Maternal and Child Health Services in the United States

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GUEST EDITORIAL

IN 1990, Patricia Stephenson stated: "Who should provide maternity, infant, and pre-school child health services in the US, and how should they be paid? This is a subject which does not need further research. There is more than adequate information, both inside and outside the US, to make decisions and set policy. What is needed is action, not research."

WHO SHOULD PROVIDE THE CARE?

Maternity Care

In every developed country in the world except the US and Canada, the maternity care system has two basic care givers: a midwife (or rarely general practitioner) for normal care and a hospital-based obstetrician for complications. This system has produced the best results. For example, the Nordic countries (Finland, Sweden, Norway, Denmark, Iceland) have the world's best safety record—i.e. the lowest perinatal mortality rates, significantly lower than the US. In these countries pregnant women, after initial screening by a physician, never again see a doctor during pregnancy, unless they develop a complication, as they are followed only by midwives. Following a normal pregnancy, it is the midwife who admits the labouring woman to the hospital, monitors and assists at the birth and discharges the woman home. Over 70% of the birthing women in these countries never see a doctor in the hospital because a complication has not developed. Clearly, midwives are the *safest* care givers for the over 70% of women with normal pregnancy and birth.

The rapid expansion of midwifery in the US is a key to unlocking the present crisis in maternity care. The expanded use of midwives will

contribute in important ways to solving at least six aspects of this crisis. First, over 70% of US obstetricians have been sued one or more times. Even in this litigious atmosphere, midwives are rarely sued. Midwives, nevertheless, need malpractice insurance, and midwifery organizations, often working together with State governments, have found a variety of solutions within the means of midwives.

A second aspect is that in some large urban centres in the US, 70–80% of all practicing obstetricians refuse to accept Medicaid clients. Midwives eagerly accept these women.

Because of this refusal, a third aspect of the maternity crisis occurs—the public-sector health care cannot handle the load of birthing women who are poor. On December 14, 1989 a CNN television news programme reported that a State-run hospital in Southern California had hired Security Guards to turn away uninsured women in labour. The same programme reported that the administrator of the Los Angeles County Hospital had admitted that they could not handle the load of birthing women, creating a dangerous situation. The use of midwives in such hospitals is one obvious solution.

Fourth, the scandalous 25% caesarean section rate in the US would be greatly helped by having midwives manage normal pregnancy and birth. No European country where midwives handle normal pregnancy and birth has a caesarean section rate over 15%, and it is under 10% in some European countries, yet all these countries lose fewer babies than the US. The Birth Center Study in the US (1) proved that using midwives in the US is safe and produces lower obstetrical intervention rates.

The fifth aspect of the maternity crisis in the US, improving access to and use of prenatal care, is widely discussed as a central issue. Using midwives is an important solution here. Midwives are certainly ready to do it. And using midwives will improve access and use by creating an environment compatible with poor clients. We too often blame the victims, the poor women who don't get prenatal care and too infrequently look at the relevance of this care. Pregnant women don't need just blood pressure, urinalysis, abdominal palpation and maybe an ultrasound scan. They also need help with substance abuse, nutrition, etc., and they need social support. The midwifery-provided prenatal care in Europe puts emphasis on these latter services and on creating a warm, supportive care, and the result is no problem with access or use.

The sixth aspect of the maternity crisis in the US is its medicalized,

dehumanized nature. Pregnancy is not an illness and birth is not a surgical procedure. Expanding midwifery will automatically improve this regrettable trend.

Midwifery can be readily expanded in the US but will require resolving misunderstandings, both among health professionals and the public. Midwifery is a basic health profession, predating nursing by hundreds of years. For example, Switzerland formally recognized and gave legal status to midwives over 500 years ago. It is not a sub-specialty of nursing, and everywhere in the world outside of North America the term "nurse-midwife" sounds like carpenter-plumber. The model of four-year training in nursing leading to a bachelor's degree, followed by graduate training in midwifery leading to a master's degree, proposed by the US nursing establishment, doesn't exist anywhere else in the world, and to insist on it in the US would put an enormous hurdle in the path of the further development of midwifery. In most European countries midwifery is a 3-year course without prerequisite nursing training. In the US a 4-year course in midwifery leading to a bachelor's degree seems more feasible. Oxford, England has a model quite applicable to the US situation: two years' preclinical training provided together for nursing and midwifery students, followed by two years' clinical training in either nursing or midwifery leading to a bachelor's degree. Direct entry (i.e. no previous nursing training) midwifery schools would flourish in the US if properly supported. Such a school in Seattle has plenty of students but not enough funds. Many more mature women become interested in midwifery and need opportunities. Throughout history midwives have been central to the informal women's network in the community—hence the French name for midwife, sage-femme, or "wise woman."

Because the tradition of having a midwife as birth attendant was lost in North America, a major promotion of this profession is essential. Too many people in North America believe midwifery is second-class obstetrics—a serious misunderstanding. European women demand a midwife as their right and get her. Education of the public, including mass media, is important.

Experiencing midwifery care will also help its promotion. Right now in the US midwives can be brought in to serve as independent practitioners in areas where there is a lack of maternity care—the inner city, rural areas, etc. The public health establishment must help in ensuring that these midwives have adequate medical backup and transport systems.

Infant and Pre-school Child Health Care

In every developed country in the world except the US and Canada the infant and pre-school child health system has two basic care givers: a specially trained nurse (and occasionally a general practitioner) for normal preventive care and minor curative care, and a hospital-based pediatrician for complicated cases. This system has produced the best results. While the contribution of medical care to infant mortality rates is marginal, the countries in the world with the lowest infant mortality rates have this type of child health system. The US, on the other hand, is 21st in the world in infant mortality, and this national disgrace clearly indicates a crisis in infant health care in the US.

