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# Home Health Visiting in Europe

Sheila B. Kamerman  
Alfred J. Kahn

## Abstract

European countries have a long history of providing home health visiting services. These services contrast in many ways with the services of those programs in the United States described by Douglas Powell in this journal issue. Most notably, the European programs are typically universal in that they are offered to all families. In describing the European programs, Sheila Kamerman and Alfred Kahn give special focus to programs in Denmark and Great Britain. Universal home health visiting has been in place in these countries for decades and is widely accepted as a valuable and effective service, although formal research on its effectiveness has been limited. The authors conclude that home health visiting programs have been successful, in part, because these countries have a comprehensive maternal and child health system (both to finance and to deliver services), and home visiting is well integrated into this broader system of care and support for all families.

**H**ome visiting programs for very young children and their families are not a uniform intervention. As discussed in the article by Powell in this journal issue, these programs vary in their content, goals, and staffing. This article focuses on European home visiting programs in which public health nurses visit homes following the birth of a child. Special attention is given to describing these programs in Great Britain (England, Scotland, and Wales) and Denmark. The experience of these countries can guide U.S. policymakers as they consider expanding home visiting programs in this country.

This article will (1) provide an overview of home health visiting in Europe, (2) address some questions Americans typically ask about these programs, and (3) discuss some implications of this experience for the United States.

As a prelude to this discussion, however, it is important to note that the transferability of lessons from Europe to the United States may be complicated. Very different perspectives and premises affect policymaking in the United States compared with most European countries. In Europe, home visiting programs have existed for more than a century; they are a

well-accepted part of life that is integrated into broad government-funded health and social services systems. Despite growing concern about limited resources to expend on social programs in many European countries, their home visiting programs continue to be universal (available to all families), popular, generously supported, and viewed as effective. Generally, Europeans have not thought it necessary to evaluate formally these programs to prove their effectiveness and defend their existence.

In contrast, the United States does not have a similar tradition of broad, universal

*Sheila B. Kamerman, D.S.W., is professor of social policy and planning at the School of Social Work, Columbia University, and co-director of the Cross-National Studies Research Program at Columbia.*

*Alfred J. Kahn, D.S.W., is professor emeritus at the School of Social Work, Columbia University, and co-director of the Cross-National Studies Research Program at Columbia.*

*Kamerman and Kahn have conducted research on child and family policy and programs in the United States and European countries for more than 20 years.*

supports for families. Debate here about whether to expand home visiting programs often begins with questions about their proven effectiveness with specific targeted populations, questions simply not asked in Europe's history with these programs.

Despite these differences, familiarity with the structure and characteristics of these European programs is important. At a minimum, the extensive European experience suggests criteria for success which U.S. policymakers should carefully consider when planning home visiting programs.

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Because of the lack of written evaluation and analysis of home visiting programs in Europe, much of the following discussion is based on our more than 20 years of research in these countries, visiting and studying these and other child and family programs, and interviewing policymakers responsible for them. Our current research, which gives special attention to maternal and child health and home visiting—in the context of a general focus on children under age three—has been in six countries: Denmark, England, Finland, France, Germany, and Italy.

## Overview of the European Experience

Home health visiting (HHV) exists to some extent in all of the northern and western European countries as part of their national, universal systems of health care. These countries include Denmark, Finland, France, Germany, Great Britain, Ireland, Italy, the Netherlands, Norway, and Sweden.<sup>1</sup> All the HHV services are voluntary, free, and not income-tested.

Each of these countries believes that HHV programs are but one piece of an essential network of economic and social supports provided by the government to families.<sup>2</sup> There is strong conviction that

achievement of child health goals requires not only health services, but also cash and noncash benefits, housing supports, child care services, and social services as needed by the family. In essence, child health policies and programs are viewed as an integral component and interdependent with the other elements of social policy for children and their families. A firm social infrastructure provides the foundation and building blocks for supplementary interventions for those children and families with special needs.

In all countries, home visiting programs are carried out by professionals, typically registered nurses. In Denmark, home visitors also have pediatric hospital experience. In the Netherlands, paraprofessionals supplement the nurses' role. Where HHV occurs in Germany, social workers are the visitors and encourage regular checkup visits to private physicians or public health clinics. Often these professionals have supplemental public health training.

