White House decides it's 'too costly' to save 10,000 infants every year

by Linda Everett

The Bush administration has been accused of burying a confidential White House report on how the country could remedy its skyrocketing infant mortality rate because implementing its recommendations would be too costly.

Some 40,000 infants in America die every year before they reach their first birthday, and another 400,000 develop chronic or disabling conditions. Scores of studies and dozens of child-advocacy organizations, including two congressional groups, the National Commission to Prevent Infant Mortality and the National Commission on Children, have said the scourge could be reversed. When the White House Task Force on Infant Mortality analyzed the crisis, they also reported that by applying current knowledge along with an annual investment of $500 million, we could "save 10,000 additional infant lives each year and prevent an untold number of disabilities among infants."

The task force, which grew out of President Bush's campaign promise "to invest in our children," calls upon the President to make infant mortality an issue of "national urgency," because "this country cannot afford its current infant mortality rate in economic or in human terms." The Bush administration has been floundering ever since the report was finished in November 1989—until the media reported on a leaked copy of the document on Aug. 6.

The White House first claimed the report was just a draft, and then claimed the report was being "edited"—for the last nine months. This was challenged by Rep. John Dingell (D-Mich.), who contends that "high-level White House officials vetoed the report during critical administration budget deliberations in late 1989." Dingell, who chairs the House Subcommittee on Health and the Environment, has been trying to get a copy of the report since April.

The 100-page report states that "infant mortality and disability are not intractable problems" for the United States, which has an overall infant mortality rate of 10.1 deaths per 1,000 live births—higher than 21 other industrialized countries. The mortality rate for black infants is double that of white infants. In comparison, Japan's infant mortality rate was 20% higher than the United States' in 1960, but is now, after a major effort, the lowest in the world at 5.0 per 1,000.

'If we save but one life. . . .'

The White House task force, established under the Domestic Policy Council's Working Group on Health in July 1989, includes representatives from 10 federal departments and agencies and six offices within the Office of the President. Their report, which starts with the Talmudic quote, "If we save but one life, we save the world," reviews the well-known causes leading to premature birth and low birth weight—the major cause of 60% of infant deaths in the first four weeks of life. They found that 25% of all babies born each year are born to poor families, and another 20% are born to families with incomes of 100-185% of poverty level. "Each infant death," the report found, "represents an estimated $380,000 in lost productivity. Reducing infant mortality could lead to an increase of $2.3 billion in national productivity."

Among its recommendations, the task force calls for $480 million a year to sustain a National Health Service Corps with 2000 physicians, nurses, and other professionals; streamlining Medicaid and other assistance programs; and to initiate 20 large-scale, comprehensive community mortality reduction programs in cities where mortality rates are the highest. It also calls for debt-strapped state governments to increase services.

A representative of the National Association of Children's Hospitals and Related Institutions called it "a good report, but without a signature, it's just like every other report out there." She acknowledged, as did several agencies, that no report has considered how rapidly the infant mortality level has risen in parallel with the collapse of federal and state economies and our health care delivery system.

Some of the task force recommendations should be implemented immediately. But until the country scraps the federal malthusian policy of gutting health care for some perceived notion of "savings," we shall see mortality rates—of all ages—escalate.

An example is the care indigent pregnant women receive under emergency medical coverage through Medicaid. The program does not provide the woman with *any* prenatal health care—only her delivery is paid for. By then, it is too late to prevent the causes of premature birth, infant death, and profound life-long handicaps. The intensive neonatal care

needed for those first several years costs the taxpayer much more than any "savings." Thus, the program actually precipitates *more* infant mortality. Also, most prenatal care covered by Medicaid is through clinics—where a woman sees a different health care worker, not usually a doctor, at each visit. When she is ready to deliver, she goes to a city hospital where a different doctor or midwife delivers her child. She is lucky if they have ever seen her medical records.

The nation's infant mortality rate steadily declined for years until 1984, when the improvement slowed markedly, in correlation with the Reagan administration's reduced funding for programs for children, mothers of young children, and pregnant women. Major breakthroughs in saving low birth weight and premature infants accounted for much of the drop in infant mortality rates. Yet, major children's hospitals nationwide, where most neonatal research takes place, are penalized with 60% of their charges remaining unreimbursed, according to a 1989 U.S. General Accounting Office study. Another study charted the decline in participation of pregnant women in prenatal care in 1981-82 as being consistent with the loss of Medicaid and insurance benefits and the curtailment of support for public clinics.

