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PRENATAL CARE

Statement of
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Before the
Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Operations
House of Representatives

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SUMMARY

More than $2.5 billion is spent annually on neonatal intensive care services in the United States, primarily for low birth-weight babies. Babies born to women who received no prenatal care are three times more likely to be of low birth weight than those whose mothers received early care. According to the National Academy of Sciences' Institute of Medicine, for every dollar spent on prenatal care for high-risk women, over three dollars could be saved in the cost of care for low birth-weight infants.

GAO interviewed 1,157 Medicaid recipients and uninsured women in 32 communities in 8 states to determine the timing and number of their prenatal care visits and the barriers they perceived as preventing them from obtaining care earlier or more often. Of the women interviewed, about 63 percent obtained insufficient prenatal care, according to the Institute of Medicine's Prenatal Care Index, because they did not begin care within the first 3 months of their pregnancy or made eight or fewer visits for care. About 81 percent of a comparison group of women with private health insurance received adequate care. For the Medicaid and uninsured women, about 12.4 percent of the babies born were of low birth weight. Nationally, about 6.8 percent of births are of low weight.

Three barriers to earlier or more frequent prenatal care predominated in virtually every demographic group of women--lack of money to pay for care, lack of transportation to the provider of care, and unawareness of pregnancy. The importance of these and other barriers differed, however, by community.

A comprehensive effort is needed to identify the primary barriers in a community, develop programs to overcome those barriers, and evaluate their effectiveness in improving access to prenatal care.

Although the solutions must be designed to meet the needs of individual communities, federal funds are available to assist states and communities in such efforts. Money spent to expand prenatal care services should be more than offset by decreased newborn intensive-care costs.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here to discuss the results of our report[1] to the subcommittee on problems encountered by Medicaid recipients and uninsured women in obtaining prenatal care.

The report is based on the results of interviews with 1,157 Medicaid recipients and uninsured women and analyses of appropriate medical records to determine (1) the number and timing of their prenatal care visits and (2) the barriers they perceived as preventing them from obtaining care earlier or more often. We did our interviews and analyses in 32 communities in 8 states.

Background

According to the American College of Obstetricians and Gynecologists, every pregnant woman should begin a comprehensive program of prenatal care as early in the pregnancy as possible. For example, a woman with a normal 40-week pregnancy should see a doctor or other health care provider about 13 times. Early and continuing prenatal care plays an important role in preventing low birth weight and poor pregnancy outcomes. Babies born to women who obtain no prenatal care are three times more likely to be of low birth weight--5.5 pounds or less--than babies born to women who obtain care early in their pregnancies. Prenatal care is especially important for low-income, minority, and adolescent women, who are regarded as medically high-risk groups.

The costs of inadequate prenatal care are high, in terms of both infant mortality and increased health care costs. Nearly 40,000 infants born in 1984 died before their first birthday. The approximately 254,000 low birth-weight infants (about 6.8 percent

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[1] Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care (GAO/HRD-87-137, Sept. 30, 1987).

of all births) born in 1985 were almost 40 times more likely to die during the first 4 weeks of life than normal birth-weight babies.

More than $2.5 billion is spent annually on neonatal intensive care services, primarily for low birth-weight babies. According to the Institute of Medicine, for every dollar spent on prenatal care for high-risk women--such as those we interviewed--over three dollars could be saved in the cost of care for low birth-weight babies.

In 1980, the Surgeon General set out specific objectives for improving infant health and reducing infant mortality by 1990. One of the objectives was to reduce to 5 percent or less the percentage of babies of low birth weight. Another objective was for 90 percent of all pregnant women to obtain prenatal care within the first 3 months of their pregnancy. However, as of 1985, the latest year for which data were available, virtually no progress had been made in meeting these two objectives. For example, the percentage of women obtaining prenatal care during the first trimester was 76 percent in both 1980 and 1985.

Most Medicaid Recipients and Uninsured Women Obtained Insufficient Care

From the results of our work, it appears unlikely that the Surgeon General's goal will be met by 1990, particularly for the approximately 26 percent of women of childbearing age who lack private health insurance.[2] Of the women we interviewed, about 63 percent obtained prenatal care we considered insufficient because they did not begin care within the first 3 months of their pregnancy or made eight or fewer visits for care. About 12.4

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[2]According to 1984 data, 17 percent of women of childbearing age had no insurance to pay for prenatal care and another 9 percent had only Medicaid coverage.

percent of the babies born to these women were low birth-weight babies. The national average is 6.8 percent.

Insufficient prenatal care was a problem for women of all childbearing ages, of all races, and from all sizes of communities. But those most likely to obtain insufficient care were women who were uninsured, poorly educated, black or Hispanic, teenagers, or from the largest urban areas. The percentage of Medicaid recipients and uninsured women who had insufficient prenatal care ranged from 14 percent in Kingston, New York, to 82 percent in Montgomery, Alabama. (See attached list.)

