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

August 2011

Eliminating Disparities in Infant Mortality Critical to a Healthy Start

In his first State of the State address, Governor Rick Snyder outlined the "roadmap of initiatives" that will guide the Administration's work during 2011, and released 21 key measures, known as the Dashboard, by which Michigan will evaluate its success. The Dashboard identifies infant mortality as a key indicator for the state's health and well-being. According to the Dashboard, Michigan's infant mortality rate was nearly 8 deaths per 1000 live births in 2010, a rate that ranks Michigan at 37th in the nation. (National Kids Count data, utilizing 3-year averages, ranks Michigan at 40th on infant mortality).[i] Even more distressing is the infant mortality rate when compared by race – **Hispanic babies die at nearly twice the rate of White babies and Black babies die at three times the rate of White babies in their first year**.[ii] For Black babies, the infant mortality rate is the same as it was for White babies in 1974, indicating that the health and wellness of Black pregnant women and babies is nearly 40 years behind in progress.

Michigan Quick Facts

- Michigan is ranked 40th in the country on infant mortality with nearly 1,000 infants dying each year before their first birthdays.
- One in six Black babies are born too early compared to 1 in 10 babies overall.
- Prematurity/low birth weight is the leading cause of infant mortality.
- Black babies are 3 times more likely to die in the first year of life.
- Black and Hispanic babies are nearly two times more likely to be born following pregnancies with less than adequate prenatal care compared to White babies.

Luckily, we know how to reduce infant mortality. Michigan has a proven record of reducing infant mortality. In the past decade alone, Michigan's infant mortality rate has steadily declined from over 10 deaths per 1000 live births to under 8 deaths per 1000 live births. However, this reduction in the state's infant mortality rate is largely driven by the large drop in infant mortality for White babies. Key components to reducing infant mortality have focused not only on medical technology improvements but also on improving women's health before they become pregnant and increasing access to health care, particularly for women and families of color. Strategically targeting at-risk 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 infant mortality.

Why Equal Opportunity is Important

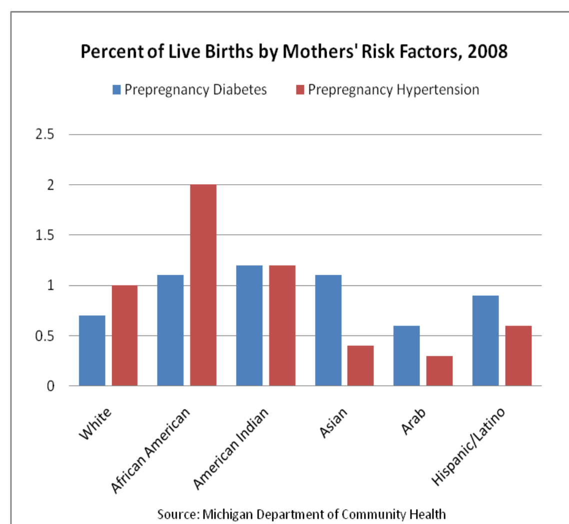
Increasing access to care reduces health care costs *and* infant mortality. Prematurity and low birth weight are the leading causes of infant mortality in Michigan, as well as the nation. As detailed below, access to health care including prenatal care are essential to reducing low birth weight and infant 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

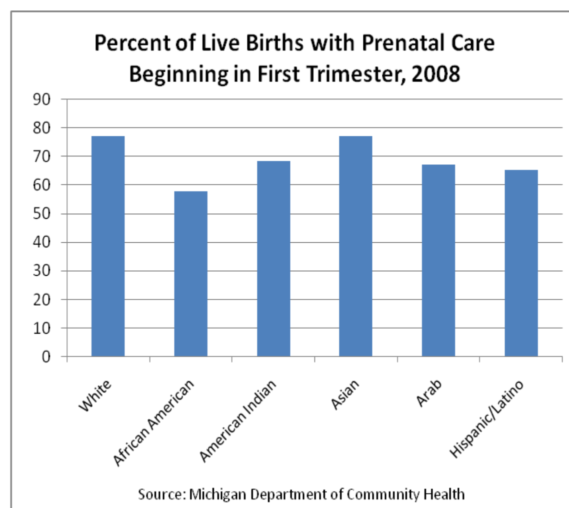
premature or low birth weight infant in Michigan is $102,103, approximately 14 times higher than for a healthy infant.[iii] With 51 percent of Michigan births covered by Medicaid in 2010, reducing preterm/low birth weight babies – and ultimately infant mortality – will save thousands of dollars for Michigan taxpayers.

