# What the Future Holds

In the United States, two to three women die of pregnancy complications each day. A woman's race, ethnicity, country of birth, and age all are associated risks for pregnancy-related complications. The states' public health divisions still have much to learn about the physical and mental effects of pregnancy complications and their short-term and long-term impact on the health of women, infants, and families. Because 4 million women give birth each year in the United States, even small advances in research and prevention efforts can improve the quality of life for hundreds of thousands of women.

The most vexing problems in future decades will continue to be the increasing rate of low birth weight infants and the growing disparities between black and white infant mortality rates. These issues not only present serious public health problems, but contribute to the enormity of healthcare and other public costs.

There are proven interventions that can help maintain progress in decreasing infant mortality and should be preserved and invested. They include Medicaid; providing family planning services; promoting early initiation of prenatal care; enhancing folic acid supplement usage; maintaining traditional public health services; and increasing education about SIDS prevention. As Medicaid expansion has shown to reduce infant mortality, it is important to continue to target women who are eligible, but not enrolled in the program. Additionally, as more poor families are enrolled in managed care systems, it will be important to ensure that the public health services such as outreach; transportation; referral and case management; and health education are maintained to ensure access to care for hard-to-reach and vulnerable populations.

Maternal and infant health programs are still evolving. States and regions differ in the methods in the delivery of services, but all are continuing to take actions to encourage the highest quality programs to benefit every newborn and their families. Although no entity can fulfill the primary responsibility of parents in caring for their children, public officials at the federal, state, and local levels have been working together with healthcare providers to help expectant mothers protect the lives of their unborn children through a number of different programs and approaches.

The efforts of the Southern Regional Project on Infant Mortality, begun 20 years ago, brought to the forefront of both legislative and executive branch agendas the need to address the critical issue of infant mortality. Prior to the formation of the Project, no joint, region-wide approach to reducing the South's infant mortality rate and extremely high incidence of babies born with low birth weight had been undertaken. Throughout the Project's existence, the South as a region, and the states individually, made great progress in ensuring a healthier start for its infants and demonstrated stronger support for expectant mothers and their families. Sadly, the progress and

changes made have been short-lived. The fiscal downturn that began in 2000 and so dramatically influenced state spending for the past five years is now beginning to show signs of improving. While the economic recovery is underway, states continue to struggle with limited resources and revenues necessary to fund even the most basic services to its most vulnerable residents.

If the South is to improve its poor ranking in infant mortality among its regional counterparts, policymakers must remain vigilant in their efforts to provide access to quality healthcare to low-income pregnant women, as well as provide preventative and ancillary services that support healthy lifestyles for the populations at risk.

Perhaps the greatest challenge to policymakers in the 21st century will be in determining the level of support that can reasonably be made for the spectrum of concerns that span its increasing elderly population and its newest members, the children, who represent the future of the South. Without a generation of productive and healthy children—the state's future workforce—the region will suffer on many fronts. This is a fight that the South cannot afford to lose.

# APPENDIX A

POLICY POSITION

6. INFANT MORTALITY IN THE SOUTH

The United States infant mortality rate ranks among the highest of all industrialized countries. In 1980, the U. S. infant mortality rate was 12.6/1000 live births as compared to a rate of 12/1000 for the United Kingdom, 11/1000 for Canada, 10/1000 for France and 7/1000 for Japan. Rates for non-whites and southerners have remained consistently higher than the national average. In 1960, when the U.S. rate was 26.1/1000 live births, the rate in the South was 29.0/1000. In 1980, the U.S. rate was 12.6/1000 live births while the rate for the South was 13.8/1000. These rates are 11.1 percent and 9.5 percent higher respectively than the national average for those years. As is true nationally, the non-white infant mortality rate in the South remains dramatically higher than the white rate.

(The "South" referred to in the statistics above is the "Census South", which includes the states of Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.)

The 1980 Commission on the Future of the South, Task Force on Children issued two reports on infant mortality in the South entitled "Factors Associated with Infant Mortality" and "Infant Mortality and Teenage Pregnancy Profile of Children in the South." The task force reported that, "… the U.S. has made substantial progress in reducing the risk factors for pregnant women and young babies; the rate is now only one-eighth of what it was in 1980… However, the picture is not equally rosy for all regions of the country, all races and all socioeconomic groups…non-whites and southerners have a distinct disadvantage in producing healthy, viable babies, and this disparity has not been significantly lessened with the recent improvement in the overall rates."

Poverty, teenage pregnancy, lack of access to care, limited education and demographic characteristics such as race and family patterns all correlate highly with infant mortality. The solutions to the problem are multiple and complex, reaching far beyond the medical scope of the issue into public policy and social awareness. Early and adequate prenatal care, pre-planning for hospital delivery, high risk screening, sufficient nutrition, counseling and financial assistance are all needed if we are to improve our rate nationally and in the region.