Home visitors in each of these countries provide health education, preventive care, and social support services to very young children and their parents. Home visitors may be assigned to families according to geographic boundaries or, in some countries, according to the general practitioner physician the family sees. In all countries, home visiting services are supplemented by more comprehensive health services available to children through a system of maternal and child health clinics or through private doctors under a universal health insurance system, or through both.

Every country focuses its home visiting programs on children under the age of three. All see the home locus as essential at the start. Visiting in the home allows the home visitor to meet other siblings and fathers, and provides a better opportunity to view mother-child interactions in a natural setting and to establish a close relationship with the mother on a one-to-one basis. However, European HHV programs vary along other indicia: whether special focus is given to specially identified families, whether a family is visited only after the birth of their first child, whether visits begin prenatally, and whether the visits are supplemented with center-based support groups and care. In addition, these programs also vary in frequency of the visits. For example, in Den-

mark, Great Britain, Ireland, and the Netherlands, nearly all newborns and their mothers are visited at home by a public health nurse at least several times during the first year. In contrast, Finland, France, Germany, and Italy offer only one or two postbirth visits, with additional visits on a discretionary basis as needed.

No matter what the frequency of visits, home visiting in each of these countries links the family, as needed, to social services, income maintenance, housing, and other government programs. Home visiting programs are often located within, or in close proximity to, the offices for broader social services. Regardless of location, they typically enjoy coordinated or integrated relationships with these other programs. Home visitors also help with early identification of risk of child abuse or neglect, developmental lags, or postpartum depression; they offer treatment or referral as appropriate for children, mothers, or other family members.

The most comprehensive HHV programs are those in Denmark and Great Britain. These programs are discussed in more detail in the following section.

## A Closer Look at Great Britain and Denmark

### When and why did HHV services first begin?

Home health visiting began in Great Britain in the mid-nineteenth century, in Denmark in the 1930s, and in most other European countries in the period immediately following World War II. The British system has been especially influential cross-nationally, and its history is instructive.<sup>3</sup>

#### Great Britain

HHV began in Britain in the mid-1850s as a public health service which focused on problems of sanitation and epidemics. Early on, nurses, sanitary engineers, or lay visitors were sent into the homes of families with young children to offer advice about health and hygiene. The first special training course for nursing and health visiting was established in 1892, a parallel in time to the first social work courses in the United States. There were early ties to the cooperative movement and workers' institutes, again paralleling early social work and settlement house work in this country. By the beginning of the twentieth century, health home visit-

ing was provided by almost every British local authority, under the jurisdiction of the Medical Officer of Health (MOH), as part of the nation's maternal and child health service system.

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From 1907 on, the Notification of Births legislation, first voluntary and later mandatory (1915), required the MOH to be notified of all births in his district. On

receipt of notification, health home visitors were sent to the homes. By World War II, it was routine practice in Britain to visit every newborn at the home within 10 days after delivery. The National Health Service (NHS) Act, passed after World War II and implemented in 1948, mandated universally available service.

In 1990 legislation, general practitioners (GPs) assigned to local health authorities established under the NHS, were given more responsibility for home visiting programs. This shift resulted more from political and budget considerations than from criticism of home visitors. GPs now have the option, with parental concurrence, to assume responsibility for the traditional HHV role of ongoing monitoring of the development of preschool children. The GP has several options to ensure that the child's health and development stay on track. The GP can add community nurses to his practice to carry out this responsibility, the GP can do it on his own, or the GP can assign the task to a health home visitor who works with the GP.

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Given this increased flexibility for GPs to assume responsibility for home visiting functions, it is unclear to what extent the work of traditional home visitors will change. It is likely that the home visitor will continue to make the initial visit and outreach, as well as some additional visits when needed. However, it may be that, as GPs take on more responsibility for later care, the HHV will not be as involved.

