BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Better Management And More Resources Needed To Strengthen Federal Efforts To Improve Pregnancy Outcome

Federal programs have helped increase access to health care for many and have contributed much to the Nation's progress in preventing infant mortality. However, many persons, particularly those of low income, not only lack ready access to adequate health care but fail to effectively use services which are available.

The Federal Government, principally HEW, has recognized these problems and has taken several steps to help resolve them. However, a more systematic approach should be developed and the structure or management of several programs should be improved. Improvements in the types, amounts, and distribution of health care and better coordination between the public and private health care sectors are also needed.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report describes the progress made and problems remaining in Government efforts to reduce infant mortality and morbidity. It discusses the need for more intense and coordinated efforts by Federal agencies, particularly the Departments of Health, Education, and Welfare and Agriculture, to help alleviate remaining problems. The report also recommends several legislative changes to improve Federal programs affecting pregnancy outcome. Further, it discusses the need for additional resources for areas in the Nation continuing to experience significant adverse pregnancy outcomes that could be improved if mothers and infants had better access to appropriate health care.

Our review was made because of concern expressed about the wide disparity in pregnancy outcomes among different population groups and geographic areas within the United States and the large number of Federal programs that can or do affect pregnancy outcome.

Copies of this report are being sent to the Director, Office of Management and Budget; the Secretary of Health, Education, and Welfare; the Secretary of Agriculture; and other interested parties.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

BETTER MANAGEMENT AND MORE RESOURCES NEEDED TO STRENGTHEN FEDERAL EFFORTS TO IMPROVE PREGNANCY OUTCOME

D I G E S T

Each year about 50,000 of the more than 3 million infants born alive in the United States die before reaching age 1; another 33,000 fetal deaths occur before or at birth. Additionally, about 250,000 babies are born annually with birth defects. More ready access to and better use of appropriate health care services could improve the health of pregnant women and consequently that of their infants.

The Federal Government, along with State and local health agencies, has a number of health care programs directed at preventing or better timing pregnancies and improving the health and well-being of mothers and infants. However, a comprehensive national strategy for using and coordinating funds and staff involved in these numerous and fragmented programs is lacking.

Federal funds have been inadequate for extending health care services to all areas and to all those in need, and some areas have duplicate projects. The two major Federal programs--Maternal and Child Health, administered by the Department of Health, Education, and Welfare (HEW), and the Special Supplemental Food Program for Women, Infants, and Children, administered by the Department of Agriculture--targeted at improving pregnancy outcome have not been fully effective or well coordinated. (See ch. 3.)

SERVICES TO PREVENT OR FAVORABLY TIME HIGH-RISK PREGNANCIES

Family planning programs in recent years have helped to prevent unwanted or unplanned pregnancies. However, many women continue to have unwanted, unplanned, or ill-timed pregnancies.

Community health service
Health service administration
Health care service
Parents
Children
Medicaid programs
Health care programs
Child care programs
Birth control services
Education of Trainees programs
Health research programs

Health authorities believe that many of these pregnancies, particularly among adolescents, can and must be prevented through more or better family planning and health education programs.

Significant amounts of welfare costs can be attributed to adolescent pregnancy. According to one recent estimate, of the $9.4 billion in Aid to Families with Dependent Children funds paid in 1975, about half--or $4.65 billion--went to households of women who had borne their first child while in their teens. This estimate excludes administrative costs as well as those for health care, food stamps, or other public assistance programs.

The effectiveness of HEW's programs to prevent pregnancies, especially high-risk ones, is questionable because services are not always available, accessible, or effectively used. Many women do not receive these services or effectively use them, or they receive them too late to prevent or delay unwanted or unplanned pregnancies because of

--limited resources,

--lack of coordination among all agencies,

--patient apathy,

--limited outreach and followup for patients, and

--various attitudinal barriers.

Additionally, many health and educational professionals and parents believe that teaching youngsters about family life, including sex education, is critical to preventing unwanted pregnancies and promoting health. While few people disagree with this belief, much controversy exists over who should provide this education, what information should be taught, and when and to whom it should be provided. (See ch. 4.)

PRENATAL AND WELL BABY CARE SERVICES

Prenatal and well baby care are considered essential by many for ensuring a healthy newborn infant and maintaining a healthy mother. However, many women and infants, particularly those of low income, still do not receive adequate or timely prenatal and infant care because of

--limited funding of public health services,

--low Medicaid reimbursements,

--limited or unevenly distributed supply of health professionals,

--inability of the mother to pay for care or obtain it,

--lack of coordination among agencies and programs and between the public and private sectors, and

--lack of motivation by many to seek care.

Federal, State, and local agencies have expanded and improved access to maternity and infant care by varying degrees. Some Federal programs and initiatives, such as Maternal and Child Health, Medicaid, National Health Service Corps, Improved Pregnancy Outcome, and Improved Child Health, have helped provide access to health care for many women and infants. Health authorities also believe that these and other Federal and State efforts have significantly improved pregnancy outcome. (See ch. 5.)

LABOR, DELIVERY, AND NEWBORN SERVICES

The development of new knowledge and technology and the establishment of sophisticated infant intensive care units in many hospitals have contributed to substantial reductions in infant mortality. Various Federal programs have helped develop or pay for care which has enabled many

to receive needed services. The Federal Government has also promoted and even required the development of regionalized, efficient systems of care for mothers and infants.

Although progress has been made, women and infants in some locations still do not have easy access to appropriate labor and delivery services or infant care units, and many areas still do not have regionalized systems of perinatal care. Several factors contribute to the sporadic progress that has been made and difficult problems that persist. They include:

--Lack of or geographic maldistribution of physicians and facilities.

--High cost of in-hospital obstetric and newborn care, particularly infant intensive care.

--Inability of many to afford the cost of this care and the failure of some insurance groups, including Medicaid, to always cover the full cost.

--Refusal of some physicians or hospitals to accept Medicaid or low-income patients.

--Lack of or inadequate transportation system for getting to and receiving care.

--Lack of coordination among and between the public and private sectors for developing or implementing a comprehensive system for efficiently providing in-hospital maternity and infant care.

Maternal and Child Health, Medicaid, and health planning agencies need to work with the private medical community and other appropriate groups to develop and implement ways to make appropriate health care services more accessible to mothers and newborns. (See ch. 6.)

RECOMMENDATIONS

GAO is making a series of recommendations to the Congress and HEW aimed at improving management

of and access to pregnancy-related health care. They are:

--Consolidating or better coordinating programs, such as health service delivery and nutrition programs, with similar objectives.

--Helping State and local governments to develop and coordinate services.

--Improving management of and accountability for several programs, including Maternal and Child Health, Community Health Centers, and Family Planning, at Federal, State, and local levels.

--Eliminating or reducing barriers which impede access to health care by mothers and infants in such programs as Medicaid and National Health Service Corps.

--Expanding cooperative efforts between governmental and private organizations to better inform and educate the public on the benefits and importance of favorably timing pregnancies and obtaining early and appropriate prenatal care. (See ch. 7.)

AGENCY COMMENTS

GAO received written coments on a draft of this report from HEW, the Department of Agriculture, health or human resources agencies in the jurisdictions visited, except California, and several private organizations. They generally agreed with GAO's findings and recommendations. (Chapter 8 summarizes their comments and GAO's evaluation of them. These comments are included as appendixes VIII through XVIII.) California said that it had no comments.

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ABBREVIATIONS

BCHS	Bureau of Community Health Services
CHC	Community Health Center
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HSA	Health Systems Agency
ICH	Improved Child Health
IPO	Improved Pregnancy Outcome
MCH	Maternal and Child Health
NHSC	National Health Service Corps
WIC	Special Supplemental Food Program for Women, Infants, and Children

GLOSSARY

Abortion, induced	The purposeful interruption of pregnancy with the intention other than to produce a live-born infant or to remove a dead fetus and which does not result in a live birth. An abortion performed by a licensed physician or someone acting under his or her immediate supervision is referred to as legal. An abortion that is self-induced or induced by someone other than a licensed physician or someone acting under his or her immediate supervision is referred to as illegal. "Abortion" as used in this report refers to induced, legal abortions.
Fetal death	Death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy. For statistical reporting purposes, only fetal deaths occurring at 20 weeks or more gestation are usually tabulated.
Fetal death rate	Fetal deaths of 20 weeks or more gestation per 1,000 live births and such fetal deaths.
Gestation	The number of completed weeks of pregnancy between the first day of the last menstrual period and the date in question or the date of completion of the pregnancy.
Infant mortality	Death of a liveborn infant at any time from the moment of birth to the end of the first year of life.
Infant mortality rate	The number of infant deaths per 1,000 liveborn infants for a stated period.

Low birth weight infant	An infant weighing 2,500 grams (5 pounds, 8 ounces) or less.
Neonatal death	The death of a liveborn infant before the first 28 days of life.
Neonatal death rate	The number of neonatal deaths per 1,000 live births.
Perinatal care	Care of the mother throughout pregnancy and labor and delivery and the unborn and newborn from conception until discharge from the hospital after birth. (This definition is the one used by the National Foundation-March of Dimes, a leading private health organization involved in various activities to prevent birth defects. Others use different definitions.)
Perinatal death	An all-inclusive term referring to fetal deaths and neonatal deaths. For purposes of international comparability, the sum of fetal deaths of 28 weeks or more gestation and neonatal deaths within 7 days after birth.
Perinatal death rate	For international comparability, the number of fetal deaths of 28 weeks or more gestation plus neonatal deaths within 7 days of birth per 1,000 live births and fetal deaths of 28 weeks or more gestation.
Premature births	Births occurring prior to 37 weeks of gestation.

CHAPTER 1

INTRODUCTION

According to National Center for Health Statistics data, each year about 50,000 of the 3.2 million infants born alive in the United States die before reaching age 1, and another 33,000 fetal deaths occur before or at birth. Additionally, about 230,000 low birth-weight babies are born annually. According to the National Foundation-March of Dimes, about 250,000 babies (including many who are low birth weight) are born alive annually with birth defects. In 1976, 11 other industrialized nations reportedly had lower infant mortality rates than the United States.

State governments are primarily responsible for providing or financing health care services for low-income persons. However, the Federal Government provides a substantial portion of the funding for maternal and child health services provided to these persons by State and local health departments or private providers and has established goals to improve the Nation's health status through various programs.

Improving pregnancy outcome through more and better health care for women, infants, and children has been a national goal since 1935 with the enactment of the Maternal and Child Health (MCH) program. Since then, numerous national, State and local programs and efforts have been established which affect pregnancy outcome. Some programs provide or finance prenatal, delivery, or infant care services or health planning activities. Other programs and efforts, such as health education, are directed at preventing or better timing pregnancies.

POOR PREGNANCY OUTCOME

Poor pregnancy outcome is the termination or completion of a pregnancy with less than optimum results. Numerous indicators are available to health authorities for measuring pregnancy outcome. "Infant mortality" is the most frequently used indicator and is also one of the few universally used measures of health status. Infant mortality is the death of a live born infant under 1 year and is hereafter expressed as a rate per 1,000 live births. Other indicators include: fetal, neonatal, and perinatal (fetal plus neonatal) deaths; infant morbidity, such as congenital anomalies and mental retardation; low birth weight and prematurity; and abortions. A "fetal death" refers to death of a product of conception before the complete expulsion or extraction from its mother,

and "low birth weight" is a live birth of 2,500 grams or less. Appendix II shows 1976 statistics for the United States and the States we visited for several of these indicators.

Health authorities have identified various maternal risk factors as predictors of poor pregnancy outcome. These generally include previous maternal history, medical problems that develop during the pregnancy, and adverse socio-economic conditions. Some specific factors are: previous fetal or infant deaths, previous low birth weight, diabetes, Rh incompatibility, hypertension, age (under 18 or over 35), low income, and out-of-wedlock births. Appendix III is a composite list of many maternal risk factors used by the Department of Health, Education, and Welfare (HEW), private organizations, such as the American College of Obstetricians and Gynecologists, and the States and localities we visited.

PROGRESS HAS BEEN MADE BUT PROBLEMS REMAIN

Pregnancy outcome has improved significantly in the United States. (See table 1-1.) The most frequently used indicators that measure pregnancy outcome have shown declines in recent years. For example, infant mortality in the United States declined 29.5 percent between 1966 and 1976. The infant mortality rates for selected years for the United States and States we visited are:

Table 1-1

Infant Mortality Rates

States	1966-70 (note a)	1969-73 (note a)	1976 Rate	1976 Ranking
United States	21.7	19.3	15.2	-
California	18.9	16.5	12.4	46
District of Columbia	29.4	28.1	25.3	1
Mississippi	34.0	27.9	21.5	2
Missouri	21.6	19.4	15.3	24
North Carolina	26.2	23.2	17.8	5
Virginia	23.0	20.5	16.3	13

a/Average of a 5-year period.

The fetal mortality rate for the United States has also declined from 14.8 in 1966-70 to 10.5 in 1976. Similarly, the low birth weight rate has declined from 8.3 percent in 1966 to 7.3 percent in 1976.

Some States have infant mortality rates that compare favorably with industrialized nations that have some of the lowest infant mortality rates. For example, Hawaii and Maine--States with lowest infant mortality rates in the United States--had rates comparable to Denmark, Finland, France, and other industrialized nations having some of the lowest infant mortality rates.

Despite the progress and efforts made in improving pregnancy outcome, problems still persist in many States and localities.

Pockets of high infant mortality

Some States have infant mortality rates considerably greater than the national average. For example, Washington, D.C., and Mississippi had the highest infant mortality rates in 1976, 25.3 and 21.5, respectively. Both had a large nonwhite population and were medically underserved or had maldistribution of health care resources. The North Carolina infant mortality rate in 1976 was 17.8, the fifth highest in the United States.

In some cases, infant mortality rates have not improved or vary considerably within States. Pockets of high infant mortality rates exist in many areas. For example:

--In 1976, Missouri's rate was 15.3, only slightly higher than the national average. However, the infant mortality rates in St. Louis (24.9) and Kansas City (20.4) were the third and sixth highest, respectively, of all large U.S. cities. Racially, St. Louis had the highest white infant mortality rate (23.3) for large cities and Kansas City the highest nonwhite mortality rate (32.1).

--California, in 1976, had one of the lowest infant mortality rates (12.4) in the Nation. However, some areas of Los Angeles and Alameda counties had infant mortality rates exceeding 25. Specifically, two low-income areas of Alameda County had infant mortality rates of 33 and 26, while one other area had a rate of only 6 deaths per 1,000 live births. Some California counties also had perinatal mortality rates as high as 38 deaths per 1,000 live births.

--In 1976, the infant mortality rate among the District of Columbia's nine health service areas ranged from 5.6 in area eight to 30.1 in area four. Over the last 10 years, two areas have shown virtually

no improvement, and one area experienced an increase in its infant mortality rate. The District's fetal mortality rate in 1976 was 16.8 compared to the national rate of 10.5, and the fetal rate had increased since 1973. Low birth weight in 1976 was also a major problem in the District, 12 percent compared to the national rate of 7.3 percent.

HEW has identified 564 areas in the United States designated as "high infant mortality areas." (See p. 39.) Many of these areas are located in the States with the highest overall mortality rates. (See table 1-2.)

Table 1-2

High Infant Mortality Areas

	Number of high areas	Total number of areas in the State
United States	564	-
California	4	58
District of Columbia	1	1
Mississippi	57	82
Missouri	9	115
North Carolina	46	100
Virginia	29	137

Racial differences

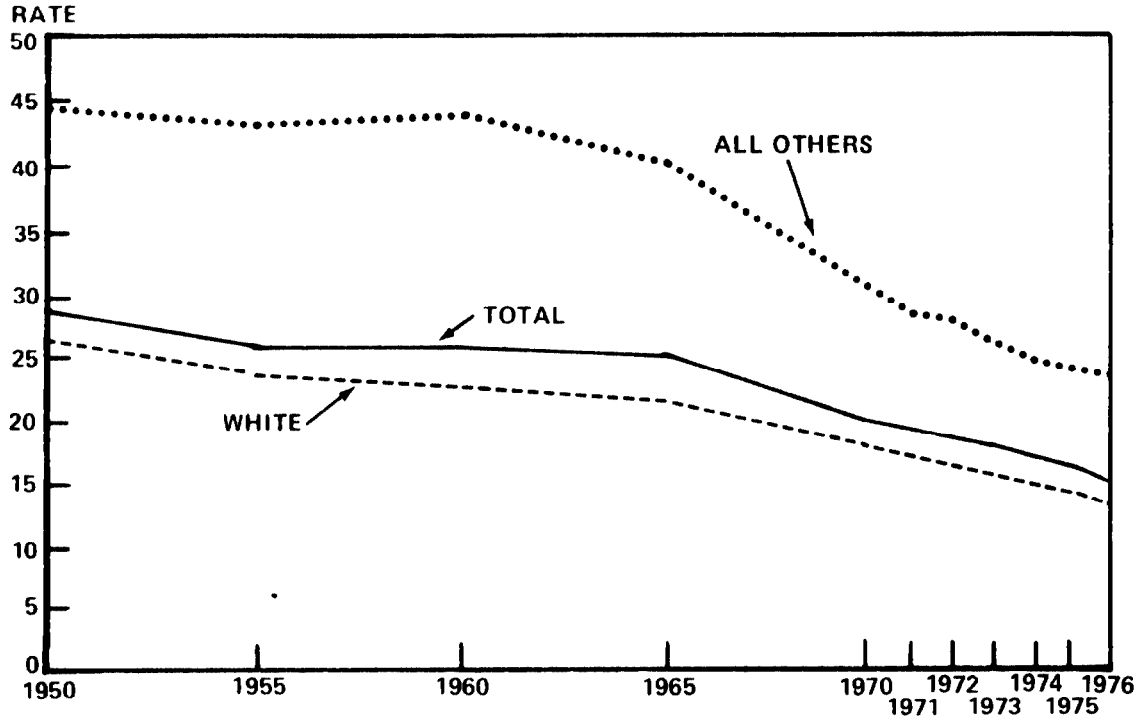
Nonwhites, particularly blacks and Indians, generally experience poorer pregnancy outcomes than whites. Also, although U.S. infant and fetal mortality rates have generally declined since 1950 for whites and nonwhites, the percentage of all infants born alive with low birth weight has not changed substantially since 1950, and the percentage of nonwhite infants born alive with low birth weight was higher in 1977 (11.9) than in 1950 (10.2). (See charts on p. 5 and table 1-3 below.)

Table 1-3

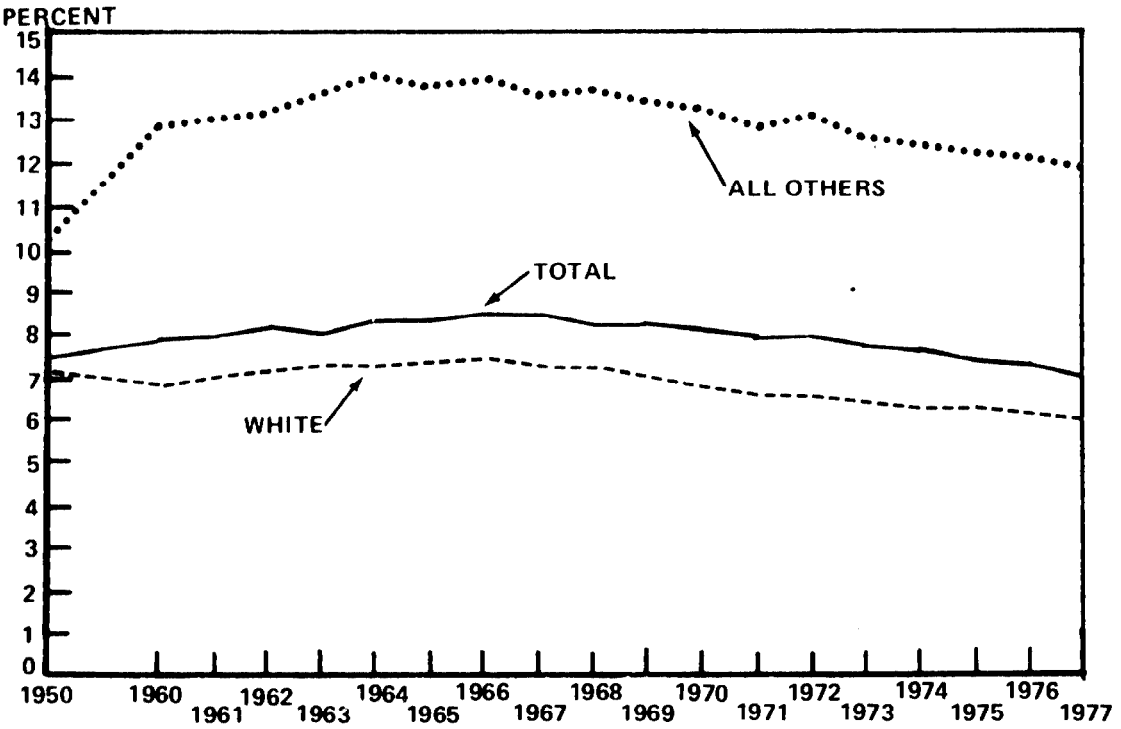
Comparison of 1976 Indicators by Race for the United States

	Nonwhite	White	Total
Infant mortality rate	23.5	13.3	15.2
Fetal mortality rate	15.2	9.3	10.5
Low birth weight (percent)	12.1	6.1	7.3

INFANT MORTALITY RATE



PERCENTAGE OF INFANTS BORN ALIVE WITH LOW BIRTH WEIGHT



SOURCE: NATIONAL CENTER FOR HEALTH STATISTICS, HEW

Racial differences in pregnancy outcome were even more dramatic among several States. For example, in Mississippi and the District of Columbia the nonwhite fetal mortality rate in 1976 was about twice as high as the white rate. The low birth weight rate for blacks in California, Virginia, North Carolina, and Missouri were more than twice as high as the rate for whites in those States.

