International Journal of Gynecology and Obstetrics 78 (2002) 105–106

International Journal of GYNECOLOGY & OBSTETRICS

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Editorial

In support of shorter hospital stays for selected high-risk obstetric patients

The cost of health care in the United States is reaching unsustainable levels. Whether measured as a portion of the gross domestic product (GDP), as a portion of state or federal budgets, or as out-of-pocket costs to consumers (especially for pharmaceuticals), health care costs are a major public policy issue. Addressing the problem of increasing health care costs requires efforts on many levels, including innovations in health care delivery that have the potential both to reduce costs and maintain or improve levels of quality of care.

An article by Dr Allen Ayres [1] in the *International Journal of Gynecology and Obstetrics* suggests one innovative approach to reducing costs and maintaining or improving quality of obstetrical care. Much of US health care (and probably much care internationally) is based on practices that have been institutionalized over time on the basis of tradition, rather than on the basis of clinical evidence. Assumptions about the need for hospitalization of certain groups of patients are a key example of this phenomenon in obstetrics and gynecology [2]. We need only remember the ease with which US regulations mandating coverage of minimal hospital stays after childbirth were passed—in the absence of supporting evidence for defined minimal stays—to know that presumptions about greater patient safety or better quality of care in the hospital, as opposed to outside the hospital, are ingrained in our thinking.

Our group at the University of Michigan has previously suggested that a comprehensive approach to prenatal care, including preconception, prenatal and postpartum services and incorporating a life-span perspective with competency-based evaluation of patients, can lead to shorter hospital stays [3,4]. Specific defined competencies, for both health providers and patient-participants, can be adapted to provide safe passage in a hospital environment to avoid all possible risks to mother or infant in the intrapartum period [5].

Innovations in practice that reduce costs by providing services outside the hospital can be defined and described by health services research and need not be inconsistent with quality improvements. Indeed, quality concerns need to be addressed first and foremost. Contemporary quality measurement focuses attention not only on patient safety and clinical outcomes, as is the focus in the Ayres article, but also on patients' perceptions of the quality of interpersonal interactions with providers, how well their needs and preferences are addressed, and their quality of life during pregnancy and immediately after childbirth. There is no reason to assume that innovations in childbirth practices that involve home care will be unacceptable to women. In fact, women's health advocacy in the United States has produced a number of innovations for childbirth outside of traditional hospital settings (for example, in freestanding birth centers and nurse midwife-attended home births) [6]. Our clinical innovations related to prenatal care and childbirth—even for high-risk patients—need to be assessed with respect to the quality of the experience from women's perspectives, including their preferences for care modalities, their needs for information and communication, their involvement

PII: S0020-7292(02)00138-8

in decision-making, and their satisfaction with care received.

As we continue to seek to control health care costs, it is imperative to identify innovations that simultaneously decrease our reliance on costly in-hospital or high-technology services and maintain or improve quality of care. High-quality, innovative, evidence-based clinical practice will remain the key to acceptable health care. Such clinical innovations and models as the home care of patients with preterm premature rupture of membranes need to be reported and shared widely so that others can benefit from our colleagues' experience.

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