Currently the typical, recommended HHV pattern in Great Britain is six visits before the child enters compulsory education at age five (visits occurring immediately following childbirth, just after hospital discharge, and at 6 weeks, 8 months, 21 months, and 39 months). Most HHVs adapt to individual circumstances after the initial visit, but the pattern described above is the basic standard.<sup>4</sup>

#### Denmark

Denmark's HHV service was established under legislation enacted in 1937, following the success of a six-year demonstration project designed to reduce the infant mortality rate. This law established HHV as a recommended service; the government subsidized half the costs for municipalities providing the service. The 1937 act was subsequently superseded by the Public Health Nursing Services Act in 1963, which stated that municipalities "ought" to establish the service but still did not make it compulsory. Although most locales implemented these programs and were pleased with them, HHV services were not universally available to Danish families. In 1971, legislation was passed that mandated provision of these services (barring refusal by the families). This was part of a larger legislative package that transformed the Danish system from national health insurance into a national health service. The Danish legislation reflected the influence of both the English HHV system and the systems of other Scandinavian countries. The English system was viewed as especially important, in particular in its demonstration of a close relationship between the GP and the home visitor.

Today, the HHV program in Denmark is a key component of its Maternal and Child Health (MCH) service. The MCH program is anchored in the country's general health service, which is a public system that provides both cash benefits (maternity and parental benefits, sickness benefits) and health/medical service.

The Ministry of Health at the national level sets overall policy for the nation's health system, but most policy and administrative authority rests at the local level, including responsibility to operate hospitals and clinics and to provide special services for the handicapped. Municipalities are responsible for social services (under the Ministry of Social Welfare), which are closely linked with the health services. Municipalities are also responsible for nursing homes, home visiting, and other public health nursing programs.

#### What are the objectives of HHV services?

In Great Britain and Denmark, HHV services are designed to meet both the health and the social objectives focused on healthy and optimal development of a young child. Initially, the HHV services were begun as a strategy for (1) case

finding, that is, the identification of problems and lags in a child's physical, emotional, cognitive, and social development; and (2) child health monitoring, that is, regularly examining children to ensure that they obtain essential inoculations and other care in a timely fashion. In both Britain and Denmark, for example, the programs began in response to concerns about high infant mortality rates and interest in assuring poor, high-risk populations access to good medical care.

Over time, in particular as national health care systems were established in each country, community-based health care clinics became more available, and the definition of "health" was broadened. Program goals for HHV shifted from the narrowly health-oriented toward a broader social focus. The reasons for this shift in focus were threefold. First, many of the original specific health goals for HHV had been achieved through national health programs. Second, the HHV experience had demonstrated that many young families were experiencing pressing social needs. Third, there was greater recognition of the connection between health and social needs. Thus, in recent years, although the health orientation continues, there is less emphasis on health monitoring in Britain, for example, and more emphasis on case finding of social problems (for example, child abuse or inadequate parenting) or maternal problems (for example, postpartum depression), and on linking parents with the local health clinic. Similarly, in Denmark, HHV services were aimed initially at improving the physical health of the child through routine and regular visits, but in subsequent years the focus shifted to include a greater emphasis on social factors.

Of particular importance in both countries is the increased emphasis on the goals of empowering mothers and fathers, that is, giving them the tools they need to be more effective parents. Home visitors are now trained to be more knowledgeable about children's social and emotional development and more skilled in helping parents to enhance their parenting roles. Family-focused goals have increasingly emerged as of equal importance to child health goals; this is most often reflected in more attention to parent education and referral to needed services.

### Whom do HHVs serve, all children and their families or only some?

#### Great Britain

As discussed briefly above, by World War II, HHV services were routinely offered to all British families, and shortly after the war, the government was formally mandated to offer these services universally. HHV in Great Britain remains a universal program, but there is more attempt to focus services on high-risk families. This change reflects both cost constraints and philosophical shifts. There was a growing sense that, for families without special needs, very frequent visits could be seen as both unnecessary and possibly intrusive. Also, the GP had assumed a greater role for routine preventive care, and home visitors were encouraged to see their role as empowering parents, not merely providing service. As parents gained more skills and the GP provided routine health care, fewer visits were needed. As the number of routine home visits decreased, the HHV program was increasingly supplemented with mother-child groups at the local health clinic.

#### Denmark

There were no advocates of limiting the program to the poor only or of other targeting. This would have been contrary to Denmark's general universalistic social policies. As a 1970 government report summarizes, the HHV service was based from the beginning "on the principle that the advisory activities were offered to the homes without regard to their financial circumstances."<sup>5</sup>

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In the late 1960s, the Danish government created a commission to review and evaluate HHV services.<sup>6</sup> As has been the trend in Great Britain, they concluded that the numbers of universal, first-year visits could be reduced, but more intensive services to special needs families should be increased. This led to

a reduction in first-year visits universally offered from 12 to about 6, with more to the firstborn child, and still more to immigrant and other special needs children and families.