Increased incidence of abortions

Legal abortions have been increasing in the United States. To the extent that abortion indicates an unwanted, unplanned pregnancy that does not result in the birth of a healthy infant, many consider it an adverse pregnancy outcome. However, many health officials believe that some improvement noted in infant mortality rates and other pregnancy outcome indicators results from the increasing number of abortions, because many women who aborted were high risk and would have been likely to have an adverse pregnancy outcome. For instance, in Missouri the number of abortions between 1975-77 increased by about 44 percent, but the number of such abortions for teenagers--a high-risk category--increased by about 64 percent.

Increased concern about adolescent pregnancy

Of significant concern and recent attention has been the problem of adolescent pregnancy. Adolescents in the United States have rates of childbearing that are among the world's highest. In addition to the economic disadvantage to the mother and infant, babies born to adolescent mothers are twice as likely to be premature and of low birth weight and twice as likely to get inadequate or no prenatal care. Health authorities believe that a reduction in adolescent pregnancy is a critical part of efforts to improve pregnancy outcome. Mississippi's MCH director said that the largest pregnancy risk factor in his State--adolescent pregnancy--accounted for about 27 percent of the State's 43,000 births in 1976.

Health services can improve pregnancy outcome

Various health authorities believe and studies demonstrate that many pregnancy outcome problems can be prevented or alleviated if adequate health education, family planning, maternity, and infant care are available to low-income people. Pregnancy outcome has significantly improved in areas where

Federal, State, or local efforts have focused on the problem. Recently, both HEW and the Congress have given considerable attention and emphasis to improving pregnancy outcome, including the adolescent pregnancy problem.

PURPOSE AND SCOPE OF THIS REVIEW

In this review, we sought to determine what has been done to improve pregnancy outcome and to identify the barriers--particularly those concerning Federal programs--that affect such progress. Our review primarily addressed problems impeding access to health care for low-income people and their offspring. Our review did not cover all factors that can or do affect pregnancy outcome, such as research and quality of medical care.

We visited HEW headquarters and four regional offices to examine their efforts for helping to improve pregnancy outcome. We also visited health departments and clinics in 15 counties and cities in 5 States, as well as the District of Columbia, to assess Federal, State, and local programs affecting pregnancy outcome. We visited several Community Health Centers (CHCs), Family Planning programs, and private providers, such as hospitals, to assess their activities. We also contacted private organizations--such as chapters of the National Foundation-March of Dimes, the Robert Wood Johnson Foundation, and various State medical societies--to learn of any pertinent ongoing or planned efforts. Several Health Systems Agencies (HSAs) were questioned to find what priority they place on pregnancy outcome in their planning, and school officials were contacted to discuss the need for and availability of health education and family planning information in the public schools.

In addition, we sent questionnaires to MCH directors of each State to obtain financial and operational information about their MCH programs and to learn of their priorities for improving pregnancy outcome. Responses were received from all States except Illinois. We consulted several MCH directors by telephone to discuss problems they encountered in attempting to improve pregnancy outcome.

Throughout this report we generally used pregnancy outcome data, such as infant mortality rates, reported by the National Center for Health Statistics. There is some indication that infant mortality data collected by some States and reported to the center may be underreported.

CHAPTER 2

MANY FEDERAL PROGRAMS AFFECT PREGNANCY OUTCOME

At least 70 Federal programs administered by several agencies can or do affect pregnancy outcome. Although some programs are specifically aimed at improving pregnancy outcome, most are not. Those programs specifically aimed at improving pregnancy outcome usually have relatively little funding, compared to other programs with more general objectives that do or may include improved pregnancy outcome.

HEW and the Department of Agriculture are the principal Federal agencies administering programs aimed at or affecting improved pregnancy outcome. HEW's MCH and Agriculture's Special Supplemental Food Program for Women, Infants, and Children (WIC) are the major Federal programs specifically aimed at improving pregnancy outcome. Other major Federal programs affect pregnancy outcome but generally are not specifically or solely targeted toward this objective.

Federally supported activities include (1) reimbursing States for part of the cost of health care provided to low-income persons through Medicaid, (2) providing funds for the delivery of health services through CHCs, (3) placing federally salaried health professionals in local areas to provide health care through the National Health Service Corps (NHSC), (4) funding training programs for health professionals, such as physicians and nurse-midwives, (5) providing funds for supplemental foods for women, infants, and children, (6) providing construction loans for rural health clinics, (7) providing funds for planning, coordinating, and promoting health care delivery through MCH and health planning programs, and (8) funding family planning programs. In addition, HEW has developed several management initiatives aimed at or affecting improved pregnancy outcome.

Although the States are primarily responsible for providing health services, including MCH services, to low-income persons, the Federal Government provides a substantial portion of funds used by State health departments for MCH services and directly funds other health care providers. For example, in fiscal year 1976, Federal MCH funds provided about 72 percent of the funds used by State health departments for general maternal and child health services, according to Association of State and Territorial Health Officials data.

As another example, in fiscal year 1978, Federal MCH formula grant funds alone (exclusive of special projects) accounted for about $4.5 million (or 63 percent) of Mississippi's $7.1 million MCH budget, according to the State's response to our questionnaire.

A brief description of some Federal programs and management initiatives affecting pregnancy outcome follows.

BUREAU OF COMMUNITY HEALTH SERVICES

HEW's Bureau of Community Health Services (BCHS) within the Health Services Administration, Public Health Service, administers most of HEW's health service delivery programs affecting pregnancy outcome. BCHS also has lead responsibility for building and maintaining health service delivery capacity throughout the Nation for low-income or disadvantaged persons.

Maternal and Child Health

The MCH program is designed to enable each State to extend and improve services to reduce infant mortality and otherwise promote the health of mothers and infants, especially in rural areas and in areas suffering severe economic distress. The program also provides for training and research activities to advance MCH services. It is administered by BCHS' Office of Maternal and Child Health.

The MCH program was authorized by the Congress in 1935 under title V of the Social Security Act (42 U.S.C. 701), hereafter referred to as title V. Funding for MCH services was given to the States through a formula grant. Some funds were allotted equally among the States, some on the basis of live births in each State, and some on the basis of need. All of the amounts, except those allotted on basis of need, were granted on an equal matching basis.

The legislative provisions of title V MCH programs have been broadened and expanded in response to changing need. The program remained basically unchanged until the mid-1960s, when a new program of special purpose grants for projects in low-income areas and for training personnel and research projects relating to MCH services were authorized, in addition to the existing formula grants.

In 1968, amendments to title V consolidated the various authorizations into one with percentage allocations to three

broad categories: (1) formula grants to States for MCH services, (2) special direct project grants for maternity and infant care, family planning services, intensive infant care services, health services for children and youth, and dental health of children, and (3) grants for research and training. The 1968 statute also provided that the special direct project grants authority would expire on June 30, 1972, and the States would take over the direct project grant responsibility at that time. Authorization for direct project grants was later extended through June 30, 1974, and supplemental funding was authorized so that no State would be eligible for less funds after that date than the total amount it had been allocated in formula and project grants for fiscal year 1973. This provision is still in effect.

To receive MCH formula grant funds, each State must prepare an MCH plan which meets legislative and HEW-imposed requirements. Also, each State MCH plan must include provision for five programs of projects: maternity and infant care, infant intensive care, family planning, children and youth, and children's dental health. Legislation further requires that each State satisfactorily show that it is extending MCH services statewide.

Currently, MCH funding consists of formula grants for services to State health agencies, and project grants (other than program of projects) for services, training, or research, or other activities to public or private, nonprofit organizations.

Distribution of MCH funding is as follows: HEW determines the proportion of title V funding for grants to States for services for MCH and Crippled Children's Services programs. Of that amount available for MCH services:

--One-half is apportioned to States on the basis of a uniform allotment of $70,000 for each State, and an additional amount of the remainder in proportion to the number of live births in each State. Each State must match these funds dollar for dollar.

--The second half is divided three ways: (1) project grants for services to mentally retarded children, (2) project grants for special projects of national or regional significance, and (3) formula grants to States based on the number of live births (with rural births receiving double weight) and per capita income. No matching is required for these funds.

Fiscal year 1978 Federal MCH funding is as follows. (App. I contains additional data on MCH funding from a questionnaire sent to State MCH agencies.)

		Amount	Percent
		(millions)	
Formula grants to States		$210.6	79.7
Special projects:			
Improved pregnancy outcome	$9.0		
Mental retardation	5.0		
Central office training	5.1		
Improved child health	2.4		
Regional office service	1.2		
Other	1.7	24.4	9.2
Training		24.0	9.1
Research		5.3	2.0
Total		$264.3	100.0

Crippled children's services

HEW's Crippled Children's program, also authorized by title V of the Social Security Act, provides funds to States for locating, diagnosing, and treating children who are crippled or who suffer from conditions which lead to crippling. In some instances, such as in California, crippled children's services program funds are used to pay for the cost of intensive care for some infants immediately after birth. Information is not available nationally on the extent to which this is done. However, according to National Foundation-March of Dimes estimates, more than $161 million in Crippled Children's program funds alone were used to treat children with birth defects in 1975, the most recent year for which data were available.

Family planning

Family planning services are primary health care services, which prevent or alleviate many health, social, and economic problems associated with unwanted or unplanned pregnancies. The primary purpose of family planning programs is to make voluntary comprehensive services available throughout the Nation with priority to those who cannot afford them and to give individuals the freedom of choice to determine the number and spacing of their children.

The Social Security Amendments of 1967 established a significant Federal initiative in family planning, requiring each State to have a plan for extending family planning services as part of the MCH formula grant program. The Social Security Amendments of 1972 required each State to make voluntary family planning services available statewide to certain Medicaid recipients and to all recipients of financial assistance under the Aid to Families with Dependent Children program through State Social Services and Medicaid programs.

Today, several Federal programs provide funding for family planning services. The principal health service delivery program funding such services is the Family Planning program, authorized under title X of the Public Health Service Act (42 U.S.C. 300), hereafter referred to as title X, and administered by BCHS' Office for Family Planning. The MCH, Medicaid, and Social Services programs, authorized under titles V, XIX, and XX of the Social Security Act, respectively, also provide funding for family planning services. According to HEW data, fiscal year 1978 funding for organized family planning services was as follows:

Program	Amount (millions)
Title X Family Planning	$128.9
MCH (title V)	25.0
Medicaid and Social Services	55.0
Total	$208.9

In fiscal year 1978, HEW awarded family planning service grants to 235 organizations, including State health departments. Also, more than 4,900 clinics receiving title X funds served about 3.5 million patients, according to HEW. The program also funds provider training, public education, and service delivery improvement activities.

The Federal Government reimburses States for up to 90 percent of the allowable costs of providing family planning services under the Medicaid and Social Services programs. HEW's Health Care Financing Administration and Office of Human Development Services administer the Medicaid and Social Services programs, respectively.

Community Health Center

The major focus of the CHC program is developing health service delivery capacity and supporting ambulatory health care projects in rural and urban medically underserved areas. Direct project grants are awarded to public and private nonprofit organizations to help them meet costs for planning, developing, or operating CHCs. BCHS' Office of Community Health Centers administers the program.

The centers are to provide or arrange for both primary health services, including diagnosis, treatment, preventive health services, diagnostic laboratory services, and emergency medical services, and supplemental health services regardless of ability to pay.

HEW regulations define preventive health services to include prenatal and postpartum care, well child care, health education, nutrition assessment and referral, and family planning services. Supplemental health services include in-hospital care, health education, and outreach services to promote and facilitate optimal use of health services.

CHCs are established to serve residents of medically underserved areas, which are defined by HEW and characterized by (1) high infant mortality rates, (2) large numbers of people over 65, (3) large numbers of persons living in poverty, and (4) shortages of health care personnel. According to HEW, about 49 million persons live in about 7,400 urban or rural medically underserved areas.

Fiscal year 1978 funding for the CHC program totaled $255 million, which provided funding for 591 CHCs--401 in rural areas and 190 in urban areas. According to HEW, CHCs served about 3 million persons in 1978.

National Health Service Corps

The NHSC program was established by the Emergency Health Personnel Act of 1970 (Public Law 91-623) and is currently authorized by Public Law 94-484. The program is designed to improve the delivery of health services to people living in areas with health manpower shortages. Under this program, HEW (1) recruits and assigns teams of appropriate health personnel to health manpower shortage areas and (2) helps communities develop the capacity to

plan, build, and maintain their own systems of health care. Health care personnel include obstetricians, pediatricians, nurse-midwives, and nutritionists.

The program provides salaries and related payroll costs for NHSC health professionals and support costs required to help communities develop NHSC sites in health manpower shortage areas, recruit and assign NHSC health professionals to these areas, and establish and maintain health care delivery systems in these areas. These support costs include technical assistance contracts, medical and dental equipment and supplies for community-sponsored (nongrant sponsored) sites, and continuing professional education.

In 1978, NHSC program funding totaled $39.7 million, which covered 1,289 NHSC personnel at 668 service sites. As of 1978, HEW designated 1,233 primary care health manpower shortage areas.

BCHS' Office for the NHSC program has developed a special initiative to place NHSC personnel in States having Improved Pregnancy Outcome (IPO) projects. As of April 1979, HEW had placed 156 NHSC personnel in 13 States as part of this initiative.

Comprehensive health grants to States

Under section 314(d) of the Public Health Service Act, HEW has provided formula grants to States for comprehensive public health services. States determine how these funds will be used. Fiscal year 1978 funding totaled $90 million. It appears that States use very little--about 1 percent--of these funds for the MCH program, according to data collected by the Association of State and Territorial Health Officials.

Public Law 95-626, enacted November 10, 1978, established a new program--Health Incentive Grants to States, which will become effective in fiscal year 1980. The new program authorizes funds to States for a number of activities, including maternal and child health services. This act also establishes a new formula grant program for States to provide preventive health services.

Other BCHS programs

BCHS administers several other project grant programs which affect pregnancy outcome. These include:

--The Health Underserved Rural Areas program, which is aimed at demonstrating the effectiveness of existing health providers in developing model systems of comprehensive rural health care delivery.

--The Migrant Health program, which provides funds for health services to migrant workers and their families.

--The Genetic Services program, which establishes a national effort to provide testing and counseling for genetic diseases by providing funds for (1) areawide systems of genetic testing and counseling and (2) screening, diagnosis, counseling, and referral services.

--The Sudden Infant Death Syndrome program, which provides grants for informing the public or training personnel about the problem, counseling families, and other activities.

--The Appalachian Demonstration Health program, jointly administered by BCHS and the Appalachian Regional Commission and designed to demonstrate the value of adequate health facilities and services to the economic development of Appalachia.

PROGRAMS ADMINISTERED BY OTHER HEW AGENCIES

Other HEW agencies administer a variety of programs which can or do affect pregnancy outcome. The agencies and programs include:

--The Health Care Financing Administration, which administers the Medicaid program.

--The Health Resources Administration, which administers health planning and resource development programs authorized under Public Law 93-641.

--The Office of the Assistant Secretary for Health, which administers the newly created adolescent pregnancy program authorized by Public Law 95-626. Also, the Office of Population Affairs directs population and family planning activities within HEW health agencies.

--The Center for Disease Control, which administers several preventive health programs, including (1) venereal disease prevention, (2) lead-based paint

poisoning prevention, (3) childhood immunization, and (4) health education and promotion, and conducts other activities, such as data collection and evaluation in such areas as birth defects, family planning, and abortion.

--The Office of Education, which administers several grant programs, including those authorized under title IV-C of the Elementary and Secondary Education Act (20 U.S.C. 1831), provides formula grants to States to support (1) strengthening management of State education departments, (2) supplementary education services, (3) nutrition and health programs, and (4) dropout prevention. 1/ This funding is for improving local education practices by developing and demonstrating approaches to solving educational problems and needs. State education agencies distribute these funds to local education agencies on a discretionary basis.

--The Office of Human Development Services, which administers such programs as the Social Services program, Head Start, Developmental Disabilities, and the Child and Family Resource program.

--The Social Security Administration, which administers the Aid to Families With Dependent Children program.

--The Alcohol, Drug Abuse, and Mental Health Administration, which administers programs aimed at preventing or treating substance abuse or mental illness.

--The National Institutes of Health, particularly the National Institute of Child Health and Human Development, which sponsors research on improving the health of mothers, infants, and children.

DEPARTMENT OF AGRICULTURE

The Department of Agriculture operates a number of programs which can or do affect MCH services. For example, Agriculture administers WIC, which was established in 1972

1/Public Law 96-88, enacted on October 17, 1979, provides for the creation of a separate Department of Education and a renaming of HEW as the Department of Health and Human Services. The new department and the renaming of HEW is to become effective by June 1980.

to provide food assistance as an adjunct to good health care for pregnant women, lactating mothers, infants, and preschool children considered to be a special nutritional risk. Agriculture makes cash grants available to State health departments or other organizations to provide specified supplemental foods and nutrition education to eligible persons. WIC funds are not to be used to pay for health services except for medical tests and specific equipment necessary to determine medical eligibility. In fiscal year 1978, WIC funding totaled about $398 million.

Agriculture also administers a Community Facilities Loan program which provides loans to government agencies and nonprofit organizations for constructing or improving community facilities--including health care facilities--in towns of less than 10,000 people. In 1978, Agriculture loaned $250 million under this program.

MANAGEMENT INITIATIVES

HEW, principally BCHS, has developed several management initiatives aimed at or affecting improved pregnancy outcome. Through these initiatives, HEW has been using existing programs to improve management of programs or improve access to health care for mothers, infants, and children. It has also sought legislation in some instances. Some of these initiatives are described briefly below.

Child Health Strategy

In 1976, BCHS formulated a Child Health Strategy, which called for a multifaceted approach, using existing programs, for (1) providing more resources for improving access to health care for women, infants, and children, (2) improving coordination among HEW programs, and (3) most importantly, developing a State-based system of child health care. The strategy envisioned using State MCH agencies as the focal point for determining needs for maternal and child health services, implementing action plans, and evaluating progress. Activities were to include identification of high-risk mothers and infants and provision of such services as family planning and prenatal, perinatal, child, and adolescent health care.

BCHS developed several specific initiatives as part of this strategy. They included IPO projects, Improved Child Health (ICH) projects, Adolescent Health Services, and Pregnancy Prevention as well as other activities.

Improved pregnancy outcome

In 1976, BCHS established its IPO initiative, which involved awarding MCH project grant funds to States having the worst pregnancy outcome problems. BCHS requires each State MCH agency eligible for these funds to develop a plan describing unmet needs and activities to be undertaken to improve maternal and infant care. The plans must cover the prenatal and perinatal period and be based on the regionalized concept of care. Special emphasis is to be given to adolescent pregnancy.

For fiscal year 1978, BCHS awarded IPO grants totaling about $9 million to 22 States, the District of Columbia, and Puerto Rico. Each State can receive up to $400,000 annually for up to 5 years under this initiative. BCHS has also given priority to placing NHSC personnel in the first 13 States selected for IPO grants. All States visited during our review, except California, received IPO grants.

Improved child health

In fiscal year 1978, BCHS began its ICH initiative, which was designed to improve pregnancy outcome in selected areas of States with excessive morbidity and mortality. Under this initiative, BCHS identified 31 target areas in 11 States and the District of Columbia with significant pregnancy outcome problems and solicited applications for ICH funds from organizations in these States. ICH funds are to be used to develop a coordinated system of comprehensive health care for high-risk mothers and infants in the selected areas.

For fiscal year 1978, BCHS made $3 million in MCH funds, $1 million in title X Family Planning funds, and NHSC personnel available for ICH projects. Programs could receive up to $300,000 in MCH funds annually for up to 4 years. Existing title X Family Planning program grantees could receive funding under the initiative indefinitely. Although BCHS originally planned to make CHC funds available under the initiative, none were awarded in fiscal year 1978.

By the end of fiscal year 1978, BCHS had awarded ICH funds--$2.4 million from MCH and about $645,800 from title X--for eight projects in nine States. Although the District of Columbia was eligible, it had not completed its application for ICH funds until May 1979. Appendix VII lists those States and territories receiving ICH funds.

Other activities

Other BCHS activities relating to the Child Health Strategy include, but are not limited to, the following:

--An Adolescent Health Services and Pregnancy Prevention Initiative under which BCHS made funds available under the CHC program for expanding comprehensive health care to adolescents--including pregnant school-aged parents and their infants--and the title X program for expanding family planning services to adolescents. In fiscal year 1978, BCHS made $14 million in CHC funds and $14.3 million in title X funds available for this initiative.

--Continued conceptualization and development of a State-based child health care system.

--Review of State MCH programs.

--Efforts to expand BCHS project grantees' provision of family planning services, prenatal care, immunizations, and nutrition (WIC) services. Efforts also include expansion of genetic disease and newborn screening programs.

During 1978, HEW sought legislative authority for a new program aimed at providing services to pregnant adolescents. Public Law 95-626 provided this authority. HEW has also sought, but has not yet obtained, congressional approval of new legislation that would require States to expand eligibility for low-income pregnant women under their Medicaid programs. In June 1979, the President proposed a National Health Insurance plan that would provide full coverage for prenatal and delivery care for pregnant women and medical care for their babies during their first year of life.