In recent years, the federal government has moved to turn financial and administrative responsibility for maternal and child health programs over to the states. While the states welcome the increased flexibility to target resources on the areas of greatest importance, the SLC is concerned that the increased responsibility for the services be accompanied by adequate federal assistance. The drain on state resources created by the immediate crisis care needed by high risk infants and the long term support services for these children over their lifetime is enormous.

The SLC believes that improved maternal and child health should be a national objective and a responsibility of all levels of government. The SLC, therefore, opposes reductions in federal support for maternal and child health services. The southern states' efforts to address the continuing problem of infant mortality through cost beneficial preventative services, outreach activities, and comprehensive health services must have, as a foundation, adequate federal support.

Several southern states have already moved to establish programs directed toward prevention, particularly in high risk populations.

› Several states, including Mississippi, Florida, Georgia, North Carolina, South Carolina and Virginia have changed their Medicaid eligibility criteria to incorporate first time pregnant women and a broader range of pregnant women and children.



› In North Carolina, Governor Hunt proclaimed 1984, "Prevention of Premature Birth Year" calling for a coordinated effort throughout the state to address causes related to premature birth, a major factor in infant mortality.

› In Florida, a statewide training program has been implemented for all health care professionals. This effort is to provide pre-term labor prevention knowledge and skills.

› Tennessee has appropriated $2.5 million for a "Healthy Children's Initiative"– a major public education program on the problems and potential solutions associated with infant mortality.

› Arkansas has established a three-year "Healthy Beginnings Programs" targeting the nine counties in the state with the highest infant mortality rates for intensive public awareness and service programs to reduce infant mortality.

› Accepting a proposal by Governor Riley, the South Carolina General Assembly approved state matching funds for implementation in FY 84-85 of $19.2 million of Medicaid coverage for medically needy pregnant women and for children ages 0-18 who are members of intact families.

In order to address the causes of infant mortality in a more complete and comprehensive way, the Southern Legislative Conference joins the Southern Governors' Association in calling for the formation of a Southern Regional Infant Mortality Task Force. The Task Force would bring together, within each southern state and across the region, governors, legislators, public health officials, clinicians and lay and professional advocates. The Task Force would promote initiatives to narrow the infant mortality gap between the South and the rest of the country and to reduce the incidence of infant mortality and low birth weight throughout the region by:

› documenting the scope of infant mortality and factors related to its prevalence throughout the South;

› raising the level of public awareness of the problem;

› monitoring the progress of individual southern states in reducing their infant mortality and low birth weight rates; and

› highlighting and transferring ideas and experiences of successful state programs, with a view toward the development of regional prototypes.

**Recommendations**

The Task Force should receive staff assistance through the region's Washington Office, through which the Southern Governors' Association and the Southern Legislative Conference conduct their federal affairs activities. Reports of the Task Force's activities should be provided to the SLC at its regular scheduled meetings.

Adopted at the Southern Legislative Conference Annual Meeting on August 15, 1984, Virginia Beach, Virginia.

Previously Adopted at the 1984 Annual Meeting of the Southern Governors' Association, Williamsburg, Virginia.

SO-84-RR29

# Endnotes

[1] Facts are combined information taken from The What to Expect Foundation, *Parenting Gets Easier When You Know What to Expect,* April 3, 2000; and RAND Health*, Preventing Very Low Birthweight Births: A Bundle of Savings*, 1998.

[2] March of Dimes Birth Defects Foundation, *National Perinatal Statistics*, *www.modimes.org*, 2000.

[3] Maternal and Child Health Bureau, Child Health USA, *Comparison of National Infant Mortality Rates*, 2002.

[4] The Alan Guttmacher Institute, Policy Analysis, *Issues in Brief: Family Planning Can Reduce High Infant Mortality Levels*, 2002.

[5] The Alan Guttmacher Institute, *Hopes and Realities: Closing the Gap Between Women's Aspirations and Their Reproductive Experiences*, 1995.

[6] The Alan Guttmacher Institute*, Issues in Brief*, Policy Analysis, 2002.

[7] *Ibid*

[8] Family Planning Perspectives, Volume 32, No. 1, *Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries*, January-February 2000.

[9] The Alan Guttmacher Institute*, Issues in Brief*, Policy Analysis, 2002.

[10] *Ibid*

[11] National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC), *Supplemental Analyses of Recent Trends in Infant Mortality*, by Kenneth D. Kochanek, M.A., and Joyce A. Martin, M.P.H., March 23, 2004.

[12] CDC, Division of Vital Statistics, National Vital Statistics Report (NVSR), Vol. 50, No. 12, *Infant Mortality Statistics from the 2000 Period Linked Birth/Infant Death Data Set*, by T.J. Mathews, M.S., Marian F. MacDorman, Ph.D., and Fay Menacker, Dr.P.H., August 28, 2002.

[13] Information on causes of death was obtained from the National Center for Health Statistics (NCHS), CDC, *Fact Sheets*, 2002.

[14] U. S. Department of Health and Human Services, Press Release, *Preventing Infant Mortality*, March 18, 2002.