In the 1940s, 50s and 60s in the US, public health nurses gave routine care to poor infants and young children—at that time this was the backbone of neighbourhood health care. This service, sadly, has been in large part lost in the US and urgently needs to be restored. In the United Kingdom and Denmark a home-visiting service by specially trained nurses is provided to all families with infants and young children. This is a very interesting model with relevance to the US. One study (2) suggests that such a service would benefit high-risk families in the US. In Sweden, Norway, France, The Netherlands, and elsewhere there is a neighbourhood clinic with a specially trained nurse who has back-up when needed by a general practitioner. In some countries a "community pediatrician" may supervise a number of clinics but it is the nurse who is the primary care giver.

The development of such a nurse to monitor and give primary care to infants and young children is a key to unlocking some of the urgent issues in the crisis in infant health in the US.

The first issue is access. A recent study by the American Academy of Pediatrics (3) showed that "only 56% of pediatricians allowed comparable access to the practices for both Medicaid and private patients." Furthermore, pediatric training is not directed to normal child care. It may be US pediatricians' bread and butter, but it is not their cake. Nurses are ready to provide such care and have a track record in the US to prove it.

A second urgent issue in the crisis in infant health is differing levels of health among different socioeconomic groups in the US. Many indicators show that the children most needing health care in the US are the least likely to get it. Perhaps the best indicator here is rates of immunization.

These rates are seriously low among poor US children leading, for example, to epidemics of measles. In European countries where nurses give immunizations in the home or neighbourhood clinic, every country has immunization rates over 90% and there are no epidemics. The issues of access to health care and differing levels of child health could benefit enormously by a system in the US using a nurse as the first-level care giver.

Another child health issue is the tendency toward the medicalization of infancy and professionalization of parenting. This is well illustrated in Israel where there is a well-baby clinic system similar to the US except that it is free of charge to all families. In Israel they now average 20 visits for health care in the first year of life alone. On the other hand, in the United Kingdom nurses who visit families with children are trained to empower families to help themselves and each other rather than turning to doctors for routine childrearing problems.

Reintroducing nurses into child health services in the US is feasible. Unlike medical education, nursing education is more and more focusing on prevention and community care. Public health nursing is an old established profession in the US. An infrastructure already exists to bring nursing as the primary care giver for normal infants and young children.

HOW SHOULD CARE PROVIDERS BE PAID?

Every developed country in the world except the US has a system of national health care which ensures health care without financial barriers to every citizen. These systems take many forms but they all have in common to do away with a double standard of health care. The health care providers are not paid out of the user's pocket in any other country. No other developed country has "dumping," with a means test before hospital admission or receipt of other health services. The present health care non-system in the US, based mainly on fee-for-service, costs the American public far more than other developed countries (i.e. the percent of GNP spent on health care is half again as much). It is not surprising that access is a problem: a large part of the fiscal bureaucracy of health care in the US is designed to keep people out of health care. Other countries are aware of these problems in US health care and, frankly, consider them obscene.

A national health insurance programme is urgently needed in the US and, for a number of reasons, universal free maternity care and infant care is the most auspicious place to start. First, such a start would firmly place a national health insurance programme on the moral highground.

The offspring (fetus, infant, young child) cannot be held responsible for the family's financial situation and should not have to pay the price for poverty.

Secondly, there is good hard data, at least with regard to maternal and infant care, to show that a health system with dual financing, public and private, even if it provides universal coverage, produces a double standard of care. We have good data showing that many US physicians do not provide equal access to care to poor pregnant women and children, and we also have good data showing that even if they do give care to poor women and children, it is of a different quality. For example, a recent article (4) showed that women from upper middle-class census tracts had twice as many caesarean section births as women from lower-class census tracts. Since obstetricians argue that poor women are at higher risk obstetrically, the data should have been in the opposite direction.

A third reason to start a national health insurance programme with universal free maternity and infant care is that it provides an opportunity to reorient present prenatal, birth and infant care to incorporate midwifery and nursing as described earlier. To continue paying health providers on a fee-for-service basis for present US maternity and infant care will simply put more money in the pockets of obstetricians and pediatricians. To expand fee-for-service will further entrench the present orthodox, medically oriented approach to prenatal care and infant care which is not designed for the needs of, nor accessible to those most at risk, poor families. An example of this orthodox medical approach comes from Indianapolis where last year the business community wanted to help lower the black infant mortality rate, the highest among US cities. Following the advice of hospital doctors, they purchased a mobile ultrasound unit to go to the inner city where poor black pregnant women have inadequate nutrition and substance abuse.

A fee-for-service system also puts financial considerations into the patient-care decision process which is fair neither to the patient nor the doctor. Fee-for-service also makes health care costs doctor-driven which makes cost containment and quality assurance very difficult. For all these reasons, expanding the number of pregnant women and babies eligible for the present Medicaid system is *not* an answer to the crisis.

A further selling point for starting national health insurance with maternal and infant care is a practical point—it is cheap and feasible. Midwifery service and nursing service are both less expensive than obstetrical service and pediatric service, and therefore cost-effective. Moving away

from a fee-for-service system would be difficult to sell to many physicians but would be acceptable to midwives and nurses. It would also be easier and more feasible to build cost containment and quality assurance systems into such a reoriented maternal and infant national health insurance programme.

CONCLUSION

In summary, maternity care and infant and young child health care are currently in crisis in the US. This crisis can be turned into an opportunity in two different ways. First, these health services can be reoriented and the crisis greatly improved by bringing in midwives and nurses as the first line-of-care for healthy women and children. Secondly, the crisis can be used to push for universal free maternity health care and infant health care. This would be an important beginning toward the goal of universal free health care for all US citizens.

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