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The focus and frequency of home visiting services is also affected by the popularity of out-of-home care in Denmark. Today, more than half of all Danish children are in out-of-home child care (family day care or centers) by the ages of 6 to 12 months, and more than 60% are in such care by age 2. Given these facts, the traditional role of home visitors in identifying early possible abuse, neglect, and developmental lags can be carried out easily in these child care programs, which are community-based and municipally organized and supervised. In addition, all children are seen in neighborhood maternal and child health clinics from shortly after birth. With these two service systems for children in place, the home visitor, while still making several visits to every family in the first year, will focus much of her efforts on following up with families specially identified by health clinics and child care services as needing assistance.

In Denmark, as in Great Britain, HHV services are often supplemented by mother-child groups. There is strong conviction that mothers, especially those with first children and those who are not working, may feel alone and isolated and could benefit from such groups.

Thus, both Britain and Denmark continue to provide a universal service, albeit one that offers more intensive and frequent visits to the more vulnerable or "needy" children and families. The population served is increasingly heterogeneous, including families from a variety of racial and ethnic backgrounds as well as across classes. Particular attention is paid to those families who are experiencing special problems, be they economic, social, health, cultural, or whatever.

### **When does the home visitor first contact the family?**

In Britain, the home visitor's contact with the mother is usually begun during pregnancy through referral by the GP or midwife. Thus a relationship is established with a family even before the baby is born. Home visitors have no legal right to visit the family, only a legal requirement that they offer the visit. Acceptance of the offer is up to the parents; the visits are strictly voluntary. However, almost all parents welcome them. The Danish system is similar in terms of referrals during pregnancy, although there is considerable discretion in determining whether to visit during the prenatal period.

### **How many families does a home visitor serve in a year?**

The British HHV Association recommends a ratio of one home visitor to a general population of 2,000. This recommendation was first made in 1956 and has never really been implemented. What was officially adopted is a standard of 1:4,000 but that was not implemented either. The average now is 1:5,000. In this context, if a home visitor is working in an inner city with a population of 5,000 in her "patch" (community), she may be working with as many as 200 to 300 families with a child under five at any one time. Most of the families living in these areas are poor; many are immigrant and not English-speaking. Given this case load, it is likely that she will visit all children in the first year only and, after that, focus on only those with the most needs.

In Denmark, the home visitor's case load of about 150 families might be the case load for one year; but here too after the first year more frequent visits are paid to the more needy families, and visits to others are curtailed. Families with very young children, single mothers, young mothers, first-time mothers, immigrant mothers, socially isolated mothers, and poor mothers constitute the priority groups. More than 80% of the visits are made to families with a child less than 1 1/2 years old.

### **What are the advantages of locating HHV in the health system?**

In both Britain and Denmark, the HHV program is integrated into a much broader network of health and social services. If the goal of the program is to produce a healthy and well-developed young

child, a basic premise is that a maternal or family and child health care delivery system is in place. Given the program's emphasis on health goals, albeit in the broadest sense, HHV in both countries is strategically located within their health care systems. This linkage also enhances the qualifications of the home visitors; families view them favorably as part of an important and friendly health system. The home visitors' ability to examine both child and mother and to offer authoritative answers to health questions is reassuring and encourages questions from the family, not only about health but also about other needs as well.

When health is not the primary goal of home visiting programs and they are focused chiefly on enhancing parenting skills, on cognitive and social aspects of child development, or on case finding for child abuse, an alternative base might be appropriate. Even then, however, close links with the health care system would be essential because of the relative medical fragility of young children and the frequency of infection and gravity of accidental injury in the early years.

In some countries (for example, Belgium, France, Hungary, and Italy), child care services for children less than three years old are located under health auspices, in health ministries or departments. Given this administrative proximity, it is easier to develop and sustain close links between child care and health care. Where the child care system is operationally separate from the health system, locating the home visiting program in the health system can be very important to improving the health—child care linkage.

