Issues for Michigan's Children

An in-depth look at some of the public policy issues affecting children and youth in Michigan

Michigan's Children

April 26, 2013

A Healthy Start for Children Promises a Healthier Future for Us All:
Reducing Infant Mortality in Michigan

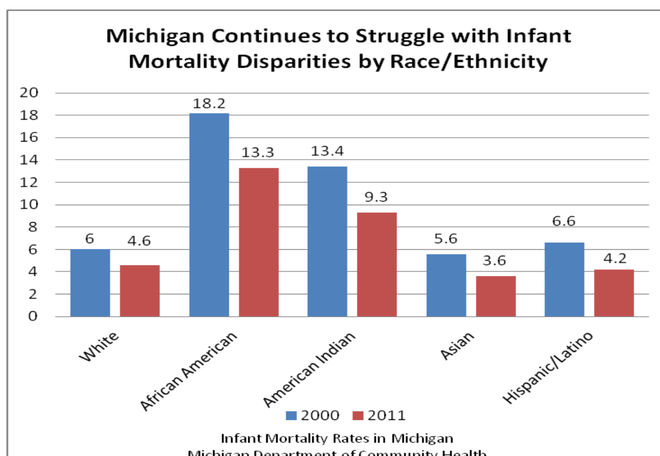
Healthy futures are built on healthy foundations. Michigan's future depends on its newborns getting off to a healthy start. The good news is that we have found ways to make that happen for some babies while saving taxpayer dollars. But as a state, we cannot be satisfied until we can ensure that all babies have the opportunity to celebrate their first birthdays.

Michigan Quick Facts

- Michigan is ranked 37th in the country on infant mortality with over 800 infants dying each year before their first birthdays.
- Prematurity/low birth weight is the leading cause of infant mortality.
- African American babies are twice as likely to be born low birth weight as white babies.
- African American babies are 3 times more likely than white babies to die in the first year of life.
- Babies of color are more likely to be born following pregnancies with inadequate prenatal care compared to White babies.

Why Equal Opportunity is Important

In his Health and Wellness message on September 4, 2011, Governor Rick Snyder outlined his vision for the state's health, which included keeping babies alive as a top priority. Infant mortality is currently tracked in the state's Dashboard as a key indicator for the state's health and well-being. According to the Dashboard, Michigan's infant mortality rate was more than seven deaths per 1000 live births in 2012, a rate that ranks Michigan at 37th in the nation according to the National Kids Count data.[i] Even more distressing is the infant mortality rate when compared by race – American Indian babies die at nearly twice the rate of White babies and African American babies die at nearly three times the rate of White babies in their first year, a ratio that worsened through the 1970s and 1980s and hasn't budged since 1990.[ii]



Michigan has focused work for decades to reduce infant mortality. In the past decade alone, Michigan's infant mortality rate has steadily declined from over 10 deaths per 1000 live births in 2000 to under 8 deaths per 1000 in 2011, including reductions for all race and ethnic groups. Despite these overall gains for African American babies, the infant mortality rate in 2011 equaled the rate for White babies in 1975, indicating that the health and wellness of African American pregnant women and babies remains nearly 40 years behind in progress. This is unacceptable, and points to both the continued urgency but also the need for adequate investment in equity building strategies proven to close this gap.

Key components to reducing infant mortality include not only medical technology improvements but also investment in improving women's health prior to pregnancy by increasing access to health care, particularly for women and families of color. Strategically targeting women of child-bearing age with key components of healthcare access – health insurance coverage and access to a source of consistent, comprehensive care (medical home) – can improve overall health while reducing overall health care costs and infant mortality.

Prematurity and low birth weight are the leading causes of infant mortality in Michigan and the nation. As detailed below, access to health care, including but not exclusive to providing adequate prenatal care, are essential to reducing low birth weight and infant mortality while saving taxpayer dollars. Currently, low birth weight and preterm babies have a significant economic burden on the state's health care costs. The average cost per discharge for a premature or low birth weight infant in Michigan is $102,103, approximately 14 times higher than for a healthy infant.[iii] With nearly half of Michigan births covered by Medicaid, reducing preterm/low birth weight babies – and ultimately infant mortality – will save thousands of dollars for Michigan taxpayers.

