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Socioeconomic Differences in Antenatal Care between the United States and Scandinavia

Abstract

Despite their analogous status as economically developed nations, the United States and Scandinavian countries have marked differences in their healthcare systems. In particular both areas discernibly differ in the antenatal treatment provided for expecting women and their babies. Sweden and Denmark's healthcare systems are universal, run primarily on taxpayer dollars, and provide equal antenatal care regardless of socioeconomic status. The United States' healthcare system is run on a combination of private and government run insurance, in which socioeconomic status often determines insurance coverage. This variability in insurance coverage often results in differing levels of antenatal care. An overarching question remains as to how women of low socioeconomic status receive differing antenatal care in the United States and Scandinavia. Antenatal care discrepancies between the two systems emanate a difference in patient outcomes and patient satisfaction of their treatment. Analyzing the differences in these outcomes can better point to which health care system provides more effective antenatal care. Women of lower socioeconomic status in Sweden and Denmark receive superior antenatal care than women of a comparable socioeconomic status in the United States. [*excerpt*]

Keywords

Socioeconomic differences, antenatal, Scandinavia

Disciplines

Health Policy | International and Area Studies | International Public Health | International Relations | Maternal and Child Health | Public Health | Women's Health

Socioeconomic Differences in Antenatal Care between the United States and Scandinavia

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Introduction

Despite their analogous status as economically developed nations, the United States and Scandinavian countries have marked differences in their healthcare systems. In particular both areas discernibly differ in the antenatal treatment provided for expecting women and their babies. Sweden and Denmark's healthcare systems are universal, run primarily on taxpayer dollars, and provide equal antenatal care regardless of socioeconomic status. The United States' healthcare system is run on a combination of private and government run insurance, in which socioeconomic status often determines insurance coverage. This variability in insurance coverage often results in differing levels of antenatal care. An overarching question remains as to how women of low socioeconomic status receive differing antenatal care in the United States and Scandinavia. Antenatal care discrepancies between the two systems emanate a difference in patient outcomes and patient satisfaction of their treatment. Analyzing the differences in these outcomes can better point to which health care system provides more effective antenatal care. Women of lower socioeconomic status in Sweden and Denmark receive superior antenatal care than women of a comparable socioeconomic status in the United States.

Observations

Pregnant women in Denmark and Sweden have free access to public healthcare through taxpayer money. There are, however, options to visit private sectors and pay out of pocket. Visits, which included lectures, to maternity and delivery wards in Denmark and Sweden and interactions with their doctors allowed for general information on the healthcare systems to be obtained, as well as information regarding prenatal, delivery, and postnatal care given to the women.

An academic visit to the obstetrics and gynecological ward at the Rigshospitalet in Copenhagen provided information regarding their duties in addition to general information about the Danish healthcare system. Overall, Parliament decides the size of the health budget and 84.7 percent of health related expenditure is paid for by the public. The primary sector of the Danish healthcare system includes midwives and general practitioners. Both of these fields provide pregnancy check ups and prenatal care to pregnant women. To get admission to the secondary sector, the hospital, a patient needs to go through the primary sector. The general practitioner will grant acute admission day or night.

At the Södersjukhuset maternity and delivery ward in Stockholm, the largest obstetric clinic in Sweden, prenatal care is also covered by the healthcare system. All of the maternity care and the youth center is free. During a woman's pregnancy, Södersjukhuset requires ten visits for maternity care by a midwife. During these ten visits, only one ultrasound is required during the 18th week. Host and midwife, Caroline Lindvall, spoke greatly to the extent the hospital goes to keep the expecting mothers

comfortable. The women are treated like soon to be mothers and not like patients. Giving birth and having children is a natural process, therefore, the ward focuses on making the pregnancy and delivery as natural and comfortable as possible. The most common age ranges here to give birth are 26-30 years old and 31-35 years old.

In comparing the Rigshospitalet's maternity and delivery ward to Södersjukhuset's maternity and delivery ward, Södersjukhuset has a larger focus on the aesthetics and the modernness of their facilities and keeping the medical equipment hidden from the women who come into the wards. Obstetrics doctor Birgitte Bruun Nielsen of Rigshospitalet mentioned during the tour of the ward her concern of the "un-homey feel" to the hospital's rooms with all the equipment out and visible. At Södersjukhuset, the rooms were more comfortable, well lit, and the equipment was barely noticeable. Nonetheless, the care is free and doctors of Denmark are held to follow national guidelines for care. This allows a chance for pregnant women regardless of socioeconomic status to have access to equal antenatal care.

Discussion and Learning Outcomes

Antenatal care is of vast importance for the health of unborn children and the mother, however, access to this care is not always equal throughout the world. Providing necessary medical care and helping pregnant women improve their general health plays an important role in alleviating risk factors and improving pregnancy outcomes, especially if the care is adequate and obtained early (Wymelenberg, 1990). A high death rate among newborns is strongly correlated to the number of infants who have a low birth weight for their gestational age (Dennis and Mollborn, 2013). Women who do not receive adequate maternity care have a higher risk of having a low birthweight baby. One of the main factors that contributes to low birth weight is low socioeconomic status (Dennis and Mollborn, 2013).

In the United States, those of lower income status have more difficulty receiving prenatal care because their expenses either have to be paid for through insurance or come out of pocket. It was found that few low income women had access to prenatal care despite there being free prenatal care services provided (Witwer, 1990). For the women insured by Medicaid, they tended to use clinics for their prenatal care appointments. Unfortunately, these clinics may be overwhelmed and difficult to schedule timely appointments. Prenatal care that is available at no cost in the United States is typically provided by charity care, care in the public health clinics, or other settings that may be publically funded. Uninsured pregnant women rely on these methods to receive the necessary prenatal care (Brown, 1988). In addition to unequal access to prenatal care, pregnant women who have private insurance are more likely to obtain prenatal care earlier in their pregnancy and attend more prenatal visits more often than women who are covered by Medicaid. For example, in Texas of 1986, about five percent of women privately insured

attended five or fewer prenatal visits whereas 25 percent of women insured by Medicaid had five or fewer visits (Brown, 1988).