Primary care capacity building initiatives

BCHS has developed Urban and Rural Health Initiatives aimed at improving access to primary health care in medically underserved urban and rural areas by integrating existing project grant programs. BCHS awards project grants and/or NHSC personnel to build or expand health service delivery capacity in these areas. BCHS project grant programs used in its capacity building effort include: CHCs, NHSC, Health

Underserved Rural Areas, Migrant Health, and Appalachian Health. Infant mortality is one, but not the only, criteria BCHS uses to select areas for funding under these initiatives. According to an HEW official, as of September 30, 1978, BCHS had funded 77 urban and 461 rural health initiative grants.

In September 1978, President Carter announced a coordinated interagency effort to improve health services and facilities in medically underserved rural areas. One element of this effort entails using (1) Agriculture's Community Facilities Loan program to construct or renovate primary health care centers in rural areas, (2) HEW funds to place medical personnel to operate these centers, and (3) Department of Labor funds under the Comprehensive Employment and Training Act program to recruit and train disadvantaged rural residents as preventive health workers at these centers.

CHAPTER 3

FEDERAL EFFORTS TO IMPROVE PREGNANCY OUTCOME HAMPERED BY STRUCTURAL, MANAGERIAL, AND FINANCIAL PROBLEMS

Federal efforts have helped improve pregnancy outcome. However, even more progress could be made with additional resources and improvements in the structure and management of Federal programs.

The Federal Government lacks a coordinated, comprehensive national strategy and approach for improving pregnancy outcome. Many problems contribute to the lack of such a strategy and approach. Some relate to limited funding, the variety of competing purposes for which available funds must be or are used, or the lack or maldistribution of health care facilities or personnel. Some relate to the structure of Federal programs; that is, the evolution of many categorical programs over a long period of time which are often (1) aimed at specific but overlapping target groups or objectives, (2) administered by different organizations, and (3) available only to persons or areas meeting certain requirements. Others relate to deficiencies in program management, such as the failure to (1) develop specific or adequate goals, objectives, or plans, (2) better coordinate efforts among agencies or programs and the public and private health care sectors, or (3) better evaluate program operations and effectiveness. No organization has been given responsibility for overseeing and coordinating Federal efforts to improve pregnancy outcome.

A comprehensive strategy and a more systematic approach are needed because:

--Many persons do not have ready access to or have difficulty obtaining health or health-related services that can help improve pregnancy outcome. Such services include health education, family planning, prenatal and well baby care, labor and delivery services, and infant intensive care services.

--The Medicaid program--established in 1965 largely to enable low-income persons to obtain needed health care from providers of their choice--has not fully met this objective and has not eliminated the need for Federal funds to help build, expand, or improve health care capacity. Limitations and restrictions

in some State Medicaid programs hamper the ability of many low-income women to get prenatal care because they may not be covered, may not be able to obtain a copayment, or physicians or hospitals may refuse to serve them because of low Medicaid payment rates, paperwork, payment delays, or reluctance to serve low-income persons.

--Many Federal agencies administer a variety of programs that can, do, or should help improve access to these services, but these agencies' efforts have often not been combined into a cohesive, systematic approach, thereby hampering efforts at State and local levels.

--The two major Federal programs--MCH and WIC--targeted at improving pregnancy outcome have not had sufficient funding to serve all in need (although WIC funding has recently increased substantially) and have not been fully effective or well-coordinated. Some State MCH agencies have generally not assumed an effective leadership role in planning, promoting, coordinating, or evaluating statewide efforts to improve pregnancy outcome. BCHS has hampered their ability to do so by (1) giving--for a number of years--little emphasis to the MCH program and (2) awarding project grants to various organizations without notifying or consulting with some State MCH agencies. Although the Congress intended WIC to be an adjunct to health care, Agriculture has sometimes administered the program independently of BCHS programs to build health care capacity, and planning for health service delivery and WIC have not been coordinated.

--BCHS administers several programs to build health delivery capacity in needy areas, including those with high infant mortality rates. It has also developed a number of initiatives to expand and integrate its efforts to help improve pregnancy outcome. These programs and initiatives have helped improve access to care. However, BCHS programs (1) vary in the extent to which they address improved pregnancy outcome, (2) are not necessarily located in areas having the most significant pregnancy outcome problems because pregnancy outcome is not their sole or only objective, (3) for the most part, bypass some State MCH agencies, making coordination difficult, or are often not coordinated with other health care or WIC providers, (4) had some grant applications which do not have specific goals or objectives for improved

pregnancy outcome, (5) are not accepted by some communities, (6) have not been evaluated in terms of their effect on pregnancy outcome, or (7) in some cases overlap with MCH.

--HEW regional offices have not (1) always given sufficient attention or emphasis to improved pregnancy outcome, (2) sufficiently coordinated their efforts with State MCH agencies, or (3) provided needed help and leadership to States to develop regionalized systems of care for mothers and infants.

--Federal agencies have provided little leadership in the area of family life education, although some State MCH directors, other health officials, and many educators believe that additional efforts in this area are essential for preventing adolescent pregnancy.

--Some State or areawide health planning agencies vary in the extent to which they address improving pregnancy outcome and often fail to coordinate with State MCH agencies.

--HEW funds two "health care systems"--public health departments and private or nongovernmental, health care providers--and these two "systems" often do not coordinate their efforts or sometimes duplicate activities.

--The recently enacted adolescent pregnancy legislation (Public Law 95-626) appears to add to the already fragmented series of related programs by establishing a separate program to deal with pregnant adolescents and a separate office to administer the program. Also, it is oriented more toward serving pregnant adolescents than to preventing such pregnancies.

COMPREHENSIVE NATIONAL GOALS HAVE NOT BEEN ESTABLISHED

The Federal Government has not developed comprehensive national goals for improving pregnancy outcome. Although some efforts have been made, they have been limited in scope.

The National Health Planning and Resources Development Act of 1974 requires HEW to, among other things, develop national health planning goals. In January 1978, in partial response to this requirement, HEW developed the following draft goal statement: the infant mortality rate should be

less than 12 for the Nation and less than 18 for any health service area or population group.

Aside from survival, other indexes of pregnancy outcome, as it relates to offspring, include fetal death, neonatal death, perinatal death, low birth weight, and morbidity. With the exception of one form of morbidity--mental retardation--HEW had not established national goals for these outcomes.

National mental retardation prevention goal

In 1971, President Nixon established a national goal to reduce the incidence of mental retardation by 50 percent by the end of this century. In 1976, the President's Committee on Mental Retardation modified this goal to reduce the incidence of mental retardation (1) from biomedical causes by at least 50 percent by the year 2000 and (2) associated with social disadvantages to the lowest level possible by the end of the century.

In October 1977, we reported to the Congress that:

--No HEW agency had been given responsibility for monitoring implementation of the goal, coordinating efforts, clarifying agency roles and resource requirements, or measuring progress in meeting the goal.

--The goal had not been designated as an objective by those HEW agencies with prevention responsibilities.

--Systems had not been established or methods developed to assess progress in achieving the goal.

--HEW could do more to prevent mental retardation resulting from several causes. 1/

LACK OF STRATEGY AND COORDINATED EFFORT

Although Federal agencies have been making some efforts to develop and implement an approach for improving pregnancy outcome, we believe the Government still lacks a comprehensive

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1/"Preventing Mental Retardation--More Can Be Done" (HRD-77-37, Oct. 3, 1977).

national strategy and approach for effectively using and coordinating its resources for this purpose. Furthermore, no organization has been given overall responsibility for overseeing, promoting, coordinating, or evaluating Federal efforts to improve pregnancy outcome.

Multiplicity and fragmentation of programs

The multiplicity of Federal programs, fragmentation of effort among several agencies, lack of coordination, and the award of grants directly by Federal agencies to local organizations which bypass State or local maternal and child health agencies impede development and implementation of comprehensive and integrated programs at State and local levels. Many of these programs have evolved over a long period to address specific problems or population groups without benefit of a comprehensive, long-range approach or plan.

Many view the multiplicity, fragmentation, and lack of coordination of Federal programs as a major barrier to improving pregnancy outcome. For example:

--BCHS and HEW regional health officials often emphasized this problem during our discussions with them.

--Minnesota's MCH director said that Federal funds come through too many channels; a package of services should be developed rather than attacking the problem from numerous directions.

--In December 1977, the National Foundation-March of Dimes wrote to the Assistant Secretary for Health urging that Federal programs funding maternal and child health services be coordinated and consolidated to the extent possible.

--HEW grantees believe that efforts should be consolidated to save time and effort required to develop, administer, monitor, and report on several different programs or initiatives with similar thrust.

Both HEW and the Congress have recognized the need for more aggressive and systematic efforts to improve pregnancy outcome. As discussed in chapter 2, BCHS has developed and implemented a child health strategy and other initiatives which are aimed at or affect this objective. HEW has also

sought legislation providing ways to improve its ability to help improve pregnancy outcome, such as a new child health assurance program, a new adolescent pregnancy program, and full National Health Insurance coverage for maternity and infant care.

Select Panel for the Promotion of Child Health and HEW task force on infant mortality

Section 211 of Public Law 95-626, enacted November 10, 1978, requires HEW to establish a Select Panel for the Promotion of Child Health. The panel is to formulate specific goals for promoting the health status of children and expectant mothers, develop a comprehensive national plan for achieving these goals, and make legislative, administrative, or other recommendations deemed appropriate to implement this plan. The recommendations are to cover such matters as:

--The types and quantities of services needed.

--Methods for delivering, financing, coordinating, and consolidating child health promotion services and programs.

--Ways to (1) teach children and parents about maintaining their health, (2) help train health care personnel, (3) encourage innovative programs, and (4) provide technical assistance to States.

--The relationship between child health promotion programs and health planning organizations.

HEW established this panel in March 1979. The panel is required to submit its report to the Congress by May 1980. Although we completed our fieldwork before the enactment of legislation requiring creation of the panel, our findings are pertinent to almost all of the areas the Congress required the panel to examine. Also in the fall of 1978, HEW's Assistant Secretary for Health established a task force within the Public Health Service to develop a strategy for improving pregnancy outcome. In November 1978, we briefed the Assistant Secretary for Health and several members of his staff on our findings. During the summer of 1979, the task force submitted options to the Assistant Secretary for Health which were still being considered as of December 1979.

The remainder of this report discusses some obstacles and problems, particularly those associated with Federal programs,

which have impeded or continue to impede efforts to improve pregnancy outcome. This chapter demonstrates the need for a more cohesive, systematic approach by the Federal Government for improving pregnancy outcome. It details some of the reasons why the MCH program has not met its expectations and shortcomings in BCHS programs--other than MCH. It also gives an overview of some problems associated with BCHS initiatives aimed at or related to improving pregnancy outcome and the lack of links between MCH, WIC, health planning, and education programs.

Subsequent chapters detail many barriers that hinder efforts to (1) prevent or better time high-risk pregnancies, including adolescent pregnancy, (2) provide sufficient and timely prenatal and well baby care, and (3) provide appropriate labor and delivery services to women and infant intensive care to newborns in need.

MCH PROGRAM HAS NOT MET EXPECTATIONS

Historically, MCH funds have enabled States to extend health services to women, infants, and children in urban and rural areas and to improve the management and promotion of MCH activities. However, MCH funds have not been sufficient to enable States to extend services to all those in need or to extend services to the extent envisioned in authorizing legislation or program regulations. In addition, State MCH agencies have had only limited effectiveness in their intended role as planner, coordinator, overseer, evaluator, or focal point for MCH activities. Although evidence indicates that various maternity and infant care and other types of projects have contributed to improvements that have been made, the extent to which the MCH program has improved pregnancy outcome nationally is not known.

Extension of services has been limited

MCH authorizing legislation provides that States strive to extend services to improve pregnancy outcome to mothers and children statewide. However, limited funding has precluded State MCH programs from extending services to improve pregnancy outcome to all areas or to all women and infants in need. Although low-income women often rely on publicly funded clinics for health care, MCH funding has not been sufficient to enable States to provide any or sufficient prenatal or well baby care services in many areas. For example, no public prenatal care clinics were available in 20 of North Carolina's 100 counties, and funding was insufficient to enable maternity and infant care projects in

Halifax County to fully meet the needs of the residents; the county had one of the highest infant mortality rates in the State. The maternity and infant care project serving St. Louis County discontinued providing infant care in 1973 because of decreased funding, and five of six counties in the Bootheel, Missouri, area visited had no public prenatal care clinics. MCH formula grant funding in Mississippi was insufficient to fully meet the needs in many counties. State MCH agency efforts to extend services have been further hampered because increases in MCH formula grant funding in recent years have not kept pace with inflation, increasing only about 7 percent between fiscal years 1976-79.

HEW recently awarded project grant funds through its IPO and ICH initiatives to extend and improve services in Halifax County, the Bootheel area, several areas of Mississippi, and several other States.

MCH funding is spread thin

States use MCH funds for many purposes other than serving mothers and infants, who must compete with other eligible groups for MCH funds. Following is a discussion of how States use their Federal MCH funds. Although the discussion shows that States use much of their Federal MCH funds for various activities not directly related to improving pregnancy outcome, the information should not be interpreted to indicate that these other uses are unnecessary or undesirable. We did not evaluate all the competing needs for and uses of MCH funds and are, therefore, not in a position to comment on whether States spend too much or too little of their MCH funds on maternity and infant care services as opposed to other types of services. MCH authorizing legislation generally does not specify the proportion of funds that must be spent on each type of service, although it does stipulate that at least 6 percent of State MCH formula grant funds be available for family planning services.

An analysis of fiscal year 1978 State budgets for use of Federal MCH formula grant funds shows that (1) in aggregate, only a portion of the funds is available for services that most directly relate to improved pregnancy outcome, (2) some States give relatively little emphasis to activities that most directly relate to this objective, and (3) States spend a major portion of their MCH funds on program of project activities which serve relatively few communities. We classified budgeted use of MCH funds into the following three categories. (See app. III.)

--Those that appear most likely to extend services to improve pregnancy outcome.

--Those that are generally not targeted at this objective, but which can or do have some effect.

--Those which would not generally directly affect extension of services aimed at this objective.

In aggregate, about $118.7 million (or about 59.3 percent) of the Federal MCH formula grant funds were targeted at or appear directly related to extending services to improve pregnancy outcome. Some portion of another $52.7 million would have some effect on this objective, and $28.9 million (or 14.4 percent) would not involve service extension aimed at improved pregnancy outcome.

With regard to the children and youth program of projects, it appears that less than 26 percent of the $48 million budgeted for such projects would directly relate to improved pregnancy outcome since, in 1977, 45 States reported that infants accounted for 14.7 percent of all children and youth project patients, and only 11.1 percent of all users were between the ages of 13 and 20. Less than half a percent of the patients were reported as family planning patients. Also, State MCH directors reported that 69 (or two-thirds) of their 102 children and youth projects did not provide prenatal care.

HEW's MCH program regulations require States receiving formula grant funds to provide for a program of projects in each of the following areas: maternity and infant care, infant intensive care, family planning, dental health, and children and youth. In aggregate, the States use about 54 percent of their Federal MCH funds to support these projects, leaving 46 percent for other activities. Nine States reported using 75 percent or more of their Federal MCH formula grant funds for program of project activities, and only three States reported using less than 25 percent for such activities. In some cases, States used a substantial portion of their Federal MCH funds for only one type of project. For example, Maryland reported using about 85 percent of its Federal MCH funds for program of project activities, and its children and youth project accounted for about 76 percent of these funds.

Most States have established relatively few projects under title V in each of the program of project areas. For example, 30 States report only one maternity and infant care

project; 9 report two; and only 11 report three or more. Also, of 33 States that had at least one maternity and infant care project in 1971, 24 had the same number of projects in 1978 as in 1971, 7 had more in 1978; and 2 had less.

Furthermore, maternity and infant care projects serve relatively few communities. Of the about 3,100 counties in the United States, only 242 were reportedly served by such projects in 1978. In 21 States, these projects generally served only one county, and only 13 States reported that these projects served four or more counties. In some cases, States do not have a program of projects as required by HEW. For example, the District of Columbia did not have an infant intensive care project which met HEW requirements, and in 1973 the St. Louis County, Missouri, maternity and infant care project discontinued providing infant care because of limited funding. HEW considers this project to be significantly underfunded.

Information lacking on services extension to rural area residents

Several State MCH officials told us that they have substantial difficulty in extending services to improve pregnancy outcome to rural areas. One of the major purposes of the MCH program is to enable States to extend such services to rural areas. However, information is not available nationally on the extent to which States use their MCH funds for this purpose because HEW neither collects this information nor requires States to report such data to it. Such data are not easily obtainable because several projects, such as infant intensive care projects, are usually located in urban areas, but often serve residents from both urban and rural areas.

Despite the fact that legislation authorizing the MCH program instructs States to give some special emphasis to rural areas, HEW regulations require emphasis on areas of greatest need regardless of whether they are urban or rural. Neither the authorizing legislation nor HEW's program regulations specify the degree of emphasis that should or must be given to rural areas or require States to maintain or report data on the amount of MCH funds used to serve residents of rural areas.

Medicaid restrictions impede services extension

The extent to which MCH funds have extended services to additional persons has been impeded by restrictions or limitations in Medicaid coverage or reimbursement. Many State Medicaid programs either do not cover the cost of providing prenatal care to poor women during their first pregnancies or limit the amount they pay for some services, such as prenatal care and infant intensive care. To the extent that MCH funds are used to help cover the cost of care for patients who are Medicaid eligible, but for whom Medicaid does not cover the entire cost of care, they, in effect, subsidize Medicaid patients, and therefore limit services extension to others in need but not covered by Medicaid.

For example, Missouri limits Medicaid reimbursement for inpatient hospital care to 21 days. In 1977, the average length of stay in the infant intensive care unit was 14.5 days. However, many infants served by the State's infant intensive care project require inpatient hospital care for much longer than 21 days. In addition, the Missouri Medicaid program did not cover the cost of prenatal care for women during their first pregnancy; nor did it cover all of the costs of providing prenatal or well baby services in clinics not affiliated with hospitals. The California Medicaid program did not cover the cost of providing health or nutrition education to prenatal care patients, according to State Medicaid officials.

In Pennsylvania, the Medicaid program generally paid only for a maximum of five prenatal care visits provided by hospital outpatient departments and generally limited the payment to $6 per visit. According to the State MCH agency, hospital outpatient departments provide the bulk of care under its maternity and infant care program of projects, and this Medicaid restriction on coverage hampers efforts to extend adequate prenatal care services to those in need.

MCH management needs improvement

MCH authorizing legislation and/or HEW regulations provide that State MCH agencies plan, coordinate, and promote maternal and infant care services and serve as a focal point for developing and implementing comprehensive statewide or regional systems of care for mothers and infants. For the most part, State MCH agencies have not fulfilled their intended role as a focal point for improved management of MCH activities. This has contributed to slow progress in

developing and implementing comprehensive statewide or regional systems of care for mothers and infants.

BCHS officials acknowledge that State MCH agencies need to improve their planning efforts, better coordinate MCH activities with other related efforts, and evaluate their activities. They also acknowledged that if State MCH programs were working as intended, HEW's IPO or ICH initiatives would not necessarily be needed.

Regionalization has been limited

State MCH agencies have made only limited progress in developing, implementing, or promoting comprehensive statewide or regionalized systems in perinatal care. States generally had made more progress in beginning or establishing regionalized systems of care for inpatient hospital or infant intensive care services than for such services as prenatal or well baby care. For example, the infant intensive care unit at Children's Mercy Hospital in Kansas City served as a regional center for the care of high-risk infants for an eight-county area in Missouri and Kansas.

On the other hand, a systematic approach for providing prenatal care for low-income persons in the Kansas City area had not been developed. Also, in St. Louis, services available through the local government, private providers, and Federal grantees were not coordinated or integrated. According to the St. Louis MCH Council, the lack of communication among providers and coordination and integration of services are significant problems, and the Greater St. Louis Health Systems Agency and the State MCH council agree with this assessment. To illustrate, the State's plan for an IPO project states, in part:

> "Probably the greatest health system problem found in St. Louis today is not a lack of resources, but instead--the complexity of services and lack, as yet, of a coordinated, unified and comprehensive approach to delivering effective and efficient services * * *."

The Missouri MCH agency planned to address these problems as part of its IPO project. Also, the Robert Wood Johnson Foundation agreed to provide the city $600,000 a year for 5 years to improve, expand, and better organize its ambulatory health care services, including MCH services.

Similarly, in an October 31, 1978, report to the Director, Department of Human Resources, Government of the District of Columbia, we noted that the District's MCH agency had not been able to develop or implement a comprehensive, coordinated system of care for mothers and infants or to coordinate activities between public and private health care providers. This was largely attributable to the unclear and fragmented responsibility within the District's Department of Human Resources for planning and coordinating MCH activities. HEW has been urging the District to develop a regionalized perinatal care system as part of its IPO project. The District has established a special panel to study the problem.

Better MCH plans are needed

MCH plans prepared by some State agencies were often either limited in scope, outdated, or lacked specificity with respect to measurable objectives, assessment and prioritization of need, or activities or services needed to fill unmet needs. For example, none of the States we visited had current, comprehensive, or action-oriented plans for improving pregnancy outcome. For the most part, MCH plans appeared to be a series of documents prepared merely to satisfy HEW requirements, rather than to serve as a working document. Commenting on State MCH plans he had reviewed, one HEW regional MCH program consultant said that objectives in these plans were often unrealistic, immeasurable, or nonexistent. A 1977 internal management review of California's MCH program showed that MCH funds were allocated on the basis of beliefs and observations of program personnel rather than on documented assessment and prioritization of need.

Several factors have contributed to the limited effectiveness State MCH programs have had in improving management of efforts to improve pregnancy outcome. Some of these are discussed below.