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 Black infants have found that life experiences and covert racism increase preterm births. 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.[iv] 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 racial/ethnic disparities and how improved policy can reduce disparities in outcomes for mothers and babies.

Barriers to Equal Opportunity

Access to health care for young women. With 1 out of 6 Michigan women of childbearing age lacking health care coverage[v], efforts must be made to ensure that these 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. Specifically, statistics reveal that Black and American Indian women have higher rates of diabetes and hypertension before getting pregnant and are more likely to be overweight or obese at the start of their pregnancies.[vi] Clearly these health conditions 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.





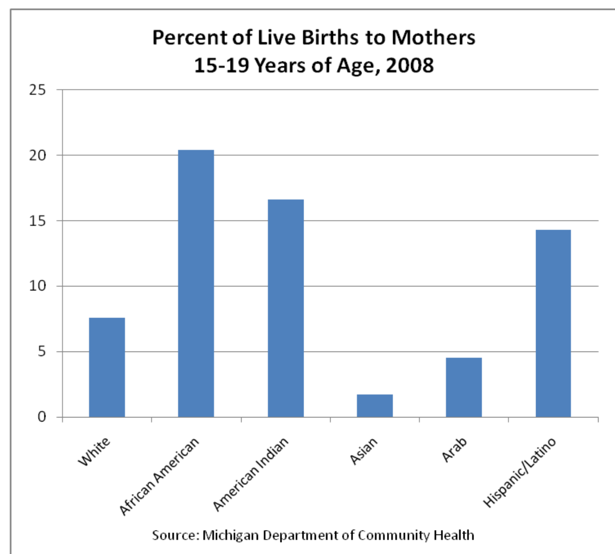
Access to care for pregnant women.
Prenatal care is the first health care intervention that new babies receive. Prenatal care can help pregnant women improve their health, thereby ensuring the best possible outcomes for their baby. Expectant women with prenatal care learn critical information, including 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

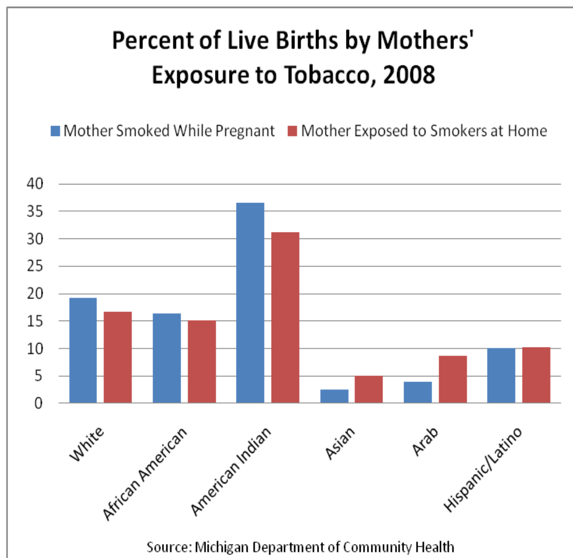
neonatal care.[vii] Yet with all this knowledge, in 2008, Black women were three times less likely than White women to receive any prenatal care during their pregnancy.[viii] Clearly increasing access to prenatal care for women of color is critical to reducing infant mortality.

