Reducing Infant Mortality: An Organizational Strategy

By Representative Thomas J. Bliley, Jr.

Nearly 40,000 babies born in the United States this year will not live to see their first birthday. While public attention generally focuses on infant mortality, the nucleus of this problem is the incidence of low birthweight. One-quarter of these infant deaths could be prevented with adequate prenatal care and proper nutrition. Although only 7 percent of all births are low birthweight, these babies account for almost 60 percent of all infant deaths.

The costs of caring for a single low birthweight infant can reach $400,000. The cost of prenatal care which might prevent the low birthweight condition in the first place may be just $400. In 1988, the hospital costs alone for low birthweight babies were approximately $2 billion.

If you look only at the aggregated infant mortality rate, you will miss important parts of the picture. Frustration over our inability to lower the infant mortality rate more quickly turns into puzzlement when we consider differences among the states. For example, Massachusetts now has the lowest overall infant mortality rate in the nation. But its rate among blacks is higher than the infant mortality rate for blacks in Louisiana, which has one of the highest overall infant mortality rates. Connecticut, which has the highest per-capita income in the nation, has a higher black infant mortality rate than Arkansas, which ranks near the bottom of the income scale in 46th place.

Three-Part Problem. There are three parts to the infant mortality issue – medical, social, and organizational. From the medical perspective, there is unanimous agreement that significant reductions in the infant mortality rate will depend on the increased use of preventive measures. Much of the decline in the infant morality rate over the past fifteen years has been attributable to technology. But we are reaching the technological limitations of acute-care medicine for newborns.

From the social perspective, we must become aware of the relationship of drug use to infant mortality. Last fall, Dr. John Niles, the President-elect of the Medical Society of the District of Columbia, informed the Select Committee on Children, Youth, and Families that the infant mortality rate in D.C. had declined to 18 percent in 1983. But now the rate is nearly 30 percent. Dr. Niles blamed the increase solely on crack cocaine.

When examining the social variables which contribute to the infant mortality rate, we must also consider adolescent pregnancy and single parenthood. In many ways, infant mortality is as much a social problem as a medical one. On the other hand, studies among migrants and refugees show that even the poorest of the poor can have healthy pregnancy outcomes if the supporting social structure is intact.

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I would like to focus on the third part of the problem, the organizational aspect of the infant mortality rate. There is now ample evidence that patterns of miscommunication, poor coordination, and emphasis on function rather than on mission plague our maternal health care delivery system.

No Fundamental Changes. Like its predecessors, the 101st Congress has chosen to take a piecemeal approach to the problem of infant mortality. It has increased funding for the Maternal and Child Health Block Grant and the Special Supplemental Food Program for Women, Infants and Children (WIC), and has expanded Medicaid coverage for pregnant women and infants to those under 133 percent of the federal poverty level. In last year's Budget Reconciliation, authority was provided to fund small demonstration projects featuring "one-stop shopping," home visiting or case management out of the MCH Block Grant if funds are available. I understand that the Public Health Service hopes to fund two projects this year.

But Congress failed to make any fundamental changes in the administration of these programs. Congress has failed to look at the effectiveness of programs both individually and as part of a comprehensive system. The growth in the number of programs makes it more difficult to evaluate program performance and creates new problems in choosing among alternatives. In a nutshell, this is the root of our budget problems. Instead of making choices, we just add another program. The action of the 101st Congress in regard to maternal and child health has been simply to put old wine into new skins. Please do not misunderstand. I have supported increases for these programs in the past and will continue to vote for them in the future, but I believe we also need another option to consider. It is time to reconsider the service delivery system itself.

The delivery of services to pregnant women and children has followed the scientific management model. Whether intentional or not, the federal government has tried to manufacture healthy children by using the same management model as it used to build bombers in World War II. That is, it broke the service system down into separate categorical programs among program specialists – social workers, dietians, family planning counselors, prenatal care providers, etc. But remember that Fredrick Taylor was an engineer, not a social worker. He may have known how to build bridges, but not strong families and healthy babies. Although the concept that an optimal solution can be found when the laws of physics or marketing apply, this management theory has not worked in the human services field.