Emphasis on service delivery

State MCH agencies have concentrated their efforts and resources on service delivery as opposed to such management activities as planning, coordination, and evaluation. Several State MCH directors indicated that the need for additional services was so great that they devoted the bulk of their MCH funds to extending or improving service delivery and did not give much emphasis to such activities as needs assessments, planning, or evaluation. State budget data indicate that, on the average, State MCH agencies were devoting about 10 percent of their Federal MCH budgets to

general administration and indirect costs, ranging from zero to about 28 percent. Nevertheless, State MCH directors collectively indicated that improved data collection and analysis would be one of their higher priority activities for using additional MCH funds for improving pregnancy outcome.

Role of MCH agencies limited

In some cases, the MCH agency role of statewide planner, promoter, coordinator, or evaluator of efforts to improve pregnancy outcome has not been accepted by either States or MCH agencies. States have not always given MCH agencies this mandate or responsibility. For example, the District of Columbia's Department of Human Resources and Missouri's Division of Health have generally viewed their MCH agencies as responsible for administering only some of the activities funded by the Federal MCH program and have not given these agencies responsibility for overseeing districtwide or statewide efforts to improve pregnancy outcome. Also, State MCH agency personnel did not always routinely monitor use of all Federal MCH funds in the State, frequently having to obtain such information from other State agencies. The director of a State MCH agency said that she did not view her agency as having the role of planner, coordinator, or evaluator of statewide activities to improve pregnancy outcome.

Lack of influence over local health departments

State MCH agencies visited do not always have influence over local health departments or clinics and therefore have limited ability to affect their activities. For example, MCH officials in North Carolina said that their lack of control over local health departments hampers their ability to see that services are always available. MCH officials in the District directly control only 3 of the 15 Department of Human Resources clinics offering MCH services.

Little or no control or influence over HEW project grants

State MCH agencies visited usually had little or no influence over--or even information on--project grants made by HEW directly to local organizations. Several State MCH directors told us that their ability to promote or develop an integrated system of care for improving pregnancy outcome is hampered because they were unaware of, had no control or influence over, or had received limited or no

cooperation from federally funded CHCs, family planning grantees, NHSC personnel, or Health Underserved Rural Area projects. For example:

--Virginia Department of Health officials said that the State had no part in providing MCH service through HEW-funded CHCs or Health Underserved Rural Area project grantees and that activities of these grantees were not part of the State's MCH plan or linked to other health care activities.

--North Carolina MCH officials said that some programs HEW administers, such as placement of NHSC personnel, bypass them and they therefore cannot coordinate effectively. (See p. 146.)

--Department of Human Resources officials in the District of Columbia believed that their ability to manage a comprehensive, concerted effort to improve pregnancy outcome would be enhanced if they had more influence over HEW project grants given directly to private grantees.

--MCH directors in Tennessee and Minnesota said that they believe services provided by HEW-funded CHCs duplicate some services provided by local health departments and CHC activities are not coordinated with other providers.

Information is limited on the extent to which projects improved pregnancy outcome

MCH authorizing legislation and HEW implementing regulations require States to offer reasonable assurance that their maternity and infant care, family planning, and infant intensive care programs of projects satisfactorily improve pregnancy outcome. Information is not available nationally on the extent to which these programs have done this because (1) HEW has not defined what constitutes satisfactory improvement, (2) neither HEW nor the States have fully evaluated the impact of these programs of projects on pregnancy outcome, and (3) such assessments are difficult to make because many factors can affect pregnancy outcome.

Limited data available for a number of maternity and infant care and infant intensive care projects indicate that they have helped improve pregnancy outcome. For example, one maternity and infant care project visited in California

had compiled data showing that the infant mortality rate in the area it served had dropped at a faster rate than in surrounding areas without such a project. Other studies indicate that other projects have also had a favorable impact on pregnancy outcome. However, comprehensive data are not available nationally, and as previously stated, State MCH directors would give high priority to improving data collection and analysis if additional funds were to become available.

On the other hand, significant pregnancy outcome problems persist in several areas. For example, over the last 10 years, two health service areas in the District of Columbia have shown virtually no decrease in infant mortality rates, and one area experienced an increase. The city of St. Louis, Missouri, which is served by a maternity and infant care project, had one of the highest infant mortality rates--in 1976--of 26 U.S. cities with 500,000 or more people. One rural area in North Carolina served by a maternity and infant care project continued to have a high infant mortality rate and a high percentage of low birth weight infants--29.4 and 11.8 percent, respectively, in 1976.

Little HEW emphasis on MCH activities

For a number of years HEW has given little emphasis to directing the MCH program and to seeing that program objectives were met. BCHS and HEW regional health officials acknowledged that monitoring of State MCH activities has been limited and that HEW has not fully enforced program requirements and exercised little leverage for obtaining better State MCH management. HEW began only recently to emphasize better MCH planning and administration and coordination with other programs. BCHS and HEW regional office staff, however, still believe that they have little authority to monitor or influence State MCH agency use of formula grant funding.

Several factors have contributed to HEW's lack of emphasis on the MCH program, including the following:

--The conversion of the program to a formula grant program under which HEW officials believed they had little leverage over State activities.

--A change in the Government's approach to administering formula grants: States were given more flexibility and were no longer required to submit MCH plans or annual plan updates to HEW.

--The ambiguity or impracticality of some MCH requirements make enforcement difficult. For example, MCH regulations differentiate between diagnostic, preventive, and treatment services for maternity and infant care projects. The regulations require that diagnostic and preventive services, such as prenatal care, be available to all women without charge in the area served by the project. According to one regional MCH representative, no solid criteria exist to distinguish among these services. In addition, resources would not be sufficient to service all women free of charge.

--Insufficient regional office staff and travel funds, according to HEW, to perform comprehensive, indepth reviews of State MCH programs.

In 1976, HEW began efforts through its IPO initiative to improve State management of MCH activities and coordinate efforts. In fiscal year 1978, HEW supplemented these efforts with its ICH initiative. Also, in fiscal year 1978, HEW initiated indepth reviews of State MCH programs using headquarters, regional, and consultant personnel. As of March 31, 1979, HEW had completed reviews in eight States and planned to complete reviews on all States by 1983. HEW had not made such indepth reviews of MCH programs for several years. For example, the last such review in the District of Columbia was done in 1971.

For the last several months, BCHS has been developing a concept for a State-based system of child health care to overcome the weaknesses and problems in Federal and State efforts. BCHS envisions the development of a more effective system of child health care using as the basis the State MCH plan. Further, it envisions strengthening the role of State MCH agencies and emphasizing (1) integration of State and Federal resources, (2) coordination between State MCH agencies and State and local planning agencies, and (3) developing links between State MCH agencies and other health care providers, including federally funded projects.

BCHS EFFORTS HELP BUT HAVE NOT ALWAYS WORKED AS ENVISIONED

BCHS has taken several steps to use its resources to help improve pregnancy outcome. These steps include, but are not necessarily limited to:

--Designating areas with significant infant mortality problems as high infant mortality areas and instructing regional offices to give these areas--along with others--priority consideration when making funding decisions for a number of programs, such as CHCs.

--Placing project grants for expanding and improving health services or NHSC personnel in many high infant mortality areas.

--Making a reduction in excessive morbidity and mortality rates experienced by mothers and children a priority for all BCHS ambulatory health care projects and expecting them to provide, as part of their basic provision of services, prenatal care, perinatal care, child health care, adolescent health care, and family planning services. This has been a priority since November 1976.

--Developing and implementing several initiatives aimed at or affecting improved pregnancy outcome, including IPO and ICH, adolescent health, teenage pregnancy, and the Child Health Strategy.

--Attempting to integrate its activities through the Urban and Rural Health Initiatives and the ICH initiative.

--Initiating comprehensive reviews of State MCH programs.

Gaps in BCHS approach

Many high infant mortality areas have not or may not receive BCHS capacity building project funds because (1) available funding has been insufficient to meet all unsatisfied needs, (2) a number of areas are not or may not be eligible for some programs, (3) HEW considers other factors and problems besides infant mortality in making funding decisions, (4) BCHS has not made infant mortality a funding priority for some project grant programs, or (5) no one from many high infant mortality areas applied. Furthermore, BCHS project grantees serving persons who reside in high infant mortality areas do not always direct their efforts to improve pregnancy outcome.

Limited funding

Although funding for BCHS capacity building project grant programs has increased, it has been insufficient to meet all unsatisfied needs. For example, HEW has designated about 7,400 medically underserved areas and 1,233 primary care health manpower shortage areas. However, as of October 1977, CHCs covered 2,357 medically underserved areas; BCHS expected 1,725 NHSC field personnel to serve 690 health manpower shortage areas by the end of fiscal year 1979.

In November 1978, BCHS identified 564--171 urban and 393 rural--high infant mortality areas. Many of these areas in States visited were not served by BCHS capacity building projects. For example, 94 (or 64.4 percent) of the 146 areas in the five States reviewed that BCHS designated as high infant mortality areas were not served by a CHC or a Rural or an Urban Health Initiative grantee, according to November 1978 BCHS data.

High infant mortality rates in areas other than those BCHS has designated as high infant mortality areas also indicate an unmet need for additional efforts. BCHS criteria designate a high infant mortality area as one which must have 2,000 or more live births and an infant mortality rate of 22.1 or greater over a 5-year period or meet other criteria. We believe that many rural areas with fewer births do not qualify for high infant mortality designation because of these criteria. For example, nine North Carolina counties with 5-year (1971-75) infant mortality rates ranging from 23.4 to 27.7, but with fewer than 2,000 live births over the same period, were not designated as high infant mortality areas by BCHS. All of these nine counties were designated as medically underserved areas, but only part of one of the nine was served by a CHC or Rural Health Initiative grantee.

Many high infant mortality areas are not or may not be eligible for some programs

Many high infant mortality areas are not or may not be eligible for CHC funds or NHSC personnel. For example, in the five States reviewed, HEW designated 146 areas as high infant mortality areas. Of these 146 areas, 6 were not designated as medically underserved, and 92 were not designated as health manpower shortage areas. Accordingly, unless these areas were to apply for or receive such designations, they would not be eligible for CHC funds or NHSC personnel.

High infant mortality is not a funding priority for some programs

Some HEW-designated high infant mortality areas may not receive capacity building project grant funds because BCHS has not required that infant mortality be a funding priority for some basic programs exclusive of special initiatives. For example, according to BCHS data, in fiscal year 1978, it placed about 500 NHSC personnel--other than dentists--in about 285 locations throughout the country. BCHS placed about 250 (or 50 percent) in areas that were not designated as high infant mortality areas. However, as of April 1979, it had placed 156 NHSC personnel in IPO projects as part of a special initiative.

Funding allocations are based on other factors besides infant mortality

For the most part, BCHS has been responsible for building and maintaining the capacity for primary health care need areas. Although infant mortality is one factor considered as a need indicator, other factors include the availability of health care for the general population or the number of low-income persons or elderly residing in an area.

Accordingly, BCHS awards capacity building project grants to many areas which are not HEW-designated high infant mortality areas. For example, of 123 BCHS rural health initiative grant awards in fiscal year 1978, 50 (or about 41 percent) went to organizations proposing to serve no HEW-designated high infant mortality areas based on BCHS' high infant mortality area designations at the time of grant award.

According to one BCHS representative, BCHS awarded rural health initiative grants to many organizations which were not proposing to serve an HEW-designated high infant mortality area because (1) infant mortality is not the only factor considered in making funding decisions, (2) no one from unfunded high infant mortality areas applied, and (3) BCHS did not have sufficient technical assistance funds to help organizations in all high infant mortality areas develop applications.

Restrictions on NHSC placements to State and local governments

In December 1978, HEW's Health Services Administration informed Regional Health Administrators of a new policy for placing NHSC personnel in IPO projects. This policy, provides, in part, that States, other than the original 13 which received IPO grants, would not be likely to receive a waiver of the requirement to reimburse the Federal Government for the full cost of providing Corps personnel. According to BCHS staff, this policy will probably make it difficult for States, other than the 13, to use NHSC personnel because they could not pay the full cost. For physicians and nurses who were NHSC scholarship recipients, the cost as determined by HEW, was $37,000 and $24,500 annually, respectively.

According to BCHS, this policy resulted from instructions from the Office of Management and Budget that States would have to reimburse the Government for the costs of NHSC personnel in State or local prisons or mental health facilities. However, Public Law 94-484 requires HEW, in approving applications for NHSC personnel, to give priority to areas or organizations--public or private--proposing to serve areas in greatest need, giving special consideration to specified indicators, including infant mortality. The act also authorizes HEW to waive requirements for reimbursing the Government for the costs of NHSC personnel if the organization is financially unable to meet such requirements, if compliance would unreasonably limit the ability to provide adequate support for the provisions of health services by NHSC members, or if a significant percentage of persons in the service area live in poverty or have other characteristics which indicate inability to pay for services. According to BCHS, the bulk of the organizations having NHSC personnel receive full or partial reimbursement waivers from HEW.

According to HEW, at least three IPO States will probably not request NHSC personnel because of this policy. For example, HEW did not anticipate requests from Ohio or Indiana because the cost of NHSC personnel exceeded the maximum salary levels established by State and local governments. A fourth State, Kentucky, withdrew a request for NHSC personnel because of this policy.

Capacity building project effect on improved pregnancy outcome uncertain

BCHS has not evaluated the effectiveness of its capacity building project grants on reducing infant mortality or otherwise improving pregnancy outcome. It has developed criteria for evaluating these projects, but for the most part they are process oriented and do not include pregnancy outcome. Infant mortality is (1) one of four specific factors HEW uses to determine eligibility for designation of medically underserved areas, (2) to be given a priority for award of CHC and Rural and Urban Health Initiative grant awards, and (3) required by by Public Law 94-484 to be given special consideration as a need indicator in designating health manpower shortage areas and placing NHSC personnel. It would appear that BCHS should evaluate the effect its capacity building projects is having on improving pregnancy outcome.

In March 1979, BCHS issued instructions for project grantees requiring them to periodically report their progress in enrolling prenatal care patients, giving special emphasis to early enrollment. The BCHS instructions include reporting requirements for project grantees relating to (1) counseling for adolescent female family planning patients, (2) anemia screening for pediatric patients between 24 and 27 months of age and for female family planning patients, and (3) immunizations for patients 17 years of age and under.

Lack of emphasis by some BCHS project grantees

BCHS project grantees do not always emphasize or focus on improved pregnancy outcome activities even though they are located in or serve high infant mortality areas. For example:

--One urban CHC we visited in California provided no prenatal care although it was not fully used and was in a high infant mortality area, and a nearby county health clinic was serving more prenatal care patients than it could adequately handle.

--Two rural CHCs in Virginia provided no prenatal care even though they were in HEW-designated high infant mortality areas.

--A rural CHC we visited in North Carolina provided only limited prenatal care. The county served by the center is an HEW-designated high infant mortality area and is now served by an IPO project.

--One CHC we contacted in August 1978 in the District of Columbia offered obstetric care only 3 hours weekly because it could obtain only limited part-time help from an obstetrician. According to the center's executive director, centers have difficulty attracting obstetricians because they can earn much more by entering or staying in private practice. She said that the center was planning to apply for an NHSC obstetrician so that it could expand its obstetrical service. Another center we contacted in the District offered obstetric services only 4 hours each week until the summer of 1978 when it received an NHSC obstetrician.

In addition, user data reported for 1977 by 483 BCHS capacity building project grantees indicate that many give relatively little emphasis to improving pregnancy outcome. For example:

--Thirty-two grantees reported serving no infants and 79 reported serving some infants, but the infants represented less than 1 percent of all their clients.

--Only 4.2 percent of all clients were reported as family planning users with 347 grantees, or nearly 72 percent, reporting no family planning users.

On the other hand, three CHCs visited in Missouri provided prenatal or well baby care, and one was planning to provide additional prenatal care and family planning services to pregnant adolescents by using nurse-midwives and other health care personnel under an Adolescent Health Initiative grant.

According to BCHS' Deputy Associate Bureau Director for Family Planning, many BCHS project grantees reported serving few or no family planning users in 1977 because BCHS had not begun to emphasize their provision of family planning services until November 1976. She expected the 1978 data to show increased emphasis on family planning services by BCHS project grantees because of this emphasis and as a result of special project grant awards specifically directed toward adolescents.

HEW regional office personnel do not always focus on improved pregnancy outcome

According to HEW region IX health officials, they gave no special emphasis to maternal and child health in administering

the CHC program. They said that centers are frequently placed in areas without significant pregnancy outcome problems.

An HEW region VII health official said that the region is more interested in overall quality of comprehensive services and did not actually know how extensive services were; specific pregnancy outcome goals for the centers for improving pregnancy outcome have not been established. For example, one rural health initiative applicant in Missouri described significant pregnancy outcome problems in the Bootheel area, but the grant application contained no specific activities, goals, or objectives aimed at these problems. The HEW region VII program consultant said he saw no problem with the applicant's failure to describe specific goals, objectives, or activities for improving pregnancy outcome. He believed that the services provided by the applicant would have some impact on improving pregnancy outcome.

An HEW region IV health official said that although CHCs should provide and emphasize prenatal care, many are not providing this service. He said that many centers were established before HEW began emphasizing improved pregnancy outcome. Another region IV official added that no special emphasis is given to this goal in the review and award of grant applications. For example, he said that, although the region could impose a grant condition requiring a focus of effort on improved pregnancy outcome, this has not been done. He said new center grantees will be required to provide prenatal care. As indicated on page 42, in March 1979, BCHS issued instructions for project grantees on prenatal care and plans to monitor grantee compliance.

According to an HEW health official responsible for administering the NHSC program in one region, pregnancy outcome or infant mortality is not a factor in making placement decisions in the basic NHSC program. He said that the placement is a matching process between what communities request and what NHSC personnel prefer. He added that many communities that need additional health care personnel to help improve pregnancy outcome do not apply, or if they do apply, (1) do not specify a specialist, such as an obstetrician or pediatrician, (2) do not have a large enough population to support such a specialist, or (3) are unacceptable to NHSC personnel because they are rural or have other unattractive characteristics.

Multiple programs, fragmented efforts, and lack of Federal leadership have contributed to diffused local efforts

CHCs frequently operate independently as opposed to part of a system of care or part of a State MCH plan. For example, the director of one CHC in Kansas City, Missouri, said that he has taken no action to coordinate its services with other providers or agencies except for the supplemental food program. The director of another center in Kansas City stated that no one has assumed leadership or responsibility for coordination of health services, and he did not believe HEW was trying to facilitate coordinated, regionalized health efforts. The executive director of the health systems agency serving Kansas City said that HEW allocates funds without considering regional needs or community concerns. He cited multiple funding of similar services by various Federal and State programs and lack of communication among providers as problems.

The Mississippi MCH director stated that coordination is lacking in some areas which may result in duplicative services. For example, in one rural Mississippi area we visited, the services of the CHC were not integrated with the local health department. Also, the executive director of a CHC we visited in Los Angeles said that he was unaware of the maternity and infant care project serving his area and therefore had no working relationship with it.

Problems created by multiple funding sources

Multiple funding sources create an additional workload on grantees. A number of HEW grantees complained about the multitude of HEW health programs and initiatives. For example, the executive director of one CHC in the District of Columbia said he has had to fill out separate applications, monitor, and account for his center's grant, NHSC personnel, Urban and Adolescent Health Initiative grants, Family Planning funds, and an ICH project grant (application in process). He believed HEW should consolidate its activities that closely relate. According to the director of a Kansas City center, existing fragmentation is costly because of the need to develop and administer separate grants.

Lack of leadership
by HEW regional offices

HEW regional offices, in our opinion, contribute to the fragmented efforts by often failing to coordinate their activities aimed at or relating to improved pregnancy outcome. For the most part, the regional offices we contacted had not implemented comprehensive, coordinated approaches to use their resources to help MCH agencies improve pregnancy outcome. For example: Regions VII and IX officials had no formal mechanism for coordinating their programs to help Missouri and California improve pregnancy outcome. In fact, two regional offices had not coordinated family planning activities funded under the MCH and family planning (title X) programs and had not assisted local officials to develop a coordinated regional approach aimed at reducing adolescent pregnancy.

According to regional officials, no one in HEW regions IV or IX was combining various programs and efforts for a comprehensive, coordinated approach to improve pregnancy outcome. Regional health officials cited the categorical nature of programs as a major deterrent. The officials said that there was no formal coordination mechanism between urban and rural initiative grantees and other providers, but said that informal coordination does exist.

HEW's region III had developed State work groups consisting of personnel responsible for administering various health service delivery programs. The work groups were to meet periodically to discuss progress and problems in each State. Although such a work group existed for the District of Columbia, HEW-funded grantees--MCH, CHCs, and family planning--in the District were not coordinated into a system of care although some links among some providers existed.

Community resistance to
some BCHS projects

Some BCHS-funded projects are not always well accepted by communities they are intended to serve. For example, an NHSC physician in a rural area in Virginia told us that the county opposes his practice because it views the practice as a Federal intrusion. An NHSC official cited similar problems for counties in the Bootheel, Missouri, region. Even though the Bootheel area needs health care personnel, opposition to Federal doctors from local consumers, doctors, and politicians existed. Additionally, an HEW region IX health official stated that in California's Central Valley region there was

opposition from health officials to Federal programs, such as the Rural Health Initiative, which were directed at special groups. County officials also pointed out the possible infringement on private providers serving the same geographical area.