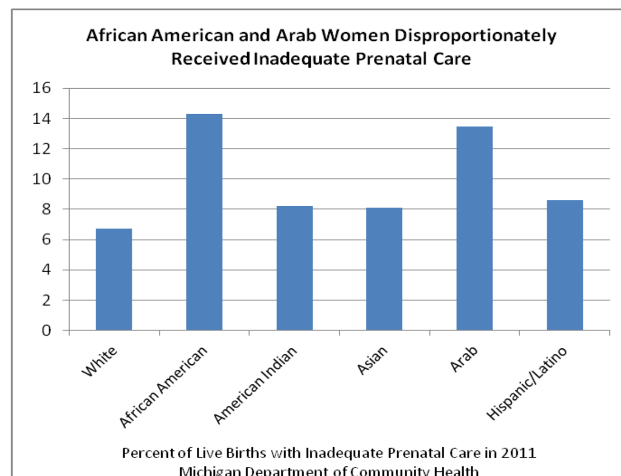
Barriers to Equal Opportunity

Access to high quality, consistent health care and healthy environments for women of childbearing age, mothers and their babies at every stage promises a healthy start for newborns.

Access to health care for young women. With 1 out of 6 Michigan women of childbearing age lacking health care coverage[iv], efforts must be made to ensure that women are healthy before they become pregnant. Statistics show that women of color are more likely to be uninsured, putting them at greater risk of health concerns even before getting pregnant. Because of the structural conditions of their lives, statistics show that African American and American Indian women are more likely to be overweight or obese at the start of their pregnancies.[v] Obesity is clearly tied to other health conditions that put moms and their babies at greater risk for medical complications during pregnancy and after birth. Improving access to health care for women of childbearing age can help ensure that more women are healthy before getting pregnant, thus improving their chances of having healthy, full-term babies.

Access to care for pregnant women.

Prenatal care is the first health care intervention that new babies receive. Prenatal care can help pregnant women improve their health, thereby ensuring the best possible outcomes for their baby. Expectant women with prenatal care learn critical information, including the basics of what to expect while pregnant, healthy behaviors such as proper nutrition and physical activity, and basic skills for caring for an infant. Furthermore, prenatal services have proven to reduce preterm births and low birth weight babies while saving taxpayer dollars; every $1 invested in prenatal care saves $7 in neonatal care.[vi] Yet in 2011, African American women

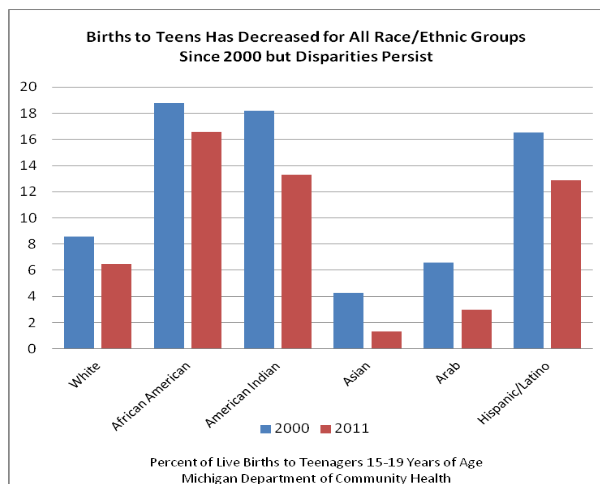


struggled to access prenatal care and were nearly three times less likely than White women to receive any prenatal care during their pregnancy.[vii] Clearly increasing access to prenatal care for women of color is critical to reducing infant mortality.

Access to care for infants and new moms. Labor and delivery units at hospitals have been closing throughout the state due to the high costs of malpractice insurance as well as low Medicaid reimbursement rates, resulting in fewer obstetricians, gynecologists and pediatricians in these areas. Currently, Michigan has 17 contiguous counties in the Lower Peninsula lacking hospital labor and delivery units, which impacts not just pregnant women of color but all women in those communities, regardless of race or socioeconomic status. Furthermore, doctors have been leaving the area and facilities have been unable to maintain an appropriate trauma system dedicated to infants born with health issues. Therefore, women and infants have been traveling further to access basic and critical care, jeopardizing their health. Fortunately, beginning in fiscal year 2013, Medicaid reimbursement rates for primary care physicians as well as obstetricians and gynecologists have been enhanced to Medicare levels in Michigan with the expectation that more pediatricians and OB/GYNS will accept Medicaid-insured patients. However, due to its recent implementation, the impact to those communities lacking labor and delivery units has yet to be determined. Ensuring that women and infants have continued access to appropriate medical care can improve the outcomes of infants, particularly premature and very low birth weight infants.