#### **What is the home visitor's role with regard to child abuse?**

In both Britain and Denmark, the case finding and early intervention role of HHV programs is directed toward a wide range of potential problems. Child maltreatment (abuse and neglect) is only one of them. The primary focus of HHV is that the baby develop normally; that the parents know and understand what normal development is and what to expect from the child at different ages and stages of development; that the parents feel competent in their parenting roles; and that, if help is needed, it is readily available. This is particularly important for first-time mothers or fathers who, unlike previous generations with numerous siblings or

close-by extended families, may come to parenting with little prior experience or exposure to very young children.

Administrators of the British and Danish programs, however, do speak of the "surveillance" provided by home visitors. Home visitors, as knowledgeable and experienced professionals, are sensitive to and become aware of potential problems. Surveillance in a pejorative sense is not emphasized. In these countries, the home visitor may be viewed as an authority figure, but she is not viewed as an instrument of social control. Thus, although she, like all professionals working with children and their families, must report incidents of child abuse to the appropriate authorities, she is not involved in the investigation of these situations nor in subsequent court proceedings, if they occur; protective service social workers carry out this role.

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HHV services are viewed, however, as effective preventive services. For example, inadequate parenting of a young baby is often linked to maternal depression, a problem to which home visitors are especially sensitive. Apart from referring severe cases of depression for treatment, the home visitor may also offer increased visits and support to mothers who would appear to need and benefit from extra help. Similarly, child abuse is often linked to parents' unrealistic expectations of their very young children, and here HHV is explicitly designed to educate and inform parents about how their child is developing, what to expect, and how to prepare for new stages. Moreover, of particular importance, the mother-baby and parent groups organized by home visitors can breach the social isolation of mothers with very young children and provide support and companionship. In Britain and Denmark, officials believe that all of these characteristics of HHV reduce child abuse and neglect, but there has been no effort to evaluate this belief.

## Box 1

### A Danish Home Visitor's Typical Day

The home visitor arrived at her office around 8:00 a.m. and began answering phone calls. These calls were requests from parents for information about a wide array of concerns: what to expect following a baby's vaccination, when to start a baby on solid food, and how to introduce a baby to a new family day care situation.

#### First Visit

At around 9:00 a.m., the home visitor left her office to visit a family living close to the center of town. The small home of a hospital worker and occupational therapist was disordered and dirty. The 10-week-old baby cried frequently. He was this couple's first and only child, and the mother seemed insecure and asked the home visitor many questions about the baby's appearance, eating, and crying. She was concerned that she was doing something to cause the crying.

After some informal talk with the mother, the home visitor took the baby and proceeded to undress and examine him. She talked to the baby quietly, playing with him, touching him, and evoking a cooing response. She paid attention to a swollen part of his leg where he had been inoculated the previous day, and explained to the mother what had happened and how to make the baby more comfortable. She then weighed the baby, measured his length and head size, and wrote the information down in the "baby book"—the baby's official health record which all Danish parents have. The home visitor compared this information with that from the prior visit and commented that the baby's growth was adequate. The nurse then took both her hands and ran them down the side of the baby's head looking into the baby's eyes, nose, and mouth, examining gums, and so forth. She carefully felt down the side of the baby's body, and his stomach, and looked at his legs to see whether they were straight. All the time, she talked to the baby and watched for responses.

During the visit, the mother expressed concern about the baby's crying. Noting that the mother always responded to the crying by offering a breast, the home visitor commented on how crying need not always be a sign of hunger. She suggested that maybe the baby wants to be picked up, talked to, played with, or walked with. She modeled child handling by showing the mother, without saying much about it explicitly.

This was a very anxious new mother who did not seem to be able to respond to the child's signals. The home visitor described a new group she was setting up, with six other new mothers. The mother agreed to come to the first meeting. The home visitor explained that she would launch the group, participate for the first few weeks, and then the mothers would be responsible for continuing the group on their own. The group could last for a few months, a year, or even longer.

#### Second Visit

The second visit that day was in an affluent suburban community. This family had a 2½-year-old in addition to a 3-week-old infant. This was the infant's second home visit. The home visitor checked mother and child physically, checked the baby's reflexes, mouth, and ears, and discussed with the mother the baby's slight rash, a possible food allergy. The mother had questions about breast-feeding and about how different she found this second child from the first. The home visitor spent about a half hour or more talking to the mother about some of her own postpartum physical problems and the breast-feeding. The home visitor also looked at some of the finger paintings of the 2½-year-old mounted on a separate wall and exchanged some words about how he was progressing.