[15] NCHS, CDC*, NVSR,* Volume 51, No. 12, *www.cdc.gov/nchs/products.htm.*, August 4, 2003.

[16] Kochanek and Martin.

[17] NCHS, CDC, *NVSR,* Volume 51, No. 11, *www.cdc.gov/nchs/products.htm.*, June 25, 2003.

[18] NCHS, CDC*, NVSR,* Volume 52, No. 2, *www.cdc.gov/nchs/products.htm.*, September 15, 2003.

[19] The March of Dimes News Desk, *www.modimes.org.*

[20] *Ibid.*

[21] CDC, Division of Vital Statistics, National Vital Statistics Report (NVSR), Vol. 50, No. 4, *Infant Mortality Statistics from the 1999 Period Linked Birth/Infant Death Data Set*, by T.J. Mathews, M.S., Marian F. MacDorman, Ph.D., and Fay Menacker, Dr.P.H., January 30, 2002.

[22] *Ibid.*

[23] Mathews, MacDorman, and Menacker, 2002.

[24] All data are secured from the *NVSR,* Volume 52, No. 2, 2003.

[25] *NVSR*, Volume 49, No. 1 and 5 and Volume 51, No. 2 and 11.

[26] *NVSR,* Volume 52, No. 2, 2003.

[27] *Ibid.*

[28] *Ibid.*

[29] Information in paragraph is supported by the *National Council on Folic Acid* and the *March of Dimes on Birth Defects*.

[30] *Ibid.*

[31] Kotelchuck and Gamble*, Healthy Futures/Healthy Generations Evaluation Project*, 1996.

[32] Maternal and Child Health Bureau, U.S. Department of Health and Human Services, *Child Health USA, State-Specific Data*, 2002.



[33] State data are secured from the Alabama Department of Public Health, *Alabama Perinatal Health Act, Annual Progress Report for FY 2002*, *www.adph.org.*

[34] *Ibid.*

[35] State data are secured from the Arkansas Department of Health, *Center for Health Statistics*, *www.healthyarkansas.com.*

[36] *Ibid.*

[37] *Ibid.*

[38] State data are secured from the Florida Department of Health, *Florida's Maternal & Child Handbook,* and the *Florida Vital Statistics Annual Report, 2002.*

[39] *Ibid.*

[40] *Florida Vital Statistics Annual Report, 2002.*

[41] State data are secured from the Georgia Division of Public Health, *Vital Statistics Reports 1997-2002*, *www.ph.dhr.state.ga.us/healthdata/vital.html.*

[42] *Ibid.*

[43] Louisiana Department of Health and Hospitals, Office of Public Health, *Center for Health Statistics*.

[44] Missouri Department of Health & Senior Services, *Missouri Birth Defects, 1996-2000*.

[45] Missouri Department of Health & Senior Services, *Missouri Pediatric Nutrition Surveillance System Report, 2001.*

[46] Missouri Department of Health and Senior Services, Missouri Epidemiologist, Volume 21, No. 1, *Missouri 1997 Prenatal Drug Prevalence Study.*

[47] All data are secured from the *Missouri Pediatric Nutrition Surveillance System, 2001.*

[48] North Carolina Department of Health and Human Services, A Special Report Series by the State Center for Health Statistics, No. 112, *Infant Mortality and Low Birthweight in North Carolina: The Last Ten Years*, by Kathy Surles, M.Ed., Paul A. Buescher, Ph.D., and Robert Meyer, Ph.D., January 1999.

[49] *Ibid.*

[50] Oklahoma KIDS COUNT Factbook, *A State Profile: Infant Mortality*, 2001.

[51] March of Dimes Birth Defects Foundation, *Health Indicators, Oklahoma 1991-2000*, *www.modimes.org.*

[52] South Carolina Department of Health and Environmental Control (DHEC), *Health of South Carolinians, Annual Report*, 2000.

[53] South Carolina DHEC, *Maternal and Child Health Databook*, March 2002.

[54] Tennessee Department of Health, *Health Statistics*, *www2.state.tn.us/health/statistics/index.html.*

[55] Bureau of TennCare, Office of the Governor, *Proposed TennCare Changes and Waiver Amendment, 2004.*

[56] *Ibid.*

[57] Bureau of Vital Statistics, Texas Department of Health, *The Health of Texans, 2002*.

[58] *Ibid.*

[59] *Ibid.*

[60] All data are secured from the Virginia Department of Health, *Virginia Center for Health Statistics*, *www.vdh.state.va.us/.*

[61] Virginia Department of Health, Family Planning Division, *Title X Needs Assessment*, *www.vahealth.org/familyplanning/datafpp.htm.*

[62] West Virginia Bureau for Public Health, Health Statistics Center, *Vital Statistics, www.wvdhhr.org/bph/,* 2000.

[63] West Virginia Healthy People 2010, Chapter 1, *Access to Quality Health Care*.

[64] *Ibid.*

[65] March of Dimes, State Health Profiles, *Peristats*, *www.modimes.org*.