This phenomenon is readily seen in the District of Columbia, where infant mortality soared in the first six months of 1989 to a rate of 32.3 deaths per 1,000 live births. By contrast, the overall rate for the District in 1988 was 23.2 deaths per 1,000.

The explosion in death rates is generally attributed to the crack cocaine epidemic. The rate of drug-exposed newborns quadrupled between 1985 and 1989, according to the House Select Committee on Children, Youth and Families. Crack cocaine used by pregnant women threatens the lives of 100,000 infants each year. Also, in 1988, seven times as many babies were born with syphilis as in 1978. One-third of the infants born to women with HIV virus will die or show evidence of the infection by age one.

However, there are other factors, like the 28% decline in the use of D.C. health clinics, because funding shortages have closed clinics, shortened hours, and severely eroded clinic staff, resources, and basic supplies. Faced with a two to three month clinic waiting period, women miss crucial first or second trimester care. Shorter clinic hours mean a scheduled visit could last all day. A woman may lose up to 20% of her income with the weekly visits needed in her last month of pregnancy. Another factor lies in the Medicaid policy of covering women who qualify for emergency Medicaid for only their labor and delivery—no prenatal care is provided. So the policy perpetuates the problem of women showing up at a city hospital with *no* prior care, to have her child delivered by a physician who has never seen her.

High malpractice premiums

When an obstetrician accepts an eight-month pregnant woman with no prior prenatal care, he is automatically charged higher malpractice insurance premiums. The Medicaid reimbursement often only covers the insurance premium for high-risk delivery, the Institute of Medicine said in 1989. Also, Medicaid pays obstetricians and hospitals a flat rate per pregnancy—whether the delivery is a major operation involving a caesarian or is routine. Some 60% of Medicaid programs and 90% of Maternal and Child Health programs nationally are unable to find maternity care providers. Nine out of 10 programs cite high malpractice insurance costs as the culprit.

Low Medicaid rates and high malpractice premiums are driving obstetricians and hospitals out of business. Some 44% of the counties in Georgia, 42% in Alabama, and 30% in Colorado no longer have any physician—either an obstetrician or family practitioner—to provide obstetrical services. President Bush's task force wants the states to help pay the insurance premiums rather than investigate what's behind such high premiums.

Another example of how federal cost-cutting has a major impact on access to timely health care, especially for the poor, is in Texas, which now ranks second worst in the nation on the number of babies born to women receiving inadequate, late, or no prenatal care. Texas also leads the nation in the number of hospital closures for the last five years, with 105 hospitals closing since 1980—more than half in rural areas. Of the 254 counties in Texas, 54 no longer have a hospital. This is largely blamed on the different ways the federal government refuses to pay for the Medicare and Medicaid program.

In 1984, Medicare would no longer pay the costs involved in treating a patient. Instead, the prospective payment system (PPS) paid hospitals a flat rate per diagnosis—no matter what the needed treatment costs. Hospitals passed on their unreimbursed Medicare costs to third-party payers or private patients. By 1986, Medicare stopped paying medical facilities 100% of their portion of capital costs, and continued to cut reimbursements. This meant dilapidated facilities and inefficient, antiquated equipment were not replaced. Finally, the federal government cut by half the percentage they added to the PPS rate to help pay for a facility's expensive training of new physicians, which covers the salaries of professors, intern stipends, and indirect education costs and extra materials used in training residents. Hospitals, as a result, were crippled with a growing debt.

Texas hospitals lose $780 per Medicare patient and $600 per Medicaid patient, and are now holding up to $10 million dollars in unpaid state Medicaid bills as well. Cities like Houston, where city health spending dropped nearly 25% per person between 1985 and 1989 (after the figures were adjusted for inflation), face major shortages of obstetricians and nurses. Houston's nurse-midwife program, intended to supplant the shortage, was also cut this year, along with several prenatal clinics. This leaves Houston's public hospitals, Ben Taub and Lyndon B. Johnson, understaffed, underfinanced, and swamped with primarily non-paying patients,

patients on Medicaid, and all emergency cases normally treated by the private Hermann Hospital, which shut its emergency unit down after losing millions in unreimbursed federal revenues.