The mother discussed the fact that she would be returning to work when the child was 6 months old, and asked for and received information about local child care.



### Third Visit

During the third visit of the day, after the standard examination of a 4-month-old, also a first child, the mother talked to the home visitor about how her sister had a baby that was born a day later than her son, and how her nephew was so physically active and was able to do all sorts of things involving physical movement while her baby was not. She attributed this to her baby's being fatter. The home visitor commented that children develop at different levels and with different skills. But at the same time, she asked the mother if her baby had much opportunity to crawl on the floor. The mother responded by complaining about the small size of the apartment, the lack of space, her concern with having the baby underfoot. The home visitor suggested that, when the mother was not cooking or involved in some other activity, she give the baby opportunity to be on the floor and to crawl around. With the mother, she looked for an area in the room that could be cleared away for the baby to crawl.

### Fourth Visit

The fourth visit of the day was to the home of a single mother with a 13-month-old son. The home visitor was concerned about how the mother was functioning and what the implications were for the child and his development. The boy was a charming youngster with an extraordinarily well-developed physical capacity and sense of coordination. In the one and one-half hour visit, it was clear that this baby was incredibly active, but he showed no signs of speech. The mother was depressed, withdrawn, and unresponsive. The home visitor admired the baby's physical dexterity and also expressed empathy with the mother about what a handful he must be. She reminded the mother of the potential dangers the apartment represented for accidents. They explored the low shelves in the kitchen to make sure nothing dangerous was within reach and discussed how to set some limits so that the baby would not get out on the terrace alone. Emphasizing the importance of talking to the child, the home visitor suggested he might need the experience of a group child care program, and they discussed how the mother might proceed. The home visitor offered to try to help the mother obtain a priority place. They agreed that it was important for the mother to seek work, not only to gain more income but also to enter a larger social arena. Here, too, the home visitor had urged participation in a group, but thus far the mother had not been able to follow through on this suggestion. ♦

### **What evidence is there that HHV services are effective?**

The duration of HHV programs testifies to the general agreement throughout Europe that it is an effective early intervention service. As stated earlier, however, Europe does not share the U.S. emphasis on formal summative evaluations of policy interventions. Their home visiting policies are an outgrowth of political decisions and value preferences, not of firm evidence regarding outcomes. There are no recent formal evaluations of these services in Denmark and only a few studies in Britain, the two countries with the most extensive and comprehensive HHV service. Their effectiveness, however, seems to be widely accepted and is not raised in policy debates.

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The Danish program was first enacted as a result of a demonstration and evaluation project.<sup>6</sup> Following some years of concern about an infant mortality rate which was viewed as high in comparison to that of the other Scandinavian countries, a carefully designed social experiment was carried out in three districts in the 1930s, initiated under the sponsorship of the Danish National Health Service with the cooperation of the Rockefeller Foundation. For six years, families in these districts received HHV services. The results of this experiment—a dramatic decline in infant mortality rates and almost total and timely prenatal care coverage [99%] of mothers, including foreign women—led to the enactment of the 1937 Act. Later legislative changes in the HHV program, however, were not driven by research, but rather were usually the result of special commission reviews with the goal of improving services.

There have been no large-scale overall evaluation studies. Nonetheless, there are a few British studies that document the general effectiveness of HHV,<sup>7</sup> the reduc-

tion of deaths by accidents within the home, the reduction of Sudden Infant Death Syndrome (SIDS),<sup>8</sup> and the reduction of postpartum depression.<sup>9</sup>

Moreover, policymakers in these countries believe that the primary value of these programs lies in educating or empowering parents and in accomplishing certain health goals. For example, as home visiting programs began to emphasize immunizations in the 1970s and 1980s, the immunization rates improved. By 1989, in England and Wales, 87% of two-year-olds were immunized against standard major childhood diseases, a very significant increase in previous rates, widely believed to be a result attributable in no small part to the work of home visitors.<sup>10</sup> Also, policy scholars and decision makers in Britain and Denmark point to data that show that, relative to worldwide rates, these countries have low rates on infant mortality, high rates of prenatal care, low rates of low birth weight, and high rates of early and timely immunizations. They cite these as evidence of the success of their overall maternal and child health system, including HHV services.