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. Furthermore, doctors are leaving the area and facilities are no longer able to maintain an appropriate trauma system dedicated to infants born with health issues. Therefore, women and infants are traveling further to access basic and critical care, jeopardizing their health. Ensuring that women and infants have access to appropriate medical care can improve the outcomes of infants, particularly premature and very low birth weight infants.

For the most at-risk women, 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, Healthy Mothers Healthy Babies, and Medicaid's Maternal Infant Health Program – connect women to essential resources for pregnant women 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.[ix]

Births to teen moms. The statistics are clear. Young women of color, particularly Black, American Indian, and Hispanic women are 2-3 times more likely to be teen moms. One out of five Black babies is born to a teenage mother who is less likely to receive prenatal care than older moms.[x] Babies born to teenage mothers are more likely to be born too soon and too small, both of which are highly correlated to other serious health problems including infant mortality.[xi] Furthermore, nearly 85 percent of births to teen moms were unintended pregnancies; and of all unintended pregnancies, 69 percent were to Black moms compared to 48.5 percent to Hispanic moms and 37 percent to White moms.[xii] 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 for young moms, it is imperative that teenage girls 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.[xiii] 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.

At a more micro level, 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.[xiv]

The Consequences of Unequal Opportunity

Michigan will continue to struggle with health and well-being. With nearly 1,000 infants 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.

Expensive health care costs. As noted above, 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. Luckily, 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

Create incentives for providers to treat pregnant women and children covered by Medicaid by increasing Medicaid provider payments to Medicare levels and creating financial incentives for the full range of health services needed by low-income women and infants. In 2010, more than half (51%) of Michigan births were covered by Medicaid. Cuts in Medicaid provider payments have shut down labor and delivery units making it more difficult for pregnant women and infants to access basic preventative and critical health care.

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, and maternal and child health services have included reductions in proven programs such as family planning, pregnancy prevention, home visitation programs

for vulnerable pregnant women such as the Nurse Family Partnership, and smoking prevention programs.

Reinstate funding for programs that serve teenage girls and ensure that they receive the proper reproductive health education necessary to make smart 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.

---

[i] National KidsCount Data, Annie E. Casey Foundation. 2007.

[ii] Michigan Department of Community Health, Presentation to House Appropriations Subcommittee on Community Health, March 8, 2011.

[iii] *Prematurity*, Issue Brief by the Center for Healthcare Research & Transformation (November 2010).

[iv] Unnatural Causes: Is Inequality Making Us Sick? (2008). PBS. www.unnaturalcausesorg

[v] http://www.marchofdimes.com/downloads/Census_data_on_Uninsured_Highlights09.pdf

[vi] Michigan Department of Community Health, 2009, http://www.mdch.state.mi.us/pha/osr/natality/RisksRacePer.asp.

[vii] Henderson JW, The cost effectiveness of prenatal care. Health Care Finance Rev 1994; 15: 21-33.

[viii] Michigan Department of Community Health, http://www.mdch.state.mi.us/pha/osr/natality/tab1.7.asp

[ix] Nurse Family Partnership. http://www.nursefamilypartnership.org/proven-results.

[x] Michigan League for Human Services, *Mothers and Infants in Michigan Communities: The Other Half*. Kids Count in Michigan 2010.

[xi] http://www.marchofdimes.com/professionals/medicalresources_teenpregnancy.html

[xii] PRAMS Report. MDCH. 2008.

[xiii] Woodruff T, Darrow LA & Parker JD (2008). Air Pollution and Postneonatal Infant Mortality in the United States, 1999-2002. National Institute of Environmental Health Sciences, 116(1): 110-115.

[xiv] Goel P, Radotra A, Singh I, Aggarwal A, Dua D. Effects of passive smoking on outcome in pregnancy. Journal of Postgraduate Medicine. 2004;50:12–6 http://www.ncbi.nlm.nih.gov/pubmed/15047992

[xv] Annie E. Casey Foundation, Kids Count Data Center. http://datacenter.kidscount.org