

Privatizing Breastfeeding: A Strategy for Increasing Breastfeeding Rates in Mississippi

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Background

IT HAS BEEN NEARLY 10 YEARS since the State of Mississippi passed a bill that protects a mother's right to breastfeed in public, to use her breaks at work to express her milk, and to receive adequate support at childcare facilities.¹

In 2010, the Federal Government went much farther and mandated employers (with 50 or more employees) to provide a clean, private space for breastfeeding employees to express their milk, as well as insurers to offer breastfeeding support, access to breastfeeding supplies and equipment, and "comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period..."² Unfortunately, these laws have had little effect, if any, on Mississippi's breastfeeding rates, which remain the lowest or near the bottom in the nation.³

Although both laws have created a legal framework on which to protect breastfeeding rights and provide additional support, many women in the private sector, *who are not Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) recipients*, are not taking advantage of these benefits because they do not have access to breastfeeding experts, such as Certified Lactation Counselors (CLCs) or International Board Certified Lactation Consultants (IBCLCs).

The problem lies within the language of the Affordable Care Act (ACA), which has failed to define the meaning of "trained professionals." Consequently, most insurers have interpreted it to mean physicians and nurses, as these groups can be reimbursed for breastfeeding counseling services because they—unlike actual breastfeeding professionals—are licensed. Although these licensed clinical professionals are *not* trained breastfeeding professionals, neither the laws nor industry requires them to earn continuing education credit in breastfeeding.

In 2014, the National Breastfeeding Center evaluated the performance of insurance companies' adherence to the ACA mandate. The companies were graded on a scale of A+ to F. The three major Mississippi insurers—Blue Cross Blue Shield of Mississippi, United Healthcare, and Humana—received a C–, D–, and D.⁴ A major factor influencing the low scores is that Blue Cross and Blue Shield of Mississippi and United Healthcare completely exclude breastfeeding professionals from their network. Although United Healthcare updated its policy to include trained breastfeeding consul-

ants, its coverage excludes reimbursement for individual counseling. Many breastfeeding professionals and advocates contend that these policies chip away at the intent of the ACA, which is to increase breastfeeding education and support.

Licensure

In response to the insurance industry's policies, growing numbers of breastfeeding professionals are pushing for state license so that insurers will be required to include the profession in their provider networks. In 2014, the small state of Rhode Island, known for being the first state to ban the formula bag, passed legislation requiring the state's health department to issue licensure to IBCLCs.⁵ In 2015, Rhode Island issued rules and regulations.

The problem with this bill is that it limits licensure to the IBCLC. The IBCLC, who typically practices in a hospital setting, is primarily a registered nurse. The IBCLC specializes in the clinical management of breastfeeding, particularly high-risk cases. There are a mere 1.81 IBCLCs and 0.57 CLCs per 1,000 live births in Mississippi.⁶

The low number of breastfeeding experts contributes to hospitals' low rates of follow-up care for breastfeeding mothers when they are discharged from the hospital. For instance, 94% of hospitals in Mississippi refer their patients to WIC lactation specialists.⁷ Moreover, only 51% of hospital breastfeeding staff make phone calls to their patients, and none performs home visits, which is crucial during the first 48–72 hours postpartum when women tend to experience breastfeeding difficulties that often lead to cessation. In addition, only 43% of hospitals report that breastfeeding patients return for a follow-up visit.

Rochelle Fields, CLC and WIC Lactation Specialist, is a veteran breastfeeding professional who contends that hospital staff often fails to inform patients about the consequences of combination feeding (telephone interview by G. Israel with Rochelle Fields. Jackson, MS, September 17, 2015):

I have observed hospital breastfeeding personnel, including the IBCLC, go along with mothers who want to give breast milk, formula, and/or pacifier to their newborns. This causes latching on and engorgement problems around the third day. These moms either stop breastfeeding or shorten breastfeeding duration. Sometimes, WIC lactation specialists successfully intervene in the home or clinic.

Expanding the Breastfeeding Workforce

Clearly, Mississippi needs to significantly increase the number of breastfeeding professionals to improve follow-up care. In addition, a larger workforce is needed to reach more pregnant women during the prenatal stage to encourage them to breastfeed. There is an urgent need for education and promotion to occur in the workplace, community, clinic, and hospital. Also, more breastfeeding counselors are needed in the hospital, home, clinic, and over the phone, especially during the first 48–72 hours following discharge. Currently, only WIC breastfeeding staff members function in these diverse settings.

IBCLCs are not meeting these needs because their interaction with women tends to be limited to the hospital during the birthing and discharge phases, and their numbers are insufficient. The International Board of Certified Lactation Examiners (IBLCE) may be primarily responsible for the low numbers as it has created barriers that may prevent many women—who are passionate about and experienced in breastfeeding but who do not have the financial means or health sciences background—from becoming an IBCLC.

Breastfeeding professionals complain that the exam is too costly (\$660) in the U.S. Moreover, the academic prerequisites to apply to take the exam as well as the exam content discourage some from taking it while preventing others from passing it. Rochelle Fields stated (telephone interview by G. Israel with Rochelle Fields, Jackson, MS, September 17, 2015):

I have been working as a breastfeeding professional for 16 years, providing care in clinics, hospitals, and homes. This test is not designed to certify my qualifications. The test is becoming more and more difficult to pass because it includes subject matter that is not relevant to effectively encouraging or helping mothers to breastfeed.

IBCLC candidates must complete 14 health science college courses, including human anatomy, human physiology, nutrition, clinical research, psychology, and sociology. “The rationale for requiring all exam candidates to complete education in these subjects is to establish that they have the foundational education necessary to function as valued, respected members of the maternal-child health care team,” states the IBLCE.⁸

The tuition costs associated with completing at least eight of the required courses could cost a minimum of \$2,400 at a local community college.⁹ Physicians, nurses, and dietitians could very well afford this cost but not lowly paid breastfeeding professionals and lay women who aspire to enter the profession.

When did breastfeeding become a complex health science? For the overwhelming majority of women, breastfeeding is a natural and simple process. Women who want to become a breastfeeding professional should not be discouraged or prevented from doing so because of extreme costs and a lack of health science education that is typically required of white collar clinical professionals. These barriers must be removed in order to provide adequate breastfeeding services to the growing non-WIC population.

Filling the Void

In Mississippi, WIC is the Number 1 source of breastfeeding information and support, but its participation rates

have dropped significantly. From 2008 to 2015, WIC experienced a 21.6% and 6% decrease in the number of pregnant women and breastfeeding women, respectively, who participated in the program.^{10–13} These rate reductions can translate into opportunities for the breastfeeding professional in the private sector.

Presently, there are only a few breastfeeding professionals in private practice. Those numbers could increase if breastfeeding professionals should become licensed and listed as health providers in insurance networks, and insurers were to actively promote breastfeeding benefits among their members. Furthermore, the privatization of breastfeeding could create private sector opportunities for poor women, which may increase breastfeeding initiation among this group.

The State of Mississippi—not international professional organizations—should determine the standards and regulations for licensure based upon empirical evidence and the needs of the State so as to level the playing field and prevent the monopolization of the industry by white collar professionals. The ACA has laid the framework to privatize breastfeeding and build the workforce, but Mississippi must seize upon the opportunity.

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