiotics for suspected neonatal sepsis (see tables 2-33 and 2-34). Congenital anomalies reported on birth certificates are shown in Table 2-35. Although Oregon occurrences are somewhat higher than national rates for some anomalies, congenital anomalies

Among Oregon resident births in 2014, the biggest baby born was 13 lbs, 2 oz.

Table 2-1. Percentage of infants born weighing more than 4,000 grams, Oregon residents		
Year	Percent	Largest infant born (in grams)
1990	14.2	6040
1991	13.9	6265
1992	13.8	5990
1993	13.8	6010
1994	13.8	5810
1995	13.5	6265
1996	13.1	6156
1997	12.8	6060
1998	13.0	6139
1999	12.8	6293
2000	12.8	6151
2001	12.4	5981
2002	11.8	5896
2003	11.5	6180
2004	10.9	5925
2005	10.9	6497
2006	10.7	5982
2007	10.5	7000
2008	10.7	7711
2009	10.7	6804
2010	10.4	6454
2011	10.9	6401
2012	10.6	6350
2013	10.6	5845
2014	10.7	5954

Year	Private insurance	Self-pay	Medicaid/OHP
	%	%	%
1990	60.4	8.7	28.7
1991	58.2	6.5	33.2
1992	57.2	5.8	35.2
1993	56.2	5.9	36.2
1994	57.5	5.6	34.9
1995	57.9	4.9	35.5
1996	58.3	5.7	35.0
1997	60.8	6.3	31.9
1998	62.2	6.3	30.7
1999	61.1	5.9	32.4
2000	61.6	5.4	32.8
2001	61.2	4.3	34.3
2002	58.7	3.5	37.8
2003	58.9	3.5	37.6
2004	56.5	3.2	40.3
2005	55.6	3.0	41.4
2006	55.1	3.2	41.3
2007	56.1	3.5	40.4
2008	53.6	3.2	40.9
2009	52.3	2.5	42.3
2010	50.9	2.4	45.1
2011	50.8	2.2	45.5
2012	51.5	2.2	44.8
2013	52.7	2.3	43.5
2014	52.2	1.9	44.7

Note: Denominator excludes births with unknown payor source, and multiple payor source.

are believed to be underreported nationally due to factors such as how recognizable and severe they are. Even at the national level, data users are advised to use caution in comparing annual occurrences for relatively small numbers.

Multiple births

Although 3.5% of births in Oregon during 2014 were multiple births, the proportion varied widely by age, race and ethnicity. During 2014, mothers aged 45 and older had the highest percentage of multiple births. The percentage of multiple births for each age group ranged from 1.8% for mothers aged 15–19 to 20.0% of births to mothers aged 45 and older. The percentage of multiple births generally increased with each five-year age group (see Table 2-24). Non-Hispanic African American women had the highest percentages of multiple births at 5.3% (see Table 2-25).

Infertility treatment

Many fertility treatments increase a woman's chance of having twins, triplets or other multiples. Multiples are at higher risk for prematurity and low birthweight. During 2014, mothers aged 45 and older had the highest rate of infertility treatment (380.0 per 1,000 births; see Table 2-23).

Source of payment

Primary source of payment for delivery is noted on Oregon birth certificates under five categories: public insurance (Medicaid/Oregon Health Plan), private insurance, self-pay (no insurance), Indian Health Services, and other and unknown payment source. Private insurance companies paid for the majority of deliveries in Oregon (52.2%), down from 52.7% in 2013 (see sidebar Table 2-J). Medicaid programs (e.g., the Oregon Health Plan) paid for more than two-fifths of Oregon resident births (44.7%). Delivery costs were more likely to be paid for by public insurance if the woman was less than age 18 (see Table 2-14).

Endnotes

1. Centers for Disease Control and Prevention (CDC). Births: preliminary data for 2014. National Vital Statistics Reports. 2015 June 17; 64(62).
2. Centers for Disease Control and Prevention (CDC). Births: final data for 2013. National Vital Statistics Reports. 2015 Jan 15; 64(1).