Specialist Arrogance. The existence of these separate programs reflects the history of the growth of federal government. The Great Society programs and their progeny relied on this quiet arrogance that the specialists at the Department of Health, Education, and Welfare could run the War on Poverty using the same management strategies which Robert McNamara used at the Pentagon.

There are a number of problems in this approach when applied to human services. First, it creates competition for resources. Although this is a good idea on the assembly line, it is counterproductive in maternal and child health. At best, the mixed-game strategy resembles "prisoners' dilemma" which requires the participants independently to make a choice for the common good in order to gain an advantage in the end. But if one party fails to cooperate, everyone loses.

Second, it is terribly wasteful. Each categorical program has generated its own set of bureaucratic demands to satisfy. While Washington is engaged in power politics, resources which could be used to serve clients are wasted on administrative costs. The Select Committee on Children, Youth, and Families visited a clinic in Connecticut last December which juggles seventeen different federal, state, and local assistance programs. In a survey we conducted last fall on the availability of maternal and child health services, we found that 88 percent of providers receive support from more than one funding source. Seventy-seven percent receive funding from more than three sources. Multiple funding sources mean that there are multiple guidelines and reporting requirements as well as unpredictable fluctuations in funding amounts.

Third, it depends on the client to assemble the parts. This often creates new artificial barriers. For example, why is transportation a medical issue? Because Congress created a fragmented delivery system. The latest buzzword in health care, case-management, is neither a new nor innovative idea. It is another Band-Aid to fix a problem created by the fragmented system. Reimbursement for case management costs about half of prenatal care itself.

Process, Not Production. Fourth, when you set up a system to "produce" something, you have to produce something that can be counted. It is very difficult, if not impossible, to prove cause and effect in a social services evaluation for the simple fact that so many variables must be considered. Thus, we tend to measure the process rather than what really matters, which is individual client outcomes.

In large measure, Congress is responsible for the lack of effectiveness in bringing down the infant mortality rate. It is a tactical error to focus on performance standards for each of these programs individually, but that is what the categorical system forces administrative officials at all levels of government to do. The most needy person who requires a wide range of services is the one most difficult to reach. It takes extra resources, including time and staff, to provide nutritional education or prenatal care or family planning services to a person who is functionally illiterate, or who does not speak English, or who faces transportation problems. These are the ones who are at the greatest risk of a low birthweight pregnancy.

Finally, the scientific management model assumes that there is someone overseeing the entire process and who is in charge of the final outcome. But it is clear in the existing MCH health system that no one is really in charge of the major financial commitment to improve the lives and health of Americans. Last fall, the Assistant Secretary of Health testified that there are 93 programs administered by 20 different agencies related to the reduction of infant mortality. The services for pregnant women and children are really quite simple. But the administrative system has become so complex that no one is held accountable.

We need a results-oriented approach to the problem of infant mortality.

Eliminating Barriers. The solution I offer, the Consolidated Maternal and Child Health Services Act, is a creative approach to harness the combined power of more than $7 billion to improve the health care of mothers and children. This proposal recognizes that the incremental approach to health care management for pregnant women is a barrier, not a gateway, to further reduction in infant mortality and other poor health outcomes.

This concept will eliminate barriers to comprehensive care by giving a woman immediate access to all services, from preventive services prior to pregnancy, to prenatal care including nutrition services during pregnancy, to postpartum care, all from a single provider. Delays in obtaining prenatal care will eliminated. Children will receive immunizations, health care examinations, preventive laboratory testing, and nutritional services all in one place. Prevention will take its rightful place to reduce long-term disabilities.

In response to the shortcomings of the existing system, my legislation provides that:

- ♦ The federal government would provide more than $5.5 billion to support the block grant by combining the resources of ten existing programs, including WIC, parts of Medicaid, the Maternal and Child Health Block Grant, and the Title X program.
- ♦ States would determine eligibility. Savings generated through administrative efficiencies and reduction of long-term health care expenses would enable states to expand eligibility.
- ♦ No state would receive less federal support than it received and spent in the prior fiscal year. However, each state would be required to maintain its existing funding levels totaling more than $1.7 billion to qualify for federal support. The block grant would be indexed for inflation, not to exceed 5 percent per year, to provide a stable funding base while controlling the rate of growth.
- ♦ Individuals would receive the full array of medical and nutritional services from a single provider. Participating providers must agree to deliver all services in an integrated setting.
- ♦ States would be offered incentives to combine federal support with their state maternal and child programs in order to achieve maximum administrative savings. Federal administrative savings would be passed on to the states.
- ♦ Qualified providers would be determined by the states. They might include private physicians, state and local health departments, HMOs, not-for-profit clinics, and hospitals.
- ♦ A statutory prohibition on the use of funds for abortions and counseling and referral to obtain an abortion, except to save the life of the mother, would be enacted.