In all but two communities studied (Kingston, New York, and Troy, Alabama), a higher percentage of privately insured women obtained adequate care. Overall, 81 percent of privately-insured women studied in the 32 communities obtained adequate care compared with 36 percent of the women with Medicaid coverage and 32 percent of women with no health insurance.

Multiple Barriers to Care Found

We asked the Medicaid recipients and uninsured women interviewed what kept them from obtaining prenatal care earlier or more often. Barriers to earlier or more frequent care varied according to such factors as age, race, and size of community, with about half of the women interviewed citing multiple barriers. Three barriers predominated in virtually every demographic group of women--lack of money to pay for care, lack of transportation to the provider of care, and lack of awareness of the pregnancy. The importance of these and other barriers differed, however, by community. For example,

-- None of the women interviewed in Birmingham, Alabama, cited lack of money as the most important barrier compared with 27 percent of the women interviewed in Los Angeles. The

difference appears to be due to the availability of free prenatal care in Birmingham.

-- Transportation was more frequently named as a barrier in rural and midsized cities that lacked public transportation.

-- Over 25 percent of women in five midsized communities said lack of awareness of the pregnancy was the most important barrier to prenatal care, while less than 10 percent of women in five other midsized communities cited this barrier.

Because of such differences, programs to overcome barriers to prenatal care need to be tailored to meet the needs of individual communities. Federal funds are available to assist states and communities in such efforts. Specifically,

1. States can extend Medicaid eligibility to pregnant women with incomes up to the Federal poverty level. As of June 1987, 19 states had done so. We found that Medicaid coverage reduced (from 23 to 10 percent) the significance of lack of money as a barrier to prenatal care for the women we interviewed. The Congressional Budget Office (CBO) estimated that federal Medicaid costs would have increased about $190 million in fiscal year 1987 had all states expanded eligibility.

2. States can extend Medicaid coverage to pregnant women while their Medicaid applications are being processed. Of the Medicaid recipients who cited lack of money as a barrier to care, most said that they encountered problems in establishing eligibility. This could delay women receiving prenatal care services under Medicaid. CBO estimated that presumptive eligibility would only cost the Federal Government about $6 million over a 3-year period. As of June 1987, no states have implemented presumptive eligibility.

3. States and communities could allocate additional Maternal and Child Health Block Grant funds to prenatal care services. Such funds could be used, among other things, to fund educational and outreach services to get women into prenatal care earlier and to provide transportation services to help them get to a health care provider.

Another solution suggested by some is to increase Medicaid reimbursement rates for maternity services to encourage more private-practice physicians to accept Medicaid patients. Few of the women we interviewed, however, had problems finding a health care provider to see them. Specifically, about 61 percent obtained care at a hospital or public health clinic. Only 2 percent of the women who obtained insufficient care cited difficulty in finding a doctor as the most important barrier to earlier or more frequent care. Although increased reimbursement might expand the choices of providers available to Medicaid-eligible women--an important goal--it would not, in our opinion, be the best use of limited resources. Expanding Medicaid eligibility would, in our view, do more to expand access to care. As I previously mentioned, for every dollar spent in providing prenatal care to high-risk women such as those we interviewed, about three dollars could be saved in reduced neonatal intensive care costs.

This concludes my statement. We would be pleased to answer any questions.

Proportion of Medicaid Recipients and Uninsured Women Having Insufficient Care, by Community

Community	Percent of women having insufficient care	Total no. of women interviewed
Montgomery, Alabama	82	22
Brunswick, Georgia	79	24
Savannah, Georgia	78	23
New York, New York	76	84
Selma, Alabama	76	45
Los Angeles, California	75	212
Huntsville, Alabama	74	19
Chicago, Illinois	72	65
Atlanta, Georgia	69	95
Bakersfield, California	69	39
Troy, Alabama	67	24
Charleston, West Virginia	66	38
Columbus, Georgia	65	26
Buffalo, New York	63	16
Birmingham, Alabama	57	35
Clarksburg, West Virginia	56	16
El Centro, California	53	19
Bluefield, West Virginia	51	39
Ukiah, California	50	18
Sacramento, California	50	26
Boston, Massachusetts	49	51
Americus, Georgia	48	23
Carbondale, Illinois	47	38
Mattoon, Illinois	47	17
Rockford, Illinois	44	34
Peoria, Illinois	42	19
Bangor, Maine	40	10
Auburn, New York	38	16
Syracuse, New York	38	16
Huntington, West Virginia	24	25
Augusta, Maine	22	9
Kingston, New York	14	14
Total	63	1,157