### **What are the costs of and financing for HHV services?**

According to communications from the Danish National Board of Health and the British Department of Health, no data are available regarding either cost-effectiveness or national cost.<sup>11</sup> The World Health Organization official at the European Regional headquarters in Copenhagen who monitors these matters knows of “no cost-effectiveness studies on home visiting in Europe.”<sup>12</sup>

The British National Health Service (NHS) is almost completely publicly funded, with about 78% of its resources from general revenue, 16% from employee-employer contributions, and 4% from fees for services. Like other NHS services, the HHV service is free to parents. The major cost to the government of providing the service is the home visitor's salary and a car used for visiting. These costs, however, are not known as they are not accounted for separately within the NHS budget.

In the highly decentralized Danish system, in which municipalities allocate funds for service out of national block grants and their own taxation, home visiting nurses are located in administrative units for social services. This makes it

difficult to identify specific HHV costs either locally or nationally. Municipalities are not required to report on the operating costs of such services to any central authority. As in Britain, the primary costs are HHV salaries and transportation.

## Implications for the United States

In summary, most European countries provide to all families a voluntary service of at least one to two home visits after the birth of a child. Several countries have more extensive programs. Only Britain and Denmark, however, currently provide ongoing services to all newborns, beginning prenatally and continuing during the first year after birth and at a few key points in years thereafter. These visits are most extensive for firstborn children and children with social problems or other special needs.

Although scientific data on the effectiveness of HHV are limited, these programs have been universal, extensive, and popular in some countries for more than 50 years. They are widely supported and viewed as a healthy, future-oriented, responsible government program. Though the amount of tax support, specific mis-

sion, and quality of program may vary locally or be the topic of debate from time to time, these programs continue to be viewed as an important investment in the future and part of the everyday life of the citizenry. What are the key components of this service?

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At a minimum, universal home visiting provides two kinds of access. First, the family gains access to the broad-based health, economic, and social service supports offered by these countries. Information and referral is a basic benefit even when there is only one home visit. Second, the health and social service system gains early access to the families and their newborns, identifying problems and allowing for early intervention. In addition, those countries which provide for multiple home visits

during the first year and a schedule of checkup visits during the remaining preschool years provide ongoing benefits—including support, counseling, advocacy, parent education, and health promotion services—all with both medical and social service dimensions. For the families offered fewer than six visits during the first year after birth, the parent groups and the clinic visits strive to build on the relationships and insights yielded by the home visits. All services are linked to social services and child care programs.

Another benefit is that the home visits and subsequent well-baby visits at the health centers generate a full medical history for each child, carried by the mother, which is supplemented by the clinic records until the child enters elementary school. This record provides a “platform” for all services, educates and alerts parents, and adds to accountability. In some places (France, for example) the health record report of checkup visits is a way of establishing eligibility for certain cash benefits.

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*The European experience suggests that HHV can be an effective strategy for improving the health and developmental status of children, but not without an adequate health infrastructure in place and an adequate health delivery system.*

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Could this be replicated in the United States? We doubt that a truly effective HHV program could be established without both a comprehensive maternal and child health delivery system and national health insurance (at least child health insurance). Both financing and delivery systems are essential. For example, HHV does well in some countries without a national health service, such as France, with its national health insurance program, because there also is a locally based, public maternal and child health system in place (Protection Maternelle Infantile). These clinics provide a place for the home visitors to have an office and for children to be examined regularly. They also maintain close ties to the broader private (but publicly reimbursed) medical care system. Finland, which has a national health insurance system, has also established a

universal system of child health clinics which provides all children with preventive care.

Without an adequate social infrastructure or, at the very least a health infrastructure, home visiting in the United States would probably provide only isolated, project-specific HHV services. This would be a haphazard system at best and one not likely to have the kinds of positive outcomes that the European programs are perceived to have.