The current levels of funding from these ten programs will be combined into a single block grant and will be passed through to the states. In addition, this proposal will enhance the states' ability to coordinate another $100 million in funding generated by local governments and program income. Further reductions in unnecessary administrative costs can be achieved by integrating preventive health care services with comprehensive pregnancy care.

Obviously, this proposal would mean significant organizational changes for all levels of government. I realize that the impact of this bill has not been fully understood. Some of the governors have written back to me, saying they could not do this or that because of constraints in the existing system. It is difficult to overcome old habits. I recognize that the new flexibility and new authority will cause some discomfort. Some powerful special interest groups may feel threatened.

Medicaid Mandates. Although the immediate purpose of this legislation is to improve maternal and child health, it also holds implications for the fiscal and constitutional relationships between the federal government and the states. First, it will help to slow down the runaway medical costs we have experienced for the past decade. Current spending patterns are on a collision course with the budgetary facts of life. In 1980, Medicaid spending accounted for only 9 percent of all state spending. In 1990, it will account for nearly 14 percent. States face double-digit growth in Medicaid expenditures as a result of federal mandates imposed in the past three years, but only a 3-4 percent increase in revenues. As greater fiscal pressures on the states are applied and the Medicaid expansions fail to realize the desired reductions in infant mortality, there will also be greater pressure to completely federalize Medicaid or to adopt some version of nationalized health insurance. Since OBRA-86, OBRA-87, and now OBRA-89 have severed the link between Medicaid and cash assistance, the federalization of Medicaid has progressed much further than we have perhaps realized. Congress needs to consider fully the implication of this before further similar action is taken.

Yet, it also avoids the mistakes of prior block grant proposals that included substantial funding reductions. The block grant would be fully funded in the first year and would be indexed to provide an increase of up to 5 percent per year. Thus, although funding would continue to rise, the costs would be controlled.

Reinvigorating States' Role. Secondly, it can serve as the model for reinvigorating the role of the states in our federalist system. Just a few years ago, as Governor of New Hampshire, John Sununu described the status of federalism as a "'Leaning Tower of Pisa', that with much more of an erosion of that foundation, much more of a lean, the structure will topple." Since those remarks at a roundtable discussion on the impact of *Garcia*, Congress has imposed more and more mandates on the states. Medicaid, the essence of "cooperative federalism," has become so dominated by the federal government that 48 governors asked Congress for a two-year moratorium on new Medicaid mandates. Of course, Congress has refused to heed these pleas, and the ground supporting federalism has been eroded further.

Congress has thus far refused to acknowledge it, but there is an increasing awareness of the success of state administration through block grants. In examining the track record of the block grants, scholars at the Urban Institute have reported favorably:

> The evidence on implementation of the Reagan block grants has successfully answered many of the concerns about the states' capacity or commitment to administer grant programs without federal categorical restrictions.
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> In a word, the administrative rationale of block-grant consolidation, and even the political rationale for returning decision-making authority to the states, has been largely vindicated by the experience since 1981.

The experience of the 1980s has unquestionably helped to change attitudes toward state administrative capabilities. Alice Rivlin, former director of the Congressional Budget Office, and herself a Great Society reformer, has written: "Most of the public investment we need should be made by the states anyway. The real problem is to give the states clearer responsibility and more resources."

Sovereign Units. We need to stop treating states as "laboratories" and begin respecting them as the sovereign units of government they are meant to be under our federalist system.

A consolidated delivery system offers great potential for breaking the welfare cycle, holding the line on skyrocketing health care costs, and for returning to the traditional federalist roles in which the federal government provides the capital for states to manage as full-fledged partners. The first step to making government programs "kinder and gentler" is by making them easier to use.