HEW INITIATIVES ARE HELPING BUT ALSO POSE SOME PROBLEMS

HEW initiatives aimed at improving pregnancy outcome seem to be helping by improving access to health care and by promoting cooperation among MCH, family planning, CHCs, and NHSC programs. This is illustrated by BCHS' effort to use NHSC personnel to help implement IPO projects. Preliminary data provided by an NHSC obstetrician providing prenatal care in several rural counties in North Carolina as part of an IPO project indicate a substantial improvement in pregnancy outcome in at least one county since project activities were initiated.

However, in some instances, these HEW special initiatives are located in areas already served by BCHS projects. We question whether BCHS' practice of awarding special initiative grant funds to organizations or for areas already receiving its funding and already required to provide prenatal and pediatric care is the most efficient and desirable way to improve pregnancy outcome. It would appear to be more practical and less burdensome to see that BCHS grantees in high infant mortality areas address this problem as part of their basic effort. This approach seems particularly more useful inasmuch as funds for the special initiatives--IPO and ICH--are limited in relation to the funding available for the basic programs.

One rural area in North Carolina with a Rural Health Initiative grantee was also served by an IPO project grant. Also, HEW recently approved a rural health initiative grant and an IPO grant for a regional health organization representing the six-county Bootheel region of Missouri. Although the grantees initially intended to operate the grants in two different counties, both grantees planned to expand their services throughout the six-county area. The Missouri MCH director said that he was not aware of the rural health initiative project until after it was approved and that, if he had known about it, the State may not have chosen to locate the improved pregnancy outcome project in that area.

BETTER LINKS NEEDED BETWEEN HEALTH PROGRAMS AND WIC

Our February 27, 1979, report, "The Special Supplemental Food Program for Women, Infants, and Children (WIC)--How Can It Work Better?" (CED-79-55), discussed several problems concerning the lack of coordination between health and WIC programs. We identified similar problems in this review.

HEW and Agriculture lacked a formal procedure for seeing that low-income women and infants in areas experiencing the most severe pregnancy outcome problems have access to both health services and supplemental foods. They also lack a procedure for coordinating planning for these areas. To a large extent, each agency operated its programs independently of the other. Consequently:

--Low-income pregnant women and infants in a number of areas either received health services but no supplemental foods or supplemental foods but no health services.

--Many HEW capacity building projects were not participating in or otherwise linked to the WIC program.

--Decisions for awarding new or expanding existing HEW capacity building projects were made independently of decisions to expand WIC program funds, even though the Congress intended WIC to be an adjunct to health care.

Many BCHS projects do not participate in WIC

In June 1978, BCHS reported that 244 (or 47 percent) of its 518 operational capacity building projects were not participating or otherwise associated with WIC. BCHS instructed its HEW regional office staff to take several steps--including coordinating with Agriculture representatives--to see that these projects are linked to WIC. Subsequently, HEW and Agriculture regional office personnel identified several reasons why WIC and BCHS projects were not linked, as follows:

--Some BCHS units did not provide the prenatal or pediatric health services required by WIC.

--Many BCHS grantees did not apply for WIC.

--Many BCHS grantees that did apply were located in areas (1) having low priority for WIC or (2) already being served by a WIC program.

Project funding decisions need to be better linked

HEW and Agriculture have not developed a procedure for seeing that health capacity building projects and WIC funds are used together to the greatest possible extent. HEW regional offices, using criteria and guidance from BCHS, decide which areas will receive health service capacity building projects. On the other hand, State agencies administering WIC decide, using criteria and guidance from Agriculture, which areas will receive WIC funds. Although pregnancy outcome and income levels are factors considered by both HEW and Agriculture (as we reported in February 1979), HEW considers other factors as well. Moreover, Agriculture officials believe that HEW should give greater emphasis to pregnancy outcome in making its funding decisions.

Recognizing that BCHS capacity building programs are generally aimed at the general population in need of health services--not just pregnant women, infants, and children--it seems that HEW, Agriculture, and the States should be able to work closer together in determining those areas which should receive highest priority for health services and supplemental foods. For example, State agencies administering WIC, State MCH agencies, and health planning agencies, could work together to identify areas they believe should receive highest priority for receiving health services and supplemental foods. In turn, HEW, the Department of Agriculture, and other interested organizations could work cooperatively in determining how best to meet the need for health services and supplemental foods in these areas with available funding.

LIMITED HEW EMPHASIS ON FAMILY LIFE/SEX EDUCATION

Several HEW agencies administer programs which are helping or could help State and local agencies develop or implement family life education programs. However, HEW has neither devoted much emphasis to nor exercised much leadership in this area, and coordination between the Public Health Service and HEW's Office of Education has been lacking in this area. As pointed out by California MCH officials, planning for sex and health education is variously done by family planning councils, public schools, and health care providers, although

responsibility for overall planning and direction of health education should be coordinated. A number of State and local health or education officials believe that more Federal leadership in the area of family life and sex education is needed.

In the fall of 1977, HEW established a task force comprised of representatives from the Office of Education and the Office of the Assistant Secretary for Health to determine what health education activities were ongoing and what additional action was needed. According to task force representatives, including the chairperson, progress has been slow; and, as of January 1979, no course of action had been outlined. Task force representatives told us that it was still unclear as to whether the Assistant Secretary for Health or the Office of Education would take or be given the lead role in the area of health education. They said that, although some parenting programs funded by the Office of Education include family life or sex education, there has been no emphasis in this area, partly because of the controversy over family life and sex education. (See p. 73.)

SPOTTY INVOLVEMENT BY AND LIMITED OR NO COORDINATION WITH HEALTH PLANNING AGENCIES

Although State MCH agencies, health systems agencies, and State health planning and development agencies have overlapping planning responsibilities for improved pregnancy outcome, there was often little or no communication among these organizations, and roles and relationships among these organizations have not been clearly defined either by the States or by HEW.

Health planning agencies visited were in various stages of development and varied greatly in the extent and manner they included improved pregnancy outcome in their planning. Some gave it a high priority and developed detailed plans for addressing problems adversely affecting it. Others gave it a low priority or covered it only to a limited extent.

The National Health Planning and Resources Development Act of 1974 provided for the development of national health planning goals and guidelines and establishment of areawide and State health planning agencies to deal with needed planning for health services, manpower, and facilities. The act was designed to improve access to and quality of health care, improve health status, restrain health care costs, and prevent unnecessary duplication of health care resources.

Health systems agencies were to prepare areawide health systems plans setting forth goals regarding health needs and resources of their areas and annual implementation plans describing objectives which will achieve the goals stated in health systems plans. State health planning and development agencies, among other responsibilities, are to prepare State health plans which recognize the health systems plans of the health systems agencies within their States.

Several MCH directors and health planning agency staffs told us that there was little or no coordination or communication among their staffs. For example:

--Virginia officials from one health systems agency we visited and the State health planning and development agency said that they had not coordinated with the State's MCH agency in developing their plans. The HSA official said improved pregnancy outcome was not considered a priority problem in his view, and his agency had been emphasizing constraining health care costs rather than improving access to health care. The State MCH agency applied for HEW improved pregnancy outcome funds to extend and improve services in five counties in this HSA's area. The HSA official added that he plans to coordinate with MCH in the future.

--The Tennessee MCH director said that the lack of communication and coordination between his agency and a health systems agency in the State resulted in duplicative effort between them to develop a regionalization plan.

--Missouri's HSA for St. Louis was represented on the St. Louis Maternal and Child Health Council and relied on the Council for preparation of the MCH section of its health systems plan. On the other hand, a similar council did not exist in Kansas City, and communication between MCH personnel and the health systems agency was lacking. At the State level, there had been very little, if any, coordination between the MCH agency and the State health planning and development agency, which did not consider improved pregnancy outcome to be one of its highest priorities.

CHAPTER 4

EFFORTS TO PREVENT OR TO FAVORABLY TIME HIGH-RISK PREGNANCIES NEED TO BE ENHANCED

Family planning programs have helped to prevent unwanted or unplanned pregnancies and to optimize the timing of desired pregnancies. However, many women likely to have "high-risk" pregnancies continue to have unwanted, unplanned, or ill-timed pregnancies. Health authorities believe that many of these pregnancies, particularly among adolescents, can and must be prevented or better timed through more or better family planning and health education programs.

HEW administers several programs that fund family planning services. However, many high-risk women either do not receive or effectively use these services or receive them too late to prevent or delay unwanted or unplanned pregnancies. This situation results from several factors: restrictive State laws, the multiplicity of such programs, patient apathy or lack of accurate information, and service provision barriers (e.g., lack of emphasis on high-risk women in many Federal programs).

HIGH-RISK PREGNANCIES: THEIR CAUSES, PREVENTION, AND DELAY

A woman is considered a high risk in childbirth when she has medical or social characteristics that make a healthy pregnancy outcome unlikely, such as:

--Age (under 17 and over 35).

--Metabolic disorders, such as hyperthyroid condition or diabetes.

--Structural abnormalities of the pelvis.

--A family history of inherited disorders.

--Incompatible Rh blood factor between mother and child.

--Cigarette smoking or alcohol and drug abuse.

--Chronic illness or contraction of an infection during pregnancy.

--A history of previous miscarriage or fetal loss, underweight or premature babies, and toxemia.

--Several previous pregnancies, or becoming pregnant too soon after a previous pregnancy.

--Low income, undereducated, or unmarried.

High-risk pregnancies generally result in higher incidences of premature births, underweight infants, infant mortality and morbidity, and maternal mortality.

Adolescent pregnancy

Among the many factors leading to high-risk pregnancy, the problem of adolescent pregnancy has recently received national concern and the attention of the Congress and HEW. Over 1 million teenagers become pregnant each year in the United States, giving rise to serious medical, social, educational, and economic concerns. (See fig. 4-1).

Pregnancy terminates adversely more often when the mother is a teenager than when she is in her early twenties; she is more likely to:

--Have toxemia, anemia, and complications during labor.

--Die during childbirth.

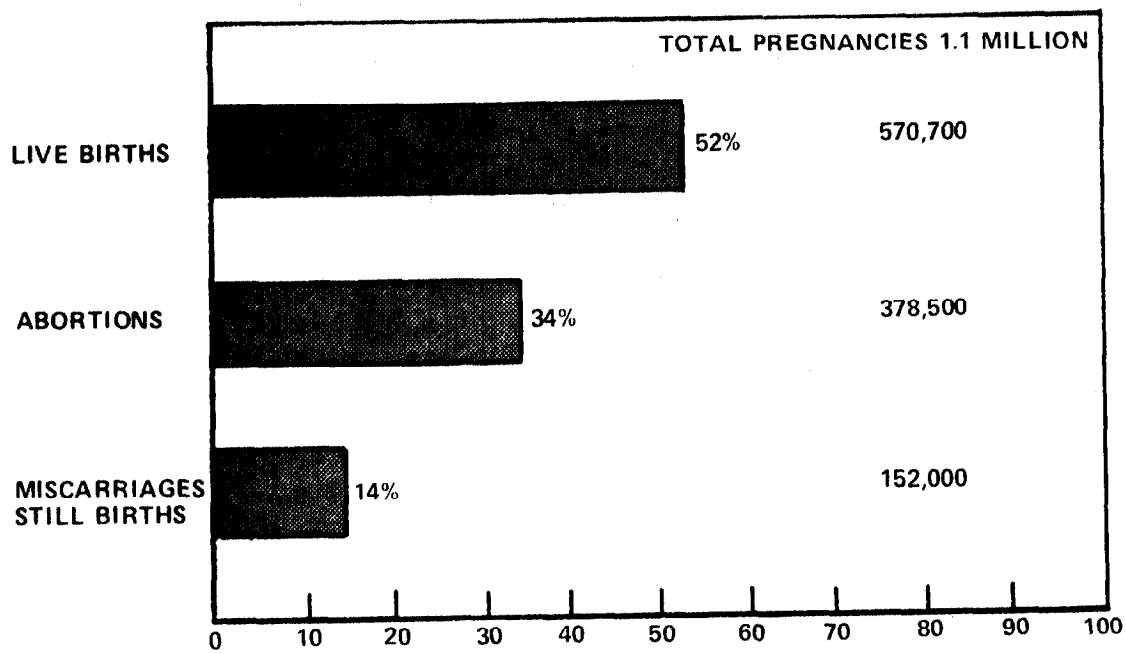
--Begin prenatal care late or not at all.

--Bear infants who die, are premature, or are underweight. Of the 1.1 million adolescent pregnancies each year, over 150,000 suffer miscarriages or stillbirths.

Many teenage girls never complete high school after becoming mothers. Of every 10 girls who become mothers at age 17 or younger, 8 never finish high school. For those who become mothers at 15 or younger, the figures are even worse: 9 out of 10 never finish high school, and 4 out of 10 never complete the eighth grade. Such births are frequently out of wedlock, and those young mothers who do marry before they are 18 are three times more likely to divorce or separate than those who marry in their early twenties.

FIGURE 4-1

ANNUAL OUTCOME OF ADOLESCENT PREGNANCIES



Significant amounts of welfare costs can be attributed to adolescent pregnancy. According to one recent estimate (Moore 1978), of the $9.4 billion in Aid to Families with Dependent Children funds paid in 1975, about half--or $4.65 billion--went to households of women who had borne their first child while in their teens. This estimate excludes administrative costs as well as those for health care, food stamps, or other public assistance programs.

Because of the magnitude and seriousness of its attendant problems, HEW has made prevention of adolescent pregnancy a major priority and has begun several actions to address the matter.

Prevention or delay of high-risk pregnancies can improve their outcome

Health authorities believe that the outcome of high-risk pregnancies can be improved by education and family planning services, which can help identify the high-risk woman early and help prevent or better time her high-risk pregnancy. According to BCHS, the identification of a high-risk person before she conceives is important whether the objective is

--to delay childbearing until the woman is biologically mature;

--to postpone pregnancy until her health status improves or she obtains genetic counseling;

--to avoid pregnancy until the woman is better educated, to enhance her chances for economic self-sufficiency; or

--to prevent pregnancy when the woman does not want a baby, whatever the reason.

State MCH directors have also stressed the importance of preventing unplanned high-risk pregnancies. In our questionnaire they indicated that, to improve pregnancy outcome, their highest priorities (after providing prenatal care) would be preventing unplanned teenage pregnancies and providing additional health education. One State also emphasized in its ICH program the importance of family planning in improving pregnancy outcome. For example, the ICH program in North Carolina made prevention of high-risk pregnancy through family planning its principal approach against infant mortality:

> "Prevention of unwanted pregnancies * * * can reduce the occurrence of fetal deaths, prematurity, and abortion--especially those occuring to unmarried women and women under 20 years of age, who experience higher rates for these outcomes than other women. Family planning services can also * * * reduce the occurrence of genetically linked malformations and other genetic diseases through counseling."

FAMILY PLANNING PROGRAMS HAVE HELPED BUT NEED TO DO MORE

Federally funded family planning programs have served and continue to serve many low-income women. According to BCHS data for 1977, title V and X family planning grantees served about 3 million women, of whom about 19 percent were 17 years old or younger. Some evidence indicates that these programs have improved pregnancy outcome by preventing high-risk pregnancies. Other evidence indicates that family planning programs have not been substantially effective.

Family planning services are unavailable, inaccessible, or ineffectually used for several reasons, including lack of coordination among programs, lack of focus on high-risk women, and limited resources. Other factors, applicable mainly to adolescents, include:

--Legal restrictions on serving adolescents.

--Unattractive location or nature of services.

--Lack of links between family planning services and schools.

--Negative attitudes of service providers, communities, and adolescents.

HEW has recognized most of these problems and taken action to help resolve some of them. However, it will have to take more aggressive and coordinated steps before it can have greater impact.

Effectiveness of family planning services in preventing high-risk pregnancies is questionable

Comprehensive data are lacking on the (1) extent to which HEW-funded family planning programs serve high-risk women and (2) their effectiveness in preventing or delaying pregnancy for these women. These programs do prevent pregnancies for many low-income and adolescent women, but too many other low-income and adolescent women are not being served, are being served late, or are served ineffectually.

Many women receive effective service

Family planning does seem to be helping many women. An authority on maternal and child health, in a review of relevant studies, stated:

> "It is likely that the recent availability of family planning services and of safe abortion services has helped to reduce infant mortality because these services are provided to high-risk women, some of whom may have otherwise had pregnancies with unfavorable outcomes."

The director of Mississippi's family planning services agrees--he believes his program has helped prevent many unwanted pregnancies. In 1977, Mississippi's family planning program served nearly 65,000 people, of whom 16,000 (or 26 percent) were teenagers.

Many women receive late, ineffectual, or no services

Despite their achievements, however, family planning services must do much more before they can significantly improve pregnancy outcome. At present, many target women receive no help at all. According to the Alan Guttmacher Institute, 1/ in 1975 only a third of all low-income women needing subsidized family planning services received them; for the teenagers in this group, program availability was even worse--only 29 percent received such services.

Moreover, significant numbers of unplanned births occur each year, indicating a chronic and severe lack of effective family planning. The Guttmacher Institute estimates that nearly two-thirds of all adolescent pregnancies and half of all adolescent childbirths are unplanned. The National Center for Health Statistics estimates that there were over 500,000 illegitimate births in 1977. Health officials and others believe that most of these were unplanned. Additionally, in 1976, there were at least 169,000 births to women of all ages which occurred less than 18 months after a previous birth, indicating ineffective family planning. Health authorities consider a birth interval of less than 18 months to be a high-risk situation.

One index of unplanned pregnancy--and, indirectly, the lack of effective family planning--is the number of abortions performed: many women, especially adolescents, control births in this way. In 1976, about 1.2 million women in the United States had abortions, with the District of Columbia having more abortions than live births. Since 1973 the teenage abortion rate has risen 60 percent, with the rate for women under 15 nearly doubling. In 1974, teenagers made up one-fifth of the female population of reproductive age but accounted for one-third of the legal abortions reported. In fiscal year 1977, California paid for 110,000 abortions, 44 percent of which was for teenagers.

1/A private corporation for research, policy analysis, and public education on family planning and population issues.

Family planning services reach many women, especially adolescents, too late to prevent an undesirable pregnancy. Teenagers often visit such clinics after they have already begun sexual activity, had an abortion, or become pregnant. In 1976, an HEW funded Urban and Rural Systems Associates' study reported that 94 percent of the adolescents attending family planning programs had already experienced sexual intercourse--usually a year before their first visit. At one Virginia clinic for family planning, 18 percent of the pregnant teenagers seen recently over a 6-month period had previously been pregnant.

When family planning services do reach teenagers before pregnancy, their efforts to promote birth control are often ineffective. The 1976 study for HEW found that nearly 70 percent of the teenagers who became pregnant after visiting a clinic had previously attended organized family planning programs. Furthermore, 42 percent of those who used contraceptives did not use them regularly, and 25 percent of the users became pregnant again within a year of their previous pregnancy. According to one estimate, it would be possible to reduce premarital pregnancies by 40 percent if all sexually active adolescents were to use contraception consistently.

Limited resources impair or deny services to many areas

The Guttmacher Institute reports that one of every five U.S. counties in 1975 lacked family planning services for adolescents; most of those counties are nonmetropolitan areas. Moreover, almost 2 million teenage women lived in metropolitan counties whose clinics could not serve them.

Augmenting and improving family planning services are often hindered by limited resources. For example, in the North Carolina counties of Halifax and Northampton staffing, space, additional types of services, outreach, and transportation were needed to provide high-risk women the necessary family planning services. 1/ According to one national estimate, increasing clinic capacity by an additional 500,000 adolescents annually would cost $74 million in 1980 and $118 million in 1981.

1/In commenting on a draft of this report, North Carolina said that HEW's ICH project aimed at these two counties provided the impetus needed to get additional resources in these areas.

Family planning programs often do not focus on high-risk women

Family planning programs have been increasing their emphasis on serving adolescents; moreover, BCHS has instructed them to give special attention to those women whose age makes them high risk. However, many family planning programs do not assign special priority goals for serving women considered high risk for reasons other than age.

For example, California's Office for Family Planning and the Virginia and North Carolina title X programs (administered by the State health departments) have no specific objectives for serving high-risk women, nor do they monitor the extent to which they serve such groups. Virginia's family planning goal was to serve 75 percent of the State's medically indigent women over a 3-year period. In North Carolina, the State's ICH program developed a specific objective for reducing the number of pregnancies in two counties considered high-risk areas because of lack of maternal education, previous adverse pregnancy outcome, Rh complications, and age. Yet a North Carolina official told us that family planning programs give no priority to improving pregnancy outcome, nor is this a factor in allocating funds to local county health departments.

Family planning grantees do not focus on high-risk women between ages 18 and 34 for several reasons: authorizing laws do not require it, some administrators do not consider it to be an appropriate goal for such programs, and limited funds often preclude major outreach efforts.

The several different laws that authorize federally funded family planning activities do not require a specific priority or focus for high-risk women. For example, the title X program aims at serving low-income persons in general and contains no mandate to give priority to specific groups of high-risk women. Similarly, MCH authorizing legislation does not specifically require family planning grantees to give such women special emphasis.

Even when such federally funded programs are given goals for high-risk women, they may lack mechanisms to monitor their progress toward such goals. In 1977, BCHS identified several criteria for high risk of poor pregnancy outcome and told HEW regional health administrators that any person who met these

criteria should have priority for family planning services. BCHS stated that for fiscal year 1977 it would use only age criteria to measure progress in reaching high-risk populations, because data were available for this. BCHS planned to refine its measurement mechanisms for the next fiscal year, but was still developing these mechanisms when we completed our fieldwork, according to family planning officials.