For pregnant women and new moms facing significant challenges, evidence-based home visiting programs provide services and support through a woman's pregnancy and into her infant's life. These programs – such as the Nurse-Family Partnership, Early Head Start, and Michigan's Maternal Infant Health Program – connect pregnant women to essential resources including medical care, transportation, nutritious food, and information to ensure a healthy pregnancy. These home visiting programs also provide counseling about risk factors such as smoking, drug use, lead exposure, and domestic violence and help women create a safe and healthy environment for a newborn baby. Evaluations of the Nurse-Family Partnership have found that it has resulted in improved prenatal health, fewer childhood injuries, fewer subsequent pregnancies, increased intervals between births, increased maternal employment, and improved school readiness – all of which result in fewer costs to taxpayers.[viii]

Births to teen moms. The statistics are clear. Lack of access to health education and basic supports, particularly in schools that serve communities facing multiple challenges, have resulted in barriers to teen pregnancy prevention. As a result, young women of color, particularly African American, American Indian, and Latina women are 2-3 times more likely to be teen moms. One out of six African American babies is born to a teenage mother who is less likely to receive prenatal care than older moms.[ix] Babies born to teenage mothers are more likely to be born premature and of low birth weight, both of which are highly correlated to other serious health problems including infant mortality.[x] Furthermore, nearly 85 percent of births to teen moms were unintended pregnancies.



Intentionality of pregnancy. More than 2/3 of all pregnancies to African American moms of any age were unintended, compared to 49 percent of Hispanic moms and 37 percent of White moms.[xi] Women with unintended pregnancies are more likely to receive little or late prenatal care, which as noted, is associated with prematurity and low birth weight. To improve birth outcomes, it is imperative that teenage girls, as well as other young women, receive better information on reproductive health and resources to avoid unintended pregnancies.

Environmental factors impact infant mortality. Environmental factors impact low birth weight, preterm births, and infant mortality. Specifically, areas with higher rates of air pollution jeopardize the health of newborn babies and increase chances for respiratory-related infant mortality.[xii] Historically, areas with higher environmental pollutants tend to be near low-income neighborhoods and communities of color, putting already disadvantaged mothers and infants further at risk.

Exposure to tobacco smoke also has health implications for infants. Mothers exposed to tobacco smoke were nearly twice as likely to have low birth weight babies compared to moms not exposed to tobacco smoke.[xiii] This is particularly detrimental to pregnant American Indian women who are much more likely to be exposed to tobacco smoke compared to all other racial and ethnic groups, and also struggle with a high infant mortality rate.

Embedded racial inequities create disparities in health. Systematic policies, practices and stereotypes work against racial/ethnic minorities, including women of child-bearing age. Studies to better understand the high infant mortality rate among African American infants have found that life experiences and covert racism increase preterm births. Covert racism is a much less obvious form of racism that's hidden in the fabric of society and increases pressure and frustration felt by the individuals being discriminated against. Covert racism has been linked to sustained, elevated cortisol levels – a stress hormone in the body. Increased cortisol levels, in turn, can impact an unborn baby, leading to prematurity and low birth weight.[xiv] Furthermore, structural barriers such as access to quality education, quality employment and health insurance, fresh produce and safe spaces for exercise make it more difficult for women of color to maintain healthy lifestyles.

To level the playing field, policymakers will need to better understand how current policies impact all of these barriers to equal opportunity and how improved policies can reduce disparities in outcomes for mothers and babies.

The Consequences of Unequal Opportunity

Michigan will continue to struggle with health and well-being. With over 800 Michigan babies dying before their first birthdays, more efforts must be made to reduce infant mortality.[xv] It is crucial to better understand this disparity and to improve the health of pregnant women and young women of color. Unless strategic efforts are made in this area, Michigan will continue to rank poorly in this key Dashboard indicator and, in particular, African American babies will continue to fare significantly worse than their White counterparts. It bears repeating – the infant mortality rate for African American babies is the same as it was for White babies in 1975. While much progress over the last 40 years has been evidenced by the reduction of overall infant mortality rates, sustained, strategic and focused efforts must be placed on reducing the unacceptable infant mortality rates for babies of color. Otherwise, disparities will persist and Michigan will continue to lag behind other states with an unacceptably high infant mortality rate.

Expensive health care costs. As previously noted, low birth weight and preterm babies have a significant economic burden on the state's health care costs and are the leading cause of infant mortality in Michigan. Women who plan for their pregnancies, are healthy before becoming pregnant, and access appropriate care before, during and after their pregnancies, are more likely to have healthy babies. Improving women's health through investments in preventive and prenatal care and reinvesting in perinatal regionalization can vastly reduce health care costs associated with infant mortality.