The United States lacks such an infrastructure, although the Medicaid program does provide health assistance to certain categories of poor women and children. Some have proposed increasing coverage of home visiting under Medicaid to expand health outreach and to provide basic educational and preventive services. Doing so could be helpful, but the benefits would be limited. The European experience has been that many of the children and families who need the education and support provided by home visiting are not poor and would therefore not be reached. Moreover, even for the poor who do receive the service, there is no assurance that they would actually gain access through the Medicaid program to appropriate medical care, another key component of the European HHV programs. A universal delivery system of local health clinics is essential to ensure access to medical services, and the United States appears to be a long way from establishing a universal financing and delivery system for health services.

A second characteristic of European programs seen as central to their popularity and success is that they are universal. This also may be difficult to replicate in the United States. Most often when home visiting programs are implemented in the United States, they are designed to target special populations of children. There is very little experience with, or commitment to, universal programs to support all children; public education is perhaps the one exception. And yet policymakers in Britain, Denmark, and other countries are strongly convinced that if only a narrowly defined group of children received HHV services, many more children would enter their schools with significant problems. Moreover, they believe that a targeted approach would stigmatize the HHV service and soon result in many families who could benefit from HHV services either avoiding or re-

fusing them rather than accepting the negatively labeled help. Furthermore, Europeans believe that there is no simple pen-and-paper way to identify which children need home visiting and follow-up services. These children are not easily identified along economic or social lines. Europeans believe that only by making at least one visit to all children can one begin to identify potential risks.

The European experience is less clear with regard to the frequency of visits. Given the variation among countries in the number of home visits made, it is difficult to draw conclusions about the required frequency for either effectiveness or popularity. It may be that those countries which have reduced the number of visits also have lower expectations for the program, expecting only that these services will link families to other needed services. England and Denmark, however, have maintained frequent visits in the belief that stronger relationships will be formed between visitor and family, and that broader health and social outcomes will be improved. Whether these expectations have been met is not scientifically known but is popularly be-

lieved to be so. We share this belief from our own observations.

In conclusion, the European experience suggests that HHV can be an effective strategy for improving the health and developmental status of children, but not without an adequate health infrastructure in place and an adequate health delivery system. Otherwise it will be just one more program, perhaps effective for some, but plagued by many gaps and deficits. If the program is not universal, it is almost guaranteed to miss a large number of the children who need services. If it is not connected with a comprehensive health delivery system, it will be unable to meet many of the needs it identifies. Finally, there is the danger that implementation of home visiting now, without these broader systems in place, will be seen as a general panacea and divert attention from the need to progress on a broader child and family policy front.

*We acknowledge with gratitude the financial support of the Carnegie Corporation and the Spencer Foundation.*

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2. This concept of health care as including all social policy, or at least a very wide range of social policies, is emphasized repeatedly by most European experts; they reject the concept of a narrow medicalized definition of health care. For some illustrations of this position, see, for example, Manciaux, M., Jestin, C., Fritz, M., and Bertrand, D. Child health care policy and delivery in France. Supplement on Child Health in 1990: The United States Compared to Canada, Britain and Wales, France, the Netherlands, and Norway. *Pediatrics* (December 1990) 86,6:1037-43; Goodwin, S. Child health services in Britain and Wales: An overview. *Pediatrics* (December 1990) 86,6:1032-36; Wagner, M. *Cross-national comparisons of child health: The U.S. dilemma*. New York: World Health Organization, 1990; and U.S. Congress. House. Select Committee on Children and Youth. *Hearing on child health: Lessons from developed nations*. 101st Cong. 2d sess., 1990. Testimony from Hans Verbrugge, M.D., D.P.H. See also note no. 1, Williams and Miller.
3. Much of the description in this article of the Great Britain experience is based on the authors' interviews in 1991 and 1992 with Ms. Shirley Goodwin, a noted expert on health visiting who is the former head of the British Health Visitors' Association, and on several of Ms. Goodwin's articles and reports. See also note no. 2, Goodwin.
4. In 1992, the authors conducted field visits in two communities in England—in London and in a town in the Midlands. In these communities, the typical home visit pattern was between seven and nine visits before the age of five, in addition to a predelivery contact.
5. *Health visiting, summary of Report I*. A report prepared by a committee appointed by the National Health Service of Denmark on health visiting and home nursing. Copenhagen, Denmark, 1970, p. 12.
6. See note no. 5, *Health visiting*, for a summary of the work of this late 1960s government commission.
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12. Wagner, M., consultant, health of women and children, World Health Organization. Correspondence with authors, January 15, 1993.