The result is that parts of Houston have an infant mortality of 18.5 deaths per 1,000 live births—higher than Costa Rica. Last year, Houston faced a measles epidemic that killed a record-breaking dozen children. Dr. Jeff Starke, a pediatric infectious disease expert at Baylor College of Medicine, reports that Houston's rate of tuberculosis among children is three times the national average. A few months ago, a year-old child died of tuberculosis at Ben Taub Hospital, just 20 hours after admission. The child had had TB for months, but the 66-day delay at the baby clinic precluded his being treated.

Another ominous sign is that between July 1989 and June 1990, 13 maternal deaths were reported at Houston's Lyndon B. Johnson Hospital. Between 1981 and 1986, there were an appalling three to four maternal deaths each year in the same district. The national maternal mortality rate is 6.6 maternal deaths per 100,000 live births. The rate for this Houston hospital alone translates into a startling 82 maternal deaths per 100,000 live births. The nation has not experienced that high a maternal mortality rate since 1950!

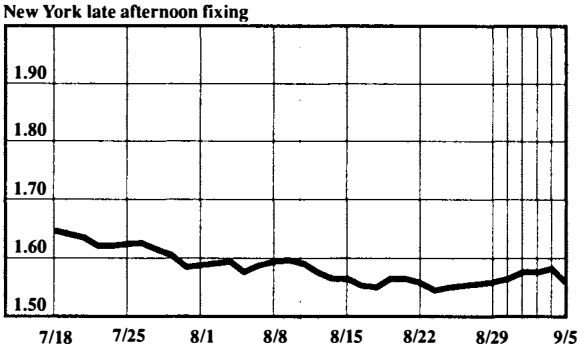
Another major factor of babies being born with dangerously low birth weight—who are 40 times more likely to die within the first 28 days of life—is under-nourishment of pregnant mothers. The federally funded program that is key in assuring proper weight gain is the Special Supplemental Food Program for Women, Infants and Children (WIC). As of 1988, only 49% of all eligible women and children in the country received WIC services. In some states, less than one-third those eligible received WIC benefits. Three months ago, the WIC program reported that 36 of 44 state governments intended to cut their portion of the WIC program. Some states found ways to sustain their caseloads, but others made major cuts. Pennsylvania, one of the 10 states with the highest number of black babies born at low birth weight, dropped 30% of those receiving WIC benfits—about 60,000 needy people. Without exception, black and non-white infant mortality rates, and neonatal and post-neonatal mortality rates in Pennsylvania have escalated between 1986 and 1987 by as much as 1.8 points. The lack of WIC benefits will lead to those rates skyrocketing.

A fundamental problem contributing to infant mortality—beyond poverty, lack of timely care, AIDS, crack-cocaine addiction, and lack of education—is the White House's unwillingness to see that the wealth of a nation is its citizenry. The task force members are correct: This nation has the answers to save lives. However, after the report was leaked, the Bush administration has not acted, and instead trotted out Secretary of Health and Human Services Dr. Louis Sullivan to announce new statistics to indicate that the country's infant mortality rate of 9.7 is at an all time low.

Currency Rates

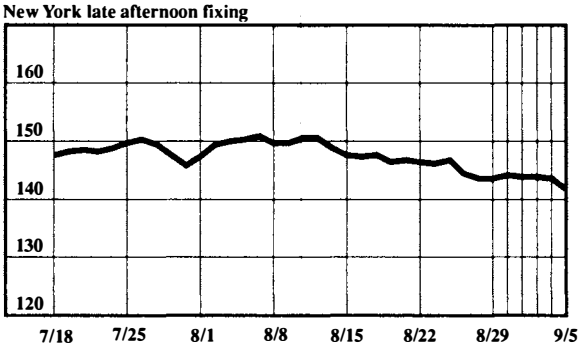
The dollar in deutschemarks

New York late afternoon fixing



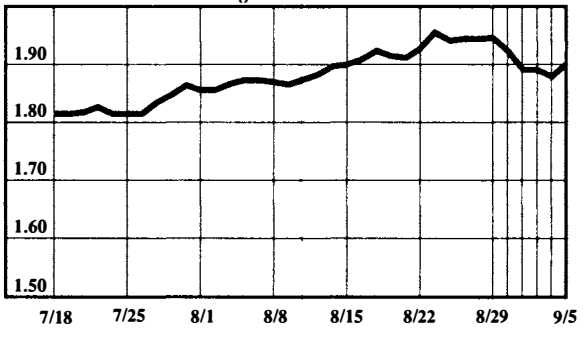
The dollar in yen

New York late afternoon fixing



The British pound in dollars

New York late afternoon fixing



The dollar in Swiss francs

New York late afternoon fixing