Despite BCHS' identification of high-risk criteria and instructions to give priority to these groups, progress may be slow. Some administrators do not view their family planning programs as directed at improved pregnancy outcome. For example, an official with California's Office of Family Planning noted that the high demand for the office's programs and its limited funding make outreach efforts a low priority. BCHS officials confirmed this, saying that family planning programs generally operate at capacity and would have to deny services to some low-income women if they were to give more emphasis to high-risk groups.

Family planning efforts often lack coordination at all levels

Family planning services are federally funded under several programs, including title X Family Planning, MCH, Medicaid and Social Services, and CHCs. At the local level, many organizations provide such services, including local health departments, nonprofit organizations (e.g., Planned Parenthood), hospitals, CHCs and private physicians. Yet, in the areas we visited, no single organization planned, coordinated, or evaluated all subsidized family planning activities at the State or local level. As a result, those activities were frequently not coordinated, with providers often operating independently.

HEW contributes to the fragmentation and lack of coordination among family planning programs by (1) not coordinating its own programs, (2) failing to require one organization at each level to assume responsibility for providing subsidized services, and (3) awarding project grants directly to local private organizations, thus bypassing State health agencies. This last problem is evident in those areas visited where State health agencies were not the title X grantee. For example:

--In the District of Columbia, HEW awarded title X family planning funds to three private organizations, bypassing Department of Human Resources officials who said that this situation impairs their ability to coordinate family planning efforts. No organization was responsible for assessing the need for and availability of such services districtwide and for coordinating and evaluating the delivery of such services. HEW region III representatives agreed that this problem needs to be addressed.

--In California, the Office of Family Planning coordinates all family planning and related programs administered by State agencies. However, the State does not administer title X family planning funds, which HEW awards directly to local grantees. The State's ability to effectively coordinate family planning activities has been further hampered by the large numbers of agencies providing such services, some of which receive State funds, title X funds from HEW, and/or fees from Medicaid or Social Services. The chief of the Family Planning Office described the task of monitoring clinics receiving title X and State general funds as an "administrative nightmare."

--In Missouri, the State Health Department administers family planning funds under the MCH program but has no responsibility for title X project grants, which are made by HEW. According to an HEW region VII consultant, this situation has made coordination difficult. He also pointed out that, until recently, personnel at the regional office responsible for the MCH and family planning programs had not coordinated their efforts in the State. In addition, the executive director of a nonprofit organization receiving title X funds in Kansas City, Missouri, told us that there has been little coordination among family planning providers in that city.

BCHS officials acknowledged that HEW's project grants to private organizations have hampered the States' ability to plan and coordinate family planning activities. BCHS had expected State MCH agencies to take the lead role, but it recognizes that this generally has not happened and so is working to resolve the problem.

HEW SHOULD REASSESS ITS INITIATIVES FOR PREVENTING HIGH-RISK PREGNANCIES

HEW, recognizing the need to prevent high-risk pregnancies, has taken several actions to coordinate family planning services. Its efforts should focus more attention on the problem, make services more accessible to high-risk groups, and improve coordination at State and local levels. However, HEW's initiatives are limited in relation to its basic programs: some focus only on adolescents; some fragment the effort; others would not be necessary if basic programs worked as intended; and a new program focuses more on serving pregnant adolescents than on preventing teenage pregnancy.

In 1977, the Secretary of HEW made the prevention of adolescent pregnancy a major departmental objective. HEW accordingly began a national study on problems encountered in providing adolescents family planning services and implemented the following initiatives:

--Adolescent Health Services and Pregnancy Prevention, under the CHC and title X Family Planning programs.

--IPO, under the MCH program.

--ICH, under the MCH, title X Family Planning, and CHC programs.

Each of these initiatives, however, has problems that could hamper achievement of its goals.

Adolescent Health Services and Pregnancy Prevention

This initiative has two components: comprehensive health services to adolescents and teenage pregnancy prevention. The first component is limited to CHCs, involves only adolescents, excludes other high-risk groups, consists of relatively little funding in relation to the basic program ($14 million, or 5.5 percent of $255 million in fiscal year 1978), and involves many basic services that BCHS expects centers to be providing already. In addition, some of the adolescent health activities are identical to present BCHS services, thereby further fragmenting an already badly disjointed system. According to the executive director of the

HSA in Kansas City, Missouri, HEW did not consult his agency before awarding grants for the adolescent initiative. He believes the funds were spread too thinly for the various providers to be effective. Furthermore, the recently enacted adolescent pregnancy program has been criticized for focusing on serving pregnant teens rather than on preventing teen pregnancy.

Funds under the teenage pregnancy prevention component are also limited in relation to total program funding--10.3 percent of $128.9 million in fiscal year 1978. These are restricted to title X grantees, cover activities which could already be provided under the basic program, and are frequently awarded by HEW directly to local grantees--thus bypassing State health agencies. A Mississippi health official believes that HEW should consolidate its teen pregnancy effort with other initiatives to improve pregnancy outcome, because they are closely interrelated and essentially directed at the same goal. At present, since they are different initiatives, the State must report the same outcome data to two different groups. Similar comments were made by other community health officials in the District of Columbia. The director of California's Office of Family Planning said that she was unaware of HEW's teenage initiative activities and believed her office should have been involved in helping plan for the initiative in the State.

Improved Pregnancy Outcome and Improved Child Health

Funds for these initiatives generally go to State MCH agencies to carry out activities they are already expected to perform. In some locales, these new programs have duplicated ongoing efforts by other federally funded projects which BCHS expects to provide family planning and prenatal care. BCHS officials acknowledge that these new initiatives would not be necessary if the basic funding programs were working as intended or had enough funds to meet all unmet needs. Moreover, under the ICH program, administrators must make separate applications for each program from which they are seeking funds.

While we do not question the need for the additional efforts and resources to prevent high-risk pregnancies and improve pregnancy outcome, we do question whether consolidating these efforts and strengthening basic programs might not achieve the same results with less fragmentation and

paperwork. While these special efforts may be an appropriate use of existing authorities and organizations to improve pregnancy outcome in the shortrun, we believe that HEW needs to develop a more streamlined, long-term approach.

HEW MUST MAKE MORE AGGRESSIVE AND COORDINATED EFFORTS TO PROVIDE ADOLESCENTS EFFECTIVE FAMILY PLANNING SERVICES

We, HEW, and others identified several obstacles that either impede adolescents' access to family planning services or hamper their effective use. HEW can--and in some cases has already begun to--address some of these problems by taking more aggressive and coordinated actions concerning adolescent pregnancy. HEW has provided additional resources to expand or improve the availability of family planning services and to link various programs, but this has not been enough. The problems fall in four major areas:

--Restrictive State legislation.

--Lack of focal point or coordinator/monitor.

--Provider characteristics (location, hours of operation, staffing, etc.).

--Attitudes of adolescents, service providers, communities, and parents.

State laws bar services to adolescents

Only 26 States and the District of Columbia specifically allow minors to receive birth control services without parental consent. Even in some of these States, however, teenagers can sometimes be denied the right to determine their own health care. For example, although North Carolina gave teens the right to such services in 1977, some family planning clinics in that State still require parental consent, because the staff is unsure of its legal authority under State law. Similar uncertainty troubled a title X grantee in the District of Columbia, prompting it to question providing services to teenagers without requesting parental consent.

Programs lack a comprehensive, coordinated approach or focal point for preventing adolescent pregnancy

Family planning services are often poorly coordinated, yet HEW has done little to centrally organize all these efforts. This lack of coordination acutely affects teenagers, because their schools usually are not involved with health care and family planning programs. Occasionally such coordination does occur. HEW, despite its adolescent pregnancy initiatives, has done little to promote or provide family life education in the schools.

In the areas visited, it appeared that no one had clear responsibility for combining efforts to prevent adolescent pregnancy. For example:

--A task force studying adolescent pregnancy in the District of Columbia cited the lack of coordination and communication among the District's school system, health care providers, and Department of Human Resources as the most significant barrier to alleviating the problem.

--According to the California MCH director, programs to prevent adolescent pregnancies are independently planned and performed by health care providers, family planning agencies, and schools. Someone, he said, needs to combine these efforts.

Providers vary in their emphasis on adolescents

Some family planning providers offer special services and hours for adolescents, operate special clinics, or make other special efforts to reach teenagers. Others, however, give little or no special emphasis to serving adolescents and operate in highly visible facilities or during restricted hours--and thereby miss serving a large number of high-risk women. BCHS user figures for 1977 confirm this. In that year, 206 family planning grantees (titles V and X) reported serving 2.9 million women, 19 percent of which were girls under 18. However, for 23 percent (48) of the grantees reporting, these teenagers made up less than 10 percent of their female caseload. Teenage women accounted for 27 percent or more of total female users for less than 10 percent of the grantees.

Some of this variance in adolescent caseload reflects grant requirements: HEW has funded many family planning programs specifically to serve adolescent men and women. For the many other programs not so constrained, any effort to serve adolescents is affected by several factors.

Outreach or followup is limited

Outreach and followup aimed directly at teens (and other high-risk patients) are frequently limited and sometimes nonexistent, often because of insufficient funding. According to the outreach coordinator, the Virginia Family Planning Bureau evaluated 24 family planning clinics during 1977, and about half of these clinics were using outreach workers in clinical services rather than outreach. For example, in the evaluation of three clinics, the Bureau found that two clinics provided no outreach to adolescents because the outreach workers were too busy providing services to the patients; the third clinic had no outreach worker. In the District of Columbia, the outreach efforts of many Department of Human Resources clinics appeared to be insufficient, and the Department describes the outreach efforts of the District's social services program as minimal.

Outreach efforts directed through public schools are also limited. Few of the family planning or local health clinics visited in North Carolina or Virginia had formal links with the schools. According to California Family Planning officials, school systems have no formal procedure for referring teens to family planning facilities. All such procedures are informal and not sanctioned by school boards or other school officials.

The need for and lack of links with schools are illustrated by a recent survey in an urban Virginia family planning clinic of new patients under 18 years of age: only 1 of the 77 new teenage patients learned of the clinic from school personnel. Between October 1977 and March 1978, this clinic served 142 adolescents, of whom 49 percent were in grades 10 to 12 and another 49 percent were in the 9th grade or below.

According to Mississippi family planning and health officials there is little coordination or formal links between family planning providers and the school system. However, occasional visits by family planning staff to some schools do occur. In commenting on a draft of this report, the Mississippi Board of Health said that it was doing its best to address this problem.

Attitudes and fears of teenagers prevent them from seeking family planning services

Many teens have psychological barriers that prevent them from seeking or effectively using family planning services. Adolescents may deny their sexual activity or look at pregnancy as a means of improving their present lives. Many teens do not seek family planning services because they are afraid of the medical examination or parental discovery.

Denial defense mechanisms

According to health officials, many teenagers, especially the younger ones, deny the reality of their sex lives and often think of sex as a result of being carried away by the moment. Several health officials feel that a "denial" defense mechanism, rather than ignorance of contraception, is the major problem preventing teenagers from seeking family planning services. The teenage girl employing this mechanism believes that (1) she isn't likely to engage in intercourse and (2) if she does, she won't become pregnant. The widespread use of this mechanism was confirmed by an official in a Mississippi community health center, who noted that pregnant teenage patients, when asked why they had not used family planning services, replied:

--Didn't plan to engage in sex.

--Didn't think it (pregnancy) would happen to them.

--Didn't think it would happen the first time.

Similarly, 49 percent of the teenage patients receiving problem pregnancy counseling at an urban Virginia clinic between February 1975 and July 1976 said they hadn't taken precautions because they "Did not think it would happen to me." Local family planning officials also found another problem associated with "denial": some teens start sex before onset of ovulation, do not become pregnant, and therefore feel safe even after ovulation begins.

Lack of motivation

According to family planning officials at all levels, some adolescents want to become pregnant, so they do not seek family planning services. Teenage girls desire these pregnancies for several reasons: (1) to hold onto their

male partners, (2) to achieve independence and obtain their own income (welfare) through pregnancy, (3) to escape intolerable family or economic situations. A 1978 HEW nationwide study of family planning clinics confirms these findings; it reported that some teens do not come to the clinic because they see pregnancy as a relative improvement over their present lives. Consequently, health and family planning officials often consider motivating adolescents to be as important as, if not more important than, informing or educating them.

Fear of the medical exam

Ignorance and fear of the medical aspects prevents some teens from seeking family planning services. Fear of the pelvic examination alone is often a deterrent. One evaluator found that many teens interviewed before seeing the clinicians were extremely apprehensive about the pelvic examination. They were afraid it would hurt or that they would be embarrassed.

We also found this problem to be a significant deterrent. The health director of a North Carolina county stated that some teens refuse to be examined even after coming in for family planning services. The director of family planning and maternal programs in another county indicated that, despite a class explaining the pelvic examination, some teens are so frightened that they will not allow the clinician to perform the examination. A clinician at an urban Virginia clinic has had similar problems with frightened girls, so to alleviate some of these fears she shows the patients a film on the pelvic examination. This has been successful with about half of the teens, but the others appear more frightened after the film.

HEW region IX and California family planning officials also see this fear as a major deterrent to serving adolescents. One California teenager told an HEW study team that "Fear of the pelvic exam kept me from coming to the clinic for a year."

Fear of parental discovery

When a teenager considers visiting a family planning clinic, confidentiality is one of the major concerns. The 1976 Urban and Rural Systems Associates' study stated that teenagers mentioned "fear of parents finding out" as a barrier to using clinics more often than any other deterrent.

Breaches of confidence at family planning clinics usually occur when parental consent is required, when patient information is mishandled, when clinic locations and facilities were "visible," or when bills for services are sent to the patient's home.

The study found that, where parental consent was required, adolescents under 18 made up only 5 to 15 percent of the patient load; figures were much higher (8 to 45 percent) when programs did not require consent. Further, most instances of breached confidence occurred when a clinic contacted the patient's home without her knowledge or permission, usually by mailing appointment reminders, lab results, or bills to her home address. Some adolescents in the District of Columbia reportedly feared such exposure by mail so much that they refused to visit family planning clinics.

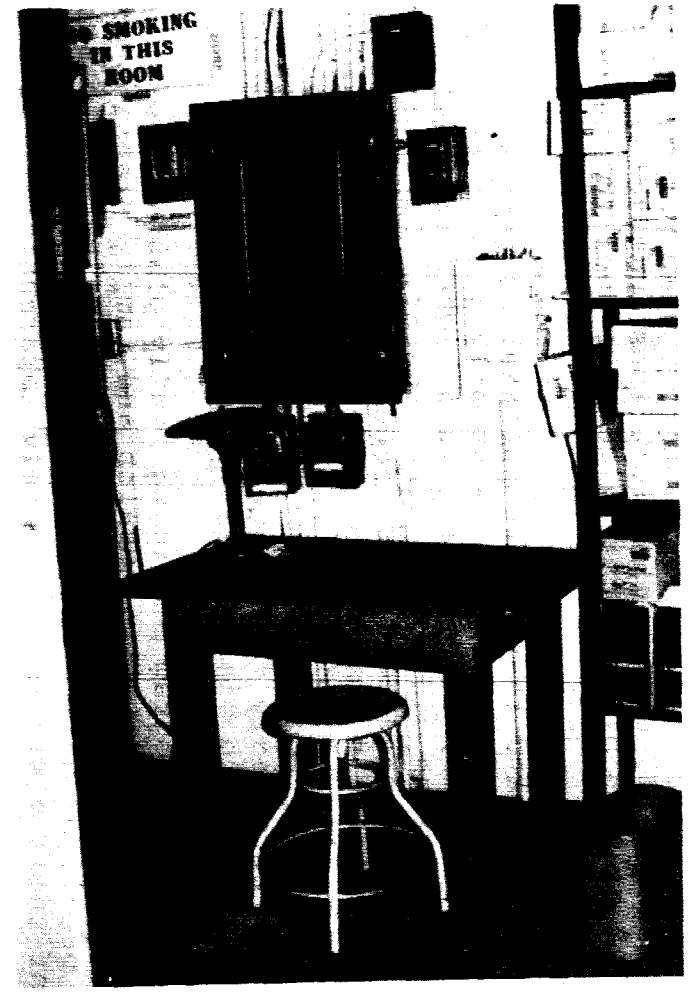
The type of program providing family planning services can also deter adolescents. Health and family planning officials believe that some adolescents are reluctant to attend clinics providing only family planning services because the nature of their visit is immediately apparent. Others believe adolescents are afraid to seek such services at the comprehensive health centers which their parents also attend, for fear the parents will discover what services their children are receiving. Proponents of comprehensive centers, however, claim that it would be much more difficult for anyone to find out why a person was attending the center.

The 1976 study also found that clinic location plays an important role in protecting the identity of the patient and the fact of her visit. Some teenagers will not go to a clinic in a highly observable location where peers or parents' friends might see them enter.

In our visits, we found confidentiality was occasionally endangered by inadequate clinic facilities. For example, at one rural clinic in North Carolina, interviews were conducted within hearing distance of the waiting area, and examining rooms were separated by only a cloth curtain (see fig. 4-2). In commenting on a draft of this report, North Carolina said that although a number of county health departments have new or expanded facilities, this situation is not unique.

FIGURE 4-2

CLINIC EXAMINATION ROOM USED FOR FAMILY PLANNING AND MATERNITY AND INFANT CARE CLINICS. NOTE THE LACK OF PRIVACY AFFORDED PATIENTS BY THE CURTAIN EVEN IF CLOSED.



SMALL MEDICAL SUPPLY ROOM WHICH ALSO SERVES AS A PATIENT INTERVIEW ROOM DURING EXAMINATIONS.

FIGURE 4-2

HALLWAY ADJACENT TO INTERVIEW AND EXAMINATION ROOMS. NOTE THE CLUTTERED CONDITIONS. THIS BECAME EVEN MORE CROWDED ON CLINIC DAYS WHEN PATIENTS WAITED IN THIS AREA.

INTERIOR WALLS OF HEALTH DEPARTMENT. NOTE PEELING PAINT AND PLASTER WHICH WAS VISIBLE SEVERAL PLACES THROUGH OUT THE BUILDING.

Community, parent, and provider attitudes hinder adolescent use

Outreach to and education of adolescents have often been hindered by conflicting attitudes of providers, school boards, parents, and others. HEW produced a study in 1978 on many of these problems, as did one of the contractors in 1976. A discussion of the major problems follow:

Outreach is often limited

In some cases, family planning clinics or health agencies have tried to work with schools but failed through lack of support from school board officials, individual schools, or the community. For example, the MCH director in the District of Columbia attempted to develop working relationships with the District's school board and several individual schools. She was able to work with some schools, but others have refused, and she has been unable to gain the support of the school board.

In California, officials of two school districts visited said their districts did not work with health or family planning programs because the providers take an extreme position on sex education. The director of a family planning program in Kern County, California, said his organization has been unable to work with the school system because of community and school board resistance. His staff has worked with some individual schools, but only informally, on a case-by-case basis, and at the request of individual teachers. According to a Los Angeles Unified School District official, a similar situation exists in his area.

Health education provided by family planning clinics is often inadequate

Patient education, though it varies widely among clinics, generally consists of birth control methods, medical history review, preparation for pelvic examination, and selection of contraceptives. Many people interviewed during the HEW study criticized the health education provided by these clinics because it excludes or superficially covers such topics as individual values or the hazards of pregnancies.

Especially lacking is education aimed at the general public--community groups, churches, and parents. Many clinic officials hesitate to publicize their services, especially those for teens, for fear of arousing negative reactions from the community.

EDUCATION'S ROLE IN PREVENTING TEENAGE PREGNANCIES

Comprehensive data are not available to demonstrate the effectiveness of education on the prevention of teenage pregnancy. Nevertheless, many health and educational professionals and parents believe that teaching youngsters about family life, including sex education, is critical to pregnancy prevention and health promotion. Although few seem to disagree with this belief, much controversy exists over who should provide this education, what information should be taught, when and to whom it should be provided, and how it should be provided. Until this controversy is resolved, it appears that progress will be slow.

Many believe that public schools should teach family life and sex education. However, many schools provide little or no such education. Barriers include: community resistance, lack of resources and information, and limited coordination among schools and family planning and other health care providers. More technical and financial assistance from a more coordinated approach by HEW could help interested communities desiring to develop and implement family life education programs but which lack funding, trained instructors, or know-how to do so.

In the longterm, the Congress may have to determine the appropriate Federal role in helping States or communities develop or implement family life education programs. One possible approach would be to earmark funds in existing programs for this purpose.

Many promote family life education in the public schools

Many educators and health officials feel that family life education is a vital part of teenage pregnancy prevention:

--State MCH directors consider additional health education and preventing unplanned teenage pregnancy as high priorities for improving pregnancy outcome.

--The health education coordinator for a rural Southern school system believes that family life education should be taught in his schools when the students are at an early age.

--According to a 1978 HEW study, family planning services and teenagers see the school system as the most critical (and controversial) link in community efforts to prevent adolescent pregnancy.

Rural and urban educators often agree on the appropriateness of family life education. Directors of an urban school system in Virginia feel their students need such education, and Mississippi school officials say sex education in the schools would prevent unwanted pregnancies more than any other program. The latter group believe sex education would be presented in the schools best through a "family life educational approach."

Several California school systems have established such educational programs in the hope of reducing teenage pregnancy. The San Francisco Unified School District participates in an HEW-supported program directed at the adults who are important in a teenager's life. "Project Teen Concern" tries to prepare teachers, school counselors, parents, and staff members at youth-oriented community agencies to help young people make responsible decisions during the transition from childhood to physical and emotional maturity. An evaluation of the project concluded that it was premature to gauge its effects on venereal disease and teenage pregnancy; however, preliminary evidence indicated that the program has reduced venereal disease among teenagers.