Along with receiving less frequent and lower quality care, pregnant women of lower socioeconomic status in the United States also experience more stress and are at higher risk of delivering prematurely (American Psychological Association, 2011). Since these babies were not brought to term, they may have a higher risk of future developmental issues. The lack of material access and low income status may also be associated with depression and decreased cognitive functioning. Furthermore, lack of sufficient prenatal care and lower quality intrapartum care can result in higher infant mortality rates. 2015 statistics estimate that in the United States infant mortality rates were three times greater than Sweden and two times greater than infant mortality rates in Denmark (UN Inter-agency Group for Child Mortality, 2015).

In Sweden and Denmark, these issues are not as prevalent because all citizens who pay taxes receive the same public health care, unless they choose care through the private sector. This essentially “free” healthcare allows for mothers of all socioeconomic statuses to have access to all the necessary care they need before and after delivery. The effectiveness of this system is apparent in the health care statistics from Scandinavia versus the United States. Despite having access to prenatal care provided by the United States government, few women of low socioeconomic status can take advantage of these services, with some never receiving care prior to giving birth. Medicaid and United States government funded clinics cover only 8 million of the 17.5 million women who are in need of publicly funded family planning services and supplies, leaving millions without the resources, information and services they need (Bingham, 2011). Due to women of lower socioeconomic status not being able to pay for available services, they are less connected with the obstetric care system.

Other potential barriers that can prevent prenatal care among these women include not reaching out to helpful services due to prior unfavorable experiences, depression, and inadequate transportation access (Nagahawatte and Goldenberg, 2008). This can have negative consequences for both the mothers and the newborn. Women are about three to four times more likely to die of complications related to pregnancy if they do not receive any prenatal care (Bingham, 2011). Healthy People 2010, of the United States’ national health objectives, aimed to have 90 percent of pregnant women to receive 13 prenatal visits from the beginning of the first trimester until delivery. It was found, however, that 25 percent of women did not receive this “adequate prenatal care” of 13 visits (Bingham, 2011). On the contrary, Swedish women received on average 6.55 antenatal visits in a 2013 study, many of which were with a midwife (Hildingsson et. al, 2013). If problems were detected in pregnancy screenings the midwife could then refer the patient to see a specialist. Overall an overwhelming majority of Swedish women surveyed

were satisfied with the emotional, medical, and educational care they received when it came to their pregnancy (Hildingsson et. al, 2013). This access to a breadth of antenatal care in multiple spectrums is believed to be a contributing factor in the exceptionally low infant mortality rate of two per one thousand births (UN Inter-agency Group for Child Mortality, 2015).

On the other hand, easy access to health care can also lead to some issues. People seeking refuge in countries such as Denmark and Sweden may not be able to gain as much access to medical care as advertised. Immigrant women of poor socioeconomic status are vulnerable, and they have a greater risk of requiring an induced abortion (Rasch et al., 2008). Even though healthcare is “universal” and “free” it can still be a challenge for those of the lowest socioeconomic class to receive the antenatal care they need.

Limitation of Research Findings

The European health care system is much more open and information is more readily available to the public in regards to how the hospital runs behind closed doors and the practices they perform on each individual patient. In the United States, information is kept much more private, and it would be difficult for students who are not directly in graduate level medicine to gain access to such knowledge. Additionally, the class did not go to hospitals in United States and receive lectures on the American health care system, whereas in Denmark and Sweden general practitioners and multiple hospitals were visited, which gave an overview of each hospital’s specific function. Since American hospitals were not visited as a group, all of the information included in this research was pulled from online sources and background knowledge of the American health care system. Many of the sources available had information that was gathered 20 or more years ago. Thus, the data collected may be slightly outdated since populations have changed.

Living in the United States allowed most of the class to have a decent background on the American health care system. Although this was not the focus on the study tours, this knowledge was used to compare to the new information received at each of the visits. Students were also able to ask the physicians questions in regard to how their health care system works in comparison to that of the United States.

A way to overcome some of these difficulties could be to ask the students to do some research on the current state of the United States’ healthcare system prior to taking the course. This would allow the students to have a more up-to-date background on non-universal health care systems and make more comparable inquiries to the Scandinavian universal health care system. The use of databases to perform research is also easily accessible and allows for the conglomeration of data between all nations. Even

though hospitals were briefly visited and the class was not completely immersed in the healthcare system or got to experience it in action first hand, much information can be acquired through online research.

Conclusion

The differences between a state run health care system and the individual insurance run health care system are evident between the United States and Sweden and Denmark. In the Scandinavian countries, nearly all women who require antenatal care, regardless of socioeconomic status, receive the same amount and quality of care. The women are more pleased with their care and the health statistics of infants in the Scandinavian countries are much better than those in the United States. Additionally, in the United States there is a large schism between the upper and lower classes of society. Those who cannot afford insurance are left to struggle to find accessible care and many are left without any medical care during their pregnancy. Although free clinics are available, they usually do not offer adequate care and are overpopulated with other patients with various issues. It is evident through first hand visits and in depth research that women of low socioeconomic status in Scandinavia receive better antenatal care than those of an equal socioeconomic class in the United States. Further research could be done on other nations who have universal healthcare, such as those in the Baltic and Mediterranean regions, to explore the effectiveness of the system. These findings could further depict the flaws in the privatized sector of health insurance used in the United States.

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