Strategies to Promote Equal Opportunity to a Healthy Start

Part of Governor Snyder's call-to-action in his 2011 Health and Wellness message included a statewide summit to reduce and prevent infant mortality. Out of this summit came the state's Infant Mortality Reduction Plan that was released in August of 2012. This plan focuses on Michigan's disproportionate infant mortality rate and includes strategies such as:

- Implementing a Regional Perinatal System to address the contiguous counties that lack health care services for pregnant women and infants,
- Promoting safer infant sleeping practices to prevent suffocation and sudden infant death,
- Expanding home-visiting programs to support vulnerable women and infants,
- Supporting better health status of women and girls,
- Reducing unintended pregnancies, and
- Weaving the social determinants of health into all targeted strategies to promote reduction of racial and ethnic disparities in infant mortality.

This legislative session, there are many opportunities, particularly in the state budget, to advance the state's Infant Mortality Reduction Plan and continue to move the dime on this unacceptable disparity.

Support the implementation of the state's Infant Mortality Reduction Plan. The Department of Community Health in partnership with key stakeholders has laid out a clear path to reduce infant mortality in Michigan, with a focus on reducing disparities. This plan is estimated to cost approximately $11 million to fully implement. The Legislature must prioritize the healthy beginnings of all Michigan children by fully funding the implementation of this plan.

Take advantage of the federal Affordable Care Act and expand Medicaid eligibility to adults up to 133 percent of the federal poverty level. Expanding access to health care ensures that more women of childbearing age can be healthy and plan for their pregnancies. This helps the odds of more babies (and particularly more babies of color) being born healthy since a woman's health prior to conception impacts pregnancy outcomes and the health of a newborn child.

Reinstate funding for crucial health prevention and promotion programs for women and infants to save millions of dollars in preventable health-related costs. Cuts over the last several years in local public health services, the Healthy Michigan Fund/Health and Wellness initiatives, and maternal and child health services have included reductions to and inconsistent funding for proven programs such as family planning, pregnancy prevention, and smoking prevention programs. At the same time, home visitation programs for vulnerable pregnant women such as the Nurse Family Partnership have seen slight increases in appropriations with support from state, federal, and private resources, but these funding levels aren't even close to what is necessary to serve all eligible families.

Reinstate funding for programs that serve teenage girls and ensure that they receive the proper reproductive health education necessary to make informed decisions. Cuts over the last several years in local public health services have included reductions in proven programs such as pregnancy prevention and teen parent counseling. Furthermore, the movement for educational curricula to focus on standardized testing has pushed out many non-mandated classes such as health education. Yet, it is essential that teenagers learn about reproductive health and their sexual health options. And when teenage girls do become pregnant, they must have access to resources to help them through the challenging process.

Utilize the Right Start Report to talk to legislators about infant mortality in your community. On May 8th, the Michigan League for Public Policy will be releasing the Right Start Report that annually provides data on maternal and child well-being. Many of the data points highlighted mirror those discussed in this report such as access to prenatal care, births to teenage moms, smoking during pregnancy, low birth weight, and preterm births – all factors which influence infant mortality. The Right Start data is broken down by local Great Start Collaboratives and can also be found on the national Kids Count Data Center website by county, so you can see how your community fares in these key indicators. Use this data to talk to your legislators about the specific challenges your community faces that impact infant mortality and leverage the report to discuss policy and budget strategies to improve maternal and child health in your community.

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[i] National KidsCount Data, Annie E. Casey Foundation. 2010.
[ii] Michigan Department of Community Health, Michigan Infant Death Statistics (April 2013).
[iii] *Prematurity*, Issue Brief by the Center for Healthcare Research & Transformation (November 2010).
[iv] http://www.marchofdimes.com/downloads/Census_data_on_Uninsured_Highlights09.pdf
[v] Michigan Department of Community Health, 2011, http://www.mdch.state.mi.us/pha/osr/Natality/WeightGainPer.asp.
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[viii] Nurse Family Partnership. http://www.nursefamilypartnership.org/proven-results.
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[xiv] Unnatural Causes: Is Inequality Making Us Sick? (2008). PBS. www.unnaturalcausesorg
[xv] Michigan Department of Community Health, 2010, http://www.mdch.state.mi.us/pha/osr/InDxMain/Tab1.asp.