The Compton Unified School District, which serves the region of Los Angeles County with the highest rate of teenage pregnancies, was testing a sex education program. The "Responsible Sexuality Module" uses a family life approach: sexuality is discussed from social, familial, and individual points of view.

The Santa Cruz School District was working on a project to sensitize teachers and is developing a sex education curriculum. The District hoped to build a package that other school districts in California can use.

These three educational models had strong community support. "Project Teen Concern," for instance, was received enthusiastically by parents, teachers, and students. A recent HEW-funded study (MATHTECH Inc., July 1979) identified several other exemplary school sex education classes and programs in different parts of the Nation. (See p. 78.)

Barriers to providing family life education in the public schools

Despite the testimonials of educators and health officials and the successful reception by such communities as the three in California, comprehensive family life or sex education occurs in relatively few public schools. Several States prohibit by regulation the teaching of such courses, while others leave the decision up to the local school boards. As a result, very few teenagers are reported to have easy, guilt-free access to such vital information. In St. Louis, for instance, the city offered only one course--in the 7th through 10th grades--on sex education. In Mississippi's public schools, only 3 percent of the students in the 7th to 12th grades had a family life education course during 1977-78.

Such courses are few for various reasons--community resistance; lack of resources, personnel, and information; limited coordination; and lack of Federal and State leadership.

Community resistance

As HEW has noted, the continuing opposition of parents, school administrators, and teachers is a major barrier to providing fully integrated sex education in the public schools. Communities vary greatly in their knowledge, understanding, support of, or resistance to family life education. School and health officials have said that under these conditions no curriculum could be developed which would satisfy everyone.

Examples of community resistance abound. When one Virginia school system tried to introduce a comprehensive sex education program, a number of citizens (including ministers and PTA members) appeared before the school board and voiced strong opposition. The school system ended up with a less detailed version of the proposed program. Similarly, the word "sex" is still taboo in most Mississippi communities according to a family planning official. A family planning director in that State, said that efforts to introduce sex education in one school district resulted in a public outcry that set the school system back 100 years. One North Carolina educator feels that parents in his rural district are not ready to accept sex education in their schools.

Lack of resources and personnel

Education and health officials cited insufficient resources and lack of trained personnel as other barriers to family life education in public schools. Funding limitations afflict many school systems and establish their priorities.

In Los Angeles, priority for health education is very low, averaging 2 percent of the high schools' budgets, and sex education is only a small fraction of that 2 percent. School districts have approached the Los Angeles Regional Family Planning Council requesting support for family life education, but the council estimates an additional $300,000 to $400,000 would be needed to fund such programs above and beyond the present budget. A North Carolina health official attributed the meager amount of sex education in that State's schools to a lack of resources. Health officials in another State also reported a lack of resources as hampering family life education in the schools.

The absence of instructors qualified to teach such courses also hinders effective family life education in schools. A Virginia State education official ascribed the lack of family life classes to a lack of qualified instructors. Another educator in the District of Columbia stated that teachers need more training in these subjects before they can communicate successfully with students. According to an official with the District of Columbia Medical Society, there seems to be no funds available to train teachers in family life courses.

An HEW task force study agrees with these officials; it found that some teachers are not comfortable with their own sexuality, much less with teaching the subject, so they must be carefully screened and thoroughly trained to teach sex education.

Lack of leadership

Most State education departments provide local school boards little positive leadership in health education programs. Few States reportedly mandate some form of family life or sex education. According to a recent HEW-funded study (MATHTECH, July 1979) only two States require sex education in the schools. In States where family life or sex education is not prohibited by regulations, the local school authorities are generally responsible for deciding whether to include such classes in their curricula.

The lack of emphasis by school authorities has resulted in limited or inadequate family life education. For instance, Virginia has had a system of sex education in some public schools since 1954--the school systems develop their own programs and submit the material to the State for approval. However, only about 16 of the 141 school systems in the State (or about 11 percent) have developed family life programs.

Federal leadership is just as weak. Although HEW's Office of Education provides funds that can be used for family life programs in the schools, no Federal program specifically earmarks funds for such school courses. Relatively little HEW funding given to States for elementary and secondary education is used for sex education.

HEW's position is to let each community decide what it wants to do in the area of sex education and then try to assist it. In November 1978, an official with HEW's Office of Education told us that the Federal Government had never made a comprehensive study of the status of family life education in the schools. According to this official, if an organization requests help from the Office of Education in setting up a program, HEW offers technical assistance, printed material, and suggestions--but no funds. He feels that the Federal Government could and should provide greater leadership for family life education, especially in the area of:

--Curriculum development.

--Service training of instructors.

--Research and its utilization.

--Evaluation of existing programs.

Health officials also feel that the Federal Government should take a more active role in supporting family life courses. In commenting on a draft of this report, HEW said that it agreed with the need to develop comprehensive family life and sex education courses and programs in both formal and nonformal settings. HEW stated that its objective is to provide young people, their parents, and communities with tested and proven approaches, materials, and methods, and with relevant and accurate information to help them in developing values that promote healthful decisions and responsible relations with others. Further, HEW said that it is acting as a catalyst to support innovative approaches, including

the development and demonstration of model programs and curricula. HEW pointed out that one of its contractors recently (July 1979) completed an extensive survey of the status of family life and sex education in the schools. In late fiscal year 1979, HEW's Center for Disease Control funded a contract for the development and evaluation of several ongoing sex education programs and funded other sex education related activites.

SOME PREGNANT TEENAGERS ARE BEING DENIED CONTINUED EDUCATION IN THE SCHOOLS

Despite Federal regulations confirming the right of pregnant students to an education, some teachers and counselors still actively encourage students who are pregnant or who are mothers to leave school. According to one of its officials, HEW's Office for Civil Rights, which is responsible for monitoring and enforcing compliance with this Federal requirement, performs no routine, systematic monitoring in this area. It has only investigated a few specific complaints. The Office has not been able to develop a routine monitoring system because no information network comprehensively reports which school systems may exclude pregnant students.

For most pregnant teenagers, though, it is a lack of special school programs rather than outright exclusion that causes them to leave the school system. For example, the States visited have no systematic programs for pregnant teens to continue their education; such matters are generally left up to individual school systems. As a result, some schools have adopted effective programs and others have not. Those systems without such programs are experiencing high dropout rates among pregnant teenagers, especially in rural areas. According to a Missouri official, most pregnant teens in rural areas are forced to drop out because of community pressure. A North Carolina county survey of rural school dropouts for the 1974-75 academic year showed that 29 percent left because of pregnancy. In California, HEW region IX officials described the dropout rate among the pregnant teens and teen mothers as "astronomical," and pregnancy in the Los Angeles Unified School District was the main reason for young girls leaving school.

In those school systems visited that have adopted special schools for pregnant girls, the teens seem to be receiving the necessary medical care and education and are also showing

reduced dropout rates. Students in Missouri and Virginia special schools are required to take family living classes, in addition to the regular academic courses. These courses include prenatal and postnatal care, child care, and obstetric methods. The schools also ensure that the pregnant teens receive adequate prenatal care. School officials in Kansas City have found that teenage mothers in the city's special school setting are returning after delivery at a rate of 95 to 97 percent. According to school authorities in Richmond, pregnant girls in the special school are more apt to graduate than pregnant girls at other schools in the system.

CHAPTER 5

PRENATAL AND WELL BABY CARE SERVICES ARE NOT ALWAYS AVAILABLE OR ACCESSIBLE

Prenatal, postpartum,.and well baby care are essential to ensuring an optimal pregnancy outcome and maintaining a healthy mother and infant. If these services are lacking or inadequate, the pregnancy can be adversely affected. Many women and infants, particularly those of low income, still do not receive adequate, timely prenatal or infant care. This situation arises from several causes: limited funding of public health services; failure of many physicians to accept Medicaid patients because of low reimbursement rates or other reasons; limited or unevenly distributed supply of health professionals; inability of the mother to obtain or pay for care; lack of coordination among agencies and programs and between the public and private health sectors; lack of motivation by many to seek care; and insufficient health education, information, and outreach efforts to convince people of the importance of such care.

Federal, State, and local agencies have expanded and improved access to maternity and infant care, although the degree of effort varies. The Federal Government, through programs such as Medicaid, MCH, CHCs, NHSC, and WIC, funds a substantial amount of the prenatal and infant care and nutrition provided to low-income persons. These efforts undoubtedly help account for the significant improvements in pregnancy outcome in recent years. However, the Federal Government should ensure that its resources are efficiently combined with State, local, and private efforts to broaden use of prenatal and infant care. The Federal Government, through the MCH, WIC, and health planning programs, should be more aggressive in seeing that State and local areas plan and deliver prenatal and well baby care in a systematic manner, which includes a maximum integration of public and private health resources. Also, HEW should

--ensure that its project grant programs tie into State, regional, and local plans and give appropriate emphasis to prenatal and well baby care;

--consider what action must be taken to widen access of low-income women to such care through Medicaid, health capacity building, MCH, or some form of national health insurance;

--develop ways to facilitate use of NHSC personnel in areas experiencing significant pregnancy outcome problems where State or local governments are willing but apparently unable to sponsor them; and

--encourage greater use of nurse-midwife-physician teams by its project grantees and others in those areas where people lack access to prenatal or well baby care.

WHAT IS PRENATAL CARE?

"Prenatal care" is the complete and adequate health supervision of the pregnant woman to maintain, protect, and promote her physical and emotional health and well-being. Early, continuous, and comprehensive prenatal care ensures that

--the expectant mother maintains good health and proper diet;

--any medical or other problems are detected early and promptly managed (such as hypertension, anemia, excessive cigarette smoking, or substance abuse); and

--the expectant mother is educated about health care and nutrition during pregnancy, childbirth, and infant care.

Early initiation of prenatal care is critical to the health of mother and child. Child health experts generally agree that prenatal care should begin during the first 3 months of pregnancy.

Prenatal care standards are those of the American College of Obstetricians and Gynecologists. According to these standards, a pregnant woman should begin prenatal care during the first trimester and ideally should be seen at least once every 4 weeks for the first 28 weeks of pregnancy, every 2 weeks until the 36th week, and weekly thereafter--13 visits for a normal 38-week pregnancy. In practice, nine or more prenatal visits have been defined as a minimum standard for pregnancies of 36 weeks or longer.

To "quickly" measure adequacy of prenatal care, HEW and other health authorities often use the time of the first prenatal visit, considering prenatal care inadequate when begun in the third trimester or not at all. Others, however, sometimes use different measurements. For example, Missouri

health officials consider prenatal care to be adequate when begun before the fifth month of pregnancy. In this report, prenatal care will be referred to as inadequate when it is initiated in the third trimester or not at all, except when specifically noted otherwise. (This criteria is used here as a rough indicator and is not intended to serve as a medical standard of care.)

Quality of prenatal care services is as important as timing, frequency, and number of visits, but it is difficult to evaluate quality in the absence of material data. BCHS often measures the quality of prenatal care by when care is initiated. Its objective for MCH programs is that at least 75 percent of the women receiving maternity care be seen and served in the first trimester and no less than 95 percent in the second trimester.

"Postpartum care" is the mother's preparation to care for herself and infant after delivery. It is generally considered part of the total health care surrounding the birth and is generally included by physicians as part of the prenatal and delivery cost. The postpartum period offers the opportunity to deal with medical and social problems which may affect the course of future pregnancies, child development, or future family health. An important part of the postpartum care is the examination about 6 weeks following delivery which should include:

--Internal history.

--Weight and blood pressure and blood test.

--Urine examination for protein.

--Breast, abdominal, and pelvic examination.

--Family planning counseling and initiation to patient's method of choice.

--Assessment of infant care plan.

--Assessment of emotional, social, and family problems.

--Checking or examining for several other conditions.

Further reference to prenatal care in this chapter will generally include postpartum care.

Prenatal care improves pregnancy outcome

HEW data indicate that women who receive early and frequent prenatal care have better pregnancy outcomes than those who do not. In a New York City study of 142,000 live births, patients who received care in the first trimester had an infant mortality rate (deaths per 1,000 live births) of 6.6, compared to 9.7 for those starting care during the second trimester. Patients who had not seen a physician prior to delivery or for whom no data were available had an infant mortality rate of 16.1. Infant death was more than twice as high for mothers who had four or fewer visits as it was for those with nine or more visits. An analysis of prenatal care for North Carolina's approximately 85,000 births in 1974 revealed similar results. Patients who received no prenatal care had an infant mortality rate of over 100. The rate for those women who started care during the first 5 months or had six or more visits was considerably lower, with mortality rates of 17.5 and 11.8, respectively.

Women who receive inadequate prenatal care are most likely to have underweight babies (a characteristic associated with nearly two-thirds of infant deaths), although other factors (such as mother's age, education, socioeconomic level, etc.) also influence pregnancy outcome. Although it is not always known which factor has the greatest influence, authorities continually stress the critical nature of prenatal care. State MCH directors responding to our questionnaire indicated that expanding or improving prenatal care services was their highest priority for improving pregnancy outcome. Also, according to BCHS,

> "Few health activities have as much potential for promoting health at crucial points in the life cycle. While projects may find the delivery of these services expensive, their effective provision can ultimately reduce some health care costs and can greatly improve the quality of life for many patients."

Risk assessment and management

One aspect of prenatal care that has gained attention and support is "risking." This involves assessing, early in the pregnancy, the degree of risk an expectant mother has for adverse outcome; developing a plan for managing the pregnancy and risk; making appropriate arrangements and referrals for labor, delivery, and care of the newborn;

and establishing systems of care based on risk-handling capability. Although some pregnancies do not become high-risk until labor begins, several high-risk conditions can be identified and dealt with before labor.

WHAT IS WELL BABY CARE?

"Well baby care" is preventive health care of children during the first year of life and the treatment of any problems arising then. Like prenatal care, well baby care ensure timely prevention, detection, and treatment of problems. Such problems as nutritional deficiencies or metabolic disorders can be detected early and corrected or their severity lessened. Well baby care also helps to ensure that infants receive proper immunizations and develop properly.

The American Academy of Pediatrics has devised well baby care standards: checkups by a physician or other health personnel should be made at least every 4 to 6 weeks during the first 6 months and every 2 months during the second 6 months--a total of six to nine visits during the first year. Checkups should include:

--Developing and maintaining a patient history.

--Performing physical examinations.

--Taking various measurements (height, weight, head circumference, etc.).

--Looking for developmental landmarks (eye and limb movement, smiles, grasping of objects, etc.).

--Discussing various subjects with the parent, such as what to look for during normal child development.

PRENATAL AND WELL BABY CARE ARE OFTEN INADEQUATE OR NONEXISTENT

Many women--often those with high-risk pregnancies--receive late or inadequate prenatal care. Teenagers, women 35 or older, those bearing their first child, unmarried women, women who do not complete high school, and nonwhite mothers are very likely to receive late or inadequate prenatal care and experience poor pregnancy outcome.

In 1976, 5.6 percent (158,000) of the women having live births in 44 States and Washington, D.C., received inadequate prenatal care. More than 25 percent of the women having live

births received less prenatal care than the minimum recommended by the American College of Obstetricians and Gynecologists. The rate of inadequate prenatal care varied considerably among and within States, ranging from 4.5 percent in North Carolina to 10.2 percent in the District of Columbia (however, timing of initial prenatal care was indicated for only about 69 percent of the births in the District).

For different population segments, the lack of care is even more acute. For example:

--In 1976, the national proportion of nonwhite mothers receiving inadequate prenatal care (9.3 percent) was about twice the rate for whites (4.6 percent).

--Among States visited, the percentage of blacks receiving inadequate prenatal care in 1976 ranged from 3.7 in Missouri to 10.8 in the District. From 1972 to 1976, the percentage of adequate prenatal care in Missouri (defined by that State as care begun before the fifth month of pregnancy) averaged 67.6 for the State, but ranged from 32.5 to 55.1 among the six counties in the Bootheel area.

--The percentage of nonblack minorities receiving inadequate prenatal care was high in those States with large Indian populations, such as Arizona (26.3), South Dakota (24.7), and Oklahoma (15.1).

In the States we reviewed, the problem was clearly illustrated: in some areas women were reportedly arriving at hospitals in labor, having received little or no prenatal care. For example, the Director of Obstetrics at the University of Mississippi Medical Center said that about 15 percent of the women delivering at the hospital arrive with no prenatal care, and many others come with little care, although the situation is improving. In Missouri, a May 1977 profile of the WIC caseload in the Bootheel area showed that 50 percent of the mothers had no personal physician or prenatal care.

Though national data are not readily available, there is indication that some infants receive inadequate or no care. This is illustrated by the high incidence of broken appointments for well baby clinics in some areas. In Halifax County, North Carolina, health officials stated that many mothers do not recognize the need for well baby care and often fail to keep such appointments. In California, a

large proportion of the women delivering in Los Angeles County hospitals were not returning to clinics for well baby care. In our recent review of WIC, we found that while the majority of WIC recipients sampled were receiving health services, we could find no evidence that some women and infants participating in the program in three States--Illinois, New York, and Washington--were receiving such care.

FUNDING OF MATERNITY AND INFANT CARE IS INSUFFICIENT

Federal funds, through such programs as MCH or CHCs, help State and local governments and private nonprofit organizations provide maternity and well baby care to many persons. Maternity and infant care projects funded under the MCH program served about 311,000 persons in 1977. However, resources from these programs or from State or local governments could not meet all needs. Many local health departments and CHCs provide limited or no prenatal and well baby care; some counties do not even have a public health department.

Insufficient resources eliminate or restrict access to prenatal and infant care by limiting (1) the number of hours or times some services are offered, (2) the types of services available, or (3) the size and type of facilities, which may discourage some persons from seeking care.

Lack of care

We found several instances where no or limited maternity or well baby care was available:

--Health departments in 20 of North Carolina's 100 counties provided no maternity care; 9 of Missouri's 115 counties/cities had no local health unit, and 21 others had very few services--employing only one nurse and perhaps some support staff. Only one of the six county health departments in the Bootheel area of Missouri provided prenatal care services.

--The health department of one Virginia city visited provided no maternity care, even though high infant mortality in the core city area is reported as a major public health concern. Also, local hospitals with maternity clinics would not provide prenatal care to women who could not pay. City health department officials recognized the need for these services,

but said that prenatal care is not one of the services mandated by the State; before the city could provide these services, it either would have to curtail services currently being provided or would have to receive additional resources. A similar problem could develop in California as a result of the recent reduction in property taxes (Proposition 13). According to California health officials, the reduction in health service funding resulting from Proposition 13 would affect prenatal and postpartum care, because they are not State-mandated.

--According to BCHS data for 1977, MCH-funded maternity and infant care projects in nine States reported serving no infants. The St. Louis county project visited was one of the projects which served no infants because of insufficient funding. Other county clinics were reportedly providing this type of care.

--Some CHCs visited offered no prenatal care.

--California's fiscal year 1978 budget provided funding for 39 of 58 counties.

Limited hours of operation

The limited hours or times many clinics offer prenatal or well baby care may be inconvenient for some women because they work or cannot leave their children. Many health officials believe that more women would seek maternity and well baby care if it were offered at more convenient times. For instance, State MCH officials described prenatal care clinics in North Carolina as "full to overflowing," and one county project we visited bore this out. Officials at this project said that employers in the county threaten to fire mothers who continually miss work to go to the health department. According to the State Division of Health Services, the ability to offer services at night or on weekends is limited by funding available for extra staff or overtime and that this situation applies to other persons besides health department patients.

In California, two rural CHCs visited had limited part-time coverage by one obstetrician and relied on nurses to provide most of the prenatal care. The manager of one center said that, in general, he did not believe this diminished the quality of care, but some high-risk women served by the center might not be getting the appropriate specialized care. Because many private physicians would not accept Medicaid

patients both centers had greater demand for prenatal care than they could handle. One center referred women elsewhere or just refused to provide prenatal care. A manager at the other clinic said that many mothers do not bring their infants back to the center because well baby care is offered only 1 day weekly, and this time may be inconvenient.

Long waiting times

Some women are discouraged from seeking maternity or well baby care or may not receive such care promptly because they have to wait 7 weeks or more for their initial visit or for several hours after they arrive at the clinic. Delays in obtaining appointments for the first visit may keep some women from getting prenatal care until late in their pregnancies:

--Women seeking prenatal care from some California maternity clinics had to wait 7 to 10 weeks between the time they registered for care and their first clinic visit because of heavy demand and limited capacity. (A CHC located near one of these clinics was underused and offered no prenatal care.)

--According to a recent HEW report, women seeking prenatal care at three Department of Human Resources clinics in the District of Columbia had to wait 2 to 8 weeks for their first visit. (In commenting an a draft of this report, the Department informed us that the waiting time for an appointment at two of these clinics has been reduced to less than 2 weeks.)

--Women seeking prenatal care at a CHC in rural California generally had to wait 2 months for their initial visit, although special arrangements were made if a problem developed.

--Some California and North Carolina clinics require women to arrive early in the day so that no time is lost through late arrivals and broken appointments. The problem is exacerbated by limited staff and large patient loads. As a result, the women must spend several hours to an entire day waiting for services. Some health officials believe that participation in the clinics would improve if patients were given appointments. The Richmond, Virginia, maternity and infant care project experienced a significant increase in clinic participation when some of its clinics began operating by appointments. (See p. 196.)

Limited types of services

Limited funding restricts the types of service many health care providers can offer: outreach, supplemental food, transportation, environmental health services, and health education. For example, Mississippi prenatal and well baby care services are limited in many areas because of insufficient funding. Comprehensive health services are usually provided only in those areas served by special projects, such as maternity and infant care or ICH. According to the State Director of Family Health Services, many Mississippi counties received MCH formula grant funds, but the amounts were small and limited the services provided. HEW special project grant funds enabled the State to augment services in several counties. According to a local health director, some areas also experienced environmental health problems, such as sanitation deficiencies, for which there was insufficient funding to correct such problems.

Supplemental food

Many low-income women or infants lacked access to WIC. In Virginia, WIC was available to all cities and counties, but funding was available to serve only 63 percent of those eligible. Only 72 of Missouri's 115 counties/cities, and 41 of Mississippi's 82 counties, participated in WIC. An MCH-funded maternity clinic in Jackson County, Mississippi, did not participate in WIC because, according to the State Board of Health, it has not yet qualified under the State's priority system. The WIC agency serving the Bootheel area had a waiting list of about 400. Recent increases in WIC funding (to $750 million in fiscal year 1980) should help make supplemental food available to more persons.

Outreach

Many health care providers offer little or no outreach to attract patients, nor do they follow up on patients who miss appointments. For example, officials at the Halifax County maternity and infant care project told us that they barely had enough staff and facilities to serve those patients actively seeking care. They had neither the staff nor the time to solicit patients who did not seek care and were often unable to follow up on patients who missed appointments.

Limited outreach and followup also occurred in the District of Columbia for many maternity patients who missed clinic appointments or for those not seeking care, although in November 1979, the District informed us that this situation

has improved. St. Louis County employs a health educator and two health aids through the family planning budget who act as outreach workers in the community and in schools. Although the patient load increased in 1977, less than one-third of the women receiving prenatal care at the St. Louis County Maternal and Infant Care project initiated care during their first trimester. This was a 3-percent decline from 1976. In addition, the percentage of low birth weight babies born to project patients increased from 7.1 in 1975 to 9.5 in 1977. The project planned to expand services in 1979 to help alleviate overcrowding and prolonged waiting times for prenatal appointments at a clinic in the North County area. According to officials of two CHCs visited in California, they provided no outreach or only some outreach for pregnant women because of insufficient funds and an overcrowded caseload.

Transportation

Several health officials cited the lack of transportation as a significant barrier which prevents low-income persons from obtaining health care, particularly in rural areas. For example, many rural North Carolina and Mississippi residents lack transportation to health clinics, which are often far from their homes. According to the director of one maternity and infant care project serving three Mississippi counties, the project lacked funds for helping persons get to and from the clinic. Some agencies send health care personnel to outlying areas to help overcome this problem, but these are usually limited to a few days or hours weekly at each site.

Health education

Although many health care providers do have skilled health educators, a number of providers offer no health education or only limited education because of limited funding. For example:

--Some clinics do not have skilled health educators but rely on nurses, social workers, outreach workers, or others to provide health education.

--Local health departments are often unable to attract skilled health educators because most positions come under State merit systems; therefore, hiring ceilings and salaries are set and not negotiable. A survey conducted by the Eastern Virginia Health Systems Agency and reported in its October 1978 draft plan showed only one of five budgeted health educator

positions filled in the five Public Health Districts of Tidewater Virginia.

--In California, State MCH officials acknowledge that, in most clinical settings, health education receives very low priority, compared to service delivery. Skilled health educator positions are often not filled because of lack of funds and reluctance to fill federally funded project positions because of concern that the Federal project could terminate. According to one study in California, about half of those women having hospital births had not received childbirth education classes.

MCH requirement for comprehensive services

MCH officials in Mississippi, California, and Virginia believed their programs would be more effective if they did not have to make comprehensive MCH services available for relatively small segments of the population in need, as HEW regulations require. Regulations governing maternity and infant care projects require that such services be available to those in the area served by the project and that, in the event of insufficient funding to provide health care to all persons in need, cutbacks be made in the numbers of persons served, not the comprehensiveness of services offered. These State MCH officials believe that they would have a greater effect on pregnancy outcome if they could use the funds tied up in these projects to provide basic services to more persons, rather than comprehensive services to a smaller number.

LACK OR MALDISTRIBUTION OF HEALTH CARE PROFESSIONALS

Many persons, particularly high-risk pregnant women, have difficulty gaining access to prenatal or well baby care because many areas lack obstetricians or pediatricians. Some areas have more than they need, while others have nothing, particularly rural or inner city areas. The problem is intensified because (1) many general practitioners do not provide obstetrical care, reportedly because of rising malpractice insurance costs or limited obstetrical training, (2) many obstetricians are decreasing or discontinuing their obstetrical services and switching to gynecology because of malpractice insurance costs or other reasons, and (3) nurse-midwives are in short supply or are restricted or discouraged from practicing in many areas. Also, many physicians refuse to accept Medicaid patients.

HEW programs have helped increase the supply of obstetricians, pediatricians, nurse-midwives, and other health professionals. The NHSC program is also helping to alleviate the problem by placing many of these health professionals in high infant mortality areas. However, a recent HEW policy (see p. 41) may hamper the ability of many State- and local government-operated health clinics from receiving needed NHSC personnel. In addition, HEW may be able to help expand the availability of maternity and well baby services by: (1) promoting greater use of nurse-midwife-obstetrician teams, (2) providing additional funds for nurse-midwife training, and (3) working with State or local governments and professional organizations to eliminate obstacles to using nurse-midwives, such as physician opposition or lack of third-party payment coverage. Expanding use of other types of nurse practitioners, such as obstetrical or pediatric nurses, should also help.

Many areas have no resident obstetricians or pediatricians

The lack of an obstetrician or pediatrician in an area does not necessarily mean that residents of that area receive no health care, but it does make it more difficult for them to obtain care, particularly if they are high risk or have complicated problems. It also means that many must often rely on publicly supported clinics for care if they are available. The following illustrates the situation in several areas.

--Thirty-nine percent of Virginia's 136 counties/cities had no obstetrician or pediatrician, and 25 percent lacked both.

--Seventeen of California's 58 counties had no obstetricians or pediatricians. Other California counties have a live-birth to obstetrician ratio as high as 338:1. In 1977, Kern County, with a population of about 355,000 and 6,750 births, had 20 practicing obstetricians and 8 general practitioners who practiced obstetrics. Almost all of the obstetricians were located in one community.

--According to the director of Mississippi's MCH program, although larger communities in the State had sufficient supply of obstetricians and pediatricians, many rural areas did not because of such factors as small population, few births, and poor economic conditions.

--The physician shortage and inadequate care in one rural county as described by a North Carolina physician is typical of several in the eastern part of that State: The county has no hospital, and before the start of a CHC (in 1972) there was only one aging general practitioner for the entire county. Prior to the start of the IPO project in 1977, few women received even minimal maternity care. The county--rural and poor--has a population of about 15,200 and about 200 live births annually. Between 1972 and 1976, it had a perinatal mortality rate of 36.4.

--Seventy-nine (or 69 percent) of Missouri's 115 counties/cities had no medical doctors specializing in some area of obstetrics, gynecology, or pediatrics.

Obstetricians are shifting from maternity care to gynecology

Obstetricians in some areas have discontinued or decreased care of maternity patients and shifted more into gynecology, reportedly because of the high incidence of obstetric malpractice suits and the cost of such insurance. This problem was cited in the District of Columbia and California but appeared most acute in California. For example:

--Many California obstetricians with relatively small numbers of maternity patients were discontinuing prenatal care or delivery and shifting to gynecology because of the high cost of malpractice insurance. We were told that the cost for such insurance for obstetricians in that State ran as high as $41,000 a year. Many general practitioners in the State were also refusing to provide prenatal care or deliver babies because of this problem.

--According to the Chairman of the District of Columbia Medial Society's Committee on Maternal and Child Health, many obstetricians are discontinuing deliveries and concentrating more on gynecology because of the high cost of medical malpractice insurance and the increasing chances of malpractice suits. The problem is particularly acute for low-income patients because many of them are high risk and require greater care.

Limited use of nurse-midwives

Although growing, the use of nurse-midwives in the United States has been limited. However, nurse-midwives seem to have been successful where they have practiced. Greater use of nurse-midwives appears to be one way to fill some of the gaps in maternity and well baby care and such other services as family planning. However, their use as obstetrical service providers has only recently been accepted by the public and some of the medical profession. The acceptance and use of nurse-midwives varies among States, because of their short supply, physician resistance, lack of funding and qualified instructors for education and training, restrictive State licensing, or limited third-party payments.

The Federal Government has done much to help educate and train nurse-midwives and to help several State MCH agencies to obtain and pay them. However, more Federal funding for education and training and more aggressive action by HEW to encourage its own health capacity building grantees and others to use nurse-midwives seem to be one alternative for enhancing access to health care for many low-income women. Also, HEW could try to help eliminate or reduce barriers to the clinical practice of nurse-midwives and help fill gaps existing from obstetrician (1) shortages, (2) maldistribution, or (3) refusal to accept low-income or Medicaid patients.

What is a nurse-midwife?

A "nurse-midwife" is a registered nurse who has obtained additional education, training, and clinical experience in managing the care of essentially healthy and normal mothers and infants throughout the maternity cycle through a program approved by the American College of Nurse-Midwives. In the United States, nurse-midwives in clinical practice generally work in association with and under the supervision of a physician, usually an obstetrician. They provide prenatal and postpartum care and family planning, manage labor and delivery, and care for newborns immediately after birth; some provide well baby care. They refer high-risk, complicated, or problem cases to physicians. Most nurse-midwives in the United States are employed by hospitals and public health departments, although they also work elsewhere, with private physicians and Department of Defense hospitals. According to the American College, in 1976 a nurse-midwife's salary in clinical practice averaged about $16,200.

Few practice in the United States

Relatively few nurse-midwives practice in the United States. According to the American College of Nurse-Midwives, in 1976, (the most recent year for which data were available), the 521 nurse-midwives known to be in clinical practice delivered about 33,600 babies, or only about 1 percent of those born in the United States that year. Almost all deliveries by nurse-midwives were in hospitals.

Successful use in the United States

Health officials have increasingly recognized the contributions nurse-midwives can make in improving access to care for low-income families, particularly in areas with significant problems. They have been successfully used in several areas. By handling low-risk cases, they have enabled obstetricians to concentrate more on high-risk cases needing specialized care and have provided skilled care, particularly to low-income women, who otherwise might not have received any prenatal care.

In addition, significant improvements in pregnancy outcome have occurred where nurse-midwifery services have been initiated. For example, the neonatal mortality rates decreased from 28.6 in 1973 to 12.0 in 1977 in one area in Appalachia that formerly had no skilled care before the nurse-midwives began practice. Health officials attributed the reduction almost totally to the nurse-midwives.

Increased use could help fill gaps

Greater use of nurse-midwives, along with physician backup, may be one way to help fill the gap between what State MCH directors see as one of the highest priorities for improving pregnancy outcome--providing more and better prenatal care--and the lack of access to skilled prenatal care. For example, Mississippi estimated it will need an additional 55 nurse-midwives through 1981 to provide clinic and hospital services for health department patients. The California MCH director also gave greater use of nurse-midwives a high priority for improving pregnancy outcome. His agency estimates that the State needs an additional 300 nurse-midwives and obstetrical nurses.

The following illustrates how some public health departments use nurse-midwives:

--Mississippi's Jackson County maternity and infant care project employs three nurse-midwives who handled an average of 26 deliveries each month. In addition to providing routine maternity care, they visit the patients' homes if they miss appointments and provide transportation to the clinic or hospital if patients have none. Prior to the inception of the nurse-midwifery program, the main hospital serving the area was delivering 10 percent of its mothers as "drop-ins," never seen before in the medical community and usually nonpaying, according to an HEW evaluation.

--In the city of St. Louis, nurse-midwives practiced at one of the city hospitals and in the city's health centers.

--The District of Columbia's public hospital has had a small nurse-midwifery program since 1973. In October 1978, we recommended that the District's Department of Human Resources consider expanding the use of nurse-midwives to community clinics, particularly in areas having insufficient resources and significant pregnancy outcome problems. HEW made a similar recommendation in 1978.

Many barriers impeded expansion of nurse-midwifery services

Several obstacles impede greater use of nurse-midwives: (1) a limited supply, (2) few training programs, (3) physician resistance, (4) nonavailability of obstetricians with whom to work, (5) reluctance of some nurse-midwives to practice in rural or other undesirable areas, and (6) restrictive State licensing or third-party reimbursement practices.

Physician resistance

Despite the 1971 official endorsement by the American College of Obstetricians and Gynecologists of nurse-midwives' ability to assume full responsibility for uncomplicated maternity care under the general supervision of a qualified obstetrician, many physicians resist their practice. To illustrate, nurse-midwives sometimes have difficulty obtaining permission to practice in hospitals. For example, the executive director of one CHC in the District of Columbia told us that he had tried to hire a nurse-midwife but he could not find one willing to accept the job because the hospitals used by the center would not let nurse-midwives deliver babies.

The short supply of nurse-midwives and physician resistance is illustrated by North Carolina's experience in trying to implement its IPO project. It took the State over a year to find the first nurse-midwife for the project. Initial resistance of local physicians also had to be overcome, and they had to be convinced to provide backup support for nurse-midwives delivering babies.

Limited resources available for training

Despite the substantial amount of funding for nurse-midwifery training provided by the Government, sufficient funding has not been available to meet demand. More financial support for nurse-midwifery training programs and more qualified instructors for such programs are needed. For example, California estimated that it would cost about $4.5 million to train the 300 additional nurse-midwives and obstetrical nurses needed in that State.

According to the American College of Nurse-Midwives, 62 percent of the nurse-midwives in the United States received financial assistance from the Federal Government when they were enrolled in their nurse-midwifery training programs. In fiscal year 1978, at least three HEW programs provided financial assistance for nurse-midwifery training programs.

Table 5-1

Program	Number of students	Financial assistance
Nurse Practitioner Training	166	$1,451,200
Maternal and Child Health Training	87	1,389,050
National Health Service Corps Scholarships	17	187,000
Total	270	$3,027,250

Nurse-midwife education and training in the United States is limited because of some schools' admission policies, availability of nurse-midwife educators, and criteria for starting new schools. Competition for training is reportedly intense and class sizes are small. Only 24 institutions offering nurse-midwifery training programs in the United States had been approved by the American College of Nurse-Midwives. HEW representatives summarized the problem as follows:

--Chief, Nursing Section, Office for Maternal and Child Health: MCH has received inquiries from at least 10 schools, including 3 in California for nurse-midwifery training funds, but MCH had no additional funds available. MCH could also increase its funding support to expand training for 57 to 150 students at the six schools it already supports if funding were available. Aside from additional financial assistance, more qualified faculty are needed to expand training.

--Chief, Nurse Practitioner Training Program, Division of Nursing, Health Resources Administration, HEW: The lack of qualified instructors is the biggest inhibitor to expanding nurse-midwifery training programs.

--Chief, Health Service Scholarship Branch, Division of Manpower and Training, Health Resources Administration: The NHSC program could fill only 12 of its 25 new nurse-midwifery training scholarship positions it had funding for in the 1978-79 school year. He said that the NHSC scholarship program is not very attractive to nurse-midwives because (1) scholarships are only available for those seeking masters degrees, (2) many either do not want a masters degree or do not want to practice in health manpower shortage areas, and (3) other financial assistance is available for which service payback is not required. According to NHSC data, as of December 1978, it had approved requests for 33 nurse-midwives, but had only 9 available for placement in fiscal year 1979.

Lack of aggressive promotion by HEW

Although HEW's Health Services Administration has endorsed establishing and expanding nurse-midwifery services in programs it funds, it has not actively or aggressively promoted use of nurse-midwives by CHCs. According to NHSC's Chief Nurse Officer, most NHSC nurse-midwives have been placed in IPO projects and migrant health projects--few have been placed in other locations, such as CHCs. Greater use of nurse-midwife teams by capacity building grantees would make maternity care more accessible in those areas where women, particularly those who are poor, cannot easily obtain such services. Such an arrangement may even be less costly than relying solely on obstetricians where centers offer no or insufficient maternity or family planning services.

For example, one rural California CHC visited had obstetric residents from a local hospital on site 1 day each week to provide prenatal care and contracted with other obstetricians to deliver babies to center patients. General nurse practitioners provided prenatal care on those days the obstetrician was not on site. However, according to the center's business manager, the center could not meet the heavy demand for maternity services and had to turn patients away or try to refer them elsewhere. Also, its contractual costs for obstetrical care had increased significantly and it could not afford to pay more without a budget increase. The center was attempting to develop a nurse-midwife program to help meet demand, as well as to most efficiently use its limited funding.

NHSC HELPS BUT NOT ENOUGH

The NHSC progam has helped provide access to health care for many women and infants by placing health care professionals, including obstetricians, pediatricians, and nurse-midwives, in rural or urban areas lacking health care providers. However, several obstacles may limit the extent to which NHSC personnel will be placed in areas having the most significant pregnancy outcome problems.

BCHS has established a special initiative to place NHSC personnel in the first 13 States receiving IPO projects. (See p. 41.) It has also placed NHSC professionals in States under its basic program who work in the maternal and child health area. For example, as of August 1978, Mississippi had 42 NHSC personnel, of whom 18 were working in the maternal and child health area. An NHSC obstetrician placed in a CHC in a high infant mortality area in Washington, D.C., in 1978 enabled the center to expand its obstetrical coverage.

An NHSC obstetrician placed in eastern North Carolina as part of an IPO project provided obstetrical services to low-income women in six rural counties where they lacked access to such care. Preliminary data for one such county, for example, indicate that the project achieved significant improvement in pregnancy outcome.

HEW's December 1978 policy essentially requiring State or local governments to pay for NHSC personnel may limit their use in those States not among the first 13 to receive IPO projects.

The following information indicates the NHSC program supply and demand as of December 1978 for obstetricians, pediatricians, and nurse-midwives.

Table 5-2

NHSC Supply and Demand Data for Selected Medical Professionals as of December 1978

	Obstetrician	Pediatrician	Nurse-midwife
Approved request	34	34	33
Available for placement in fiscal year 1979	23	135	9
Scholarship recipients seeking specialty training	129	275	(a)

a/Not applicable.

Although it appears that enough obstetricians and pediatricians will be available at least in the short run, this is not necessarily true because NHSC physicians do not always want to go to areas requesting obstetricians or pediatricians. Furthermore, according to the Chief of the NHSC Recruitment Services Branch, about 20 percent of the scholarship physicians "buy-out" of the program. Also, almost all of the NHSC personnel shown as available for placement were volunteers, many of whom cannot be enlisted for service for a number of reasons.

One problem is that several obstetricians are foreign medical graduates who are unacceptable to some communities. He also said that the number of requests for obstetricians was probably artificially low because (1) uncertainty existed about whether or how much State and local governments would have to reimburse the Federal Government for NHSC personnel and about how much funding would be available for urban health programs and (2) the IPO initiative was new.

MEDICAID HAS NOT HELPED ENOUGH

Many low-income women and infants have obtained health care through Medicaid. Yet, many other women cannot obtain prenatal care from physicians in private practice either because they are not eligible for Medicaid or because physicians refuse to accept them. Moreover, many low-income women must rely on already overburdened public health departments for prenatal and well baby care.

In addition, State Medicaid payment rates are often insufficient to cover the cost of prenatal or well baby care provided by health departments, maternity and infant care projects, or CHCs, resulting in a situation whereby MCH or CHC funds, in effect, subsidized Medicaid patients, thereby limiting services extension to those in need but not covered by Medicaid. Furthermore, some MCH-funded or other health clinics do not bill or collect Medicaid reimbursement for care provided to eligible patients.

Low Medicaid payment rates

Problems affecting access to prenatal and well baby care as a result of Medicaid payment rates or practices are described below. (Also, see app. V.)

Physician problems

HEW regulations (42 C.F.R. 447.204) require that State Medicaid payments be sufficient to enlist enough providers to ensure that services are available to eligible persons at least to the extent that they are available to the general population. However, many physicians refuse to accept Medicaid patients because of low reimbursement rates, paperwork requirements, payment delays, or for other reasons. Obstetrician refusal to accept Medicaid patients was a major problem in each of the States visited.

According to the State Director of Family Health Services, about 35 percent of Mississippi's 42,000 annual births are to medically indigent women. Most rely on public health clinics for health care. Although Mississippi's Medicaid rate for prenatal care and delivery was increased in 1978, it still totaled only $225--$135 for delivery and $90 for prenatal care. The payment rate for prenatal care was $9 for each visit, but according to a State official, the State will only pay for 10 visits. The payment rate was substantially below the average paid for prenatal care and delivery by Mississippi Blue Shield for its patients. Furthermore, the prenatal care standards of the American College of Obstetricians and Gynecologists provide that a pregnant patient ideally should receive 13 visits, assuming she initiated prenatal care visits in the first month, experienced no significant complications, and delivered after 38 weeks of gestation.

Mississippi Medicaid officials believed that other factors besides the payment rate caused the problem. They said that physicians often will not accept Medicaid patients because they

--would run other patients away,

--make too many unnecessary visits and are too demanding,

--require too much paperwork, and

--fail to keep appointments.

On the other hand, health officials cited the low payment rate as the major factor.

Missouri's maximum Medicaid rate for prenatal, normal delivery, and postpartum care provided by an obstetrician was $275, which was also substantially below the average rates paid by Blue Shield in St. Louis and Kansas City. According to health officials in Missouri, physicians refused to accept Medicaid patients reportedly because of low payment rates, delays in receiving reimbursement, paperwork requirements, or already full caseloads.

In California, many low-income and Medicaid patients were relying on already overburdened county clinics or public facilities. To illustrate, only three obstetricians in Kern County--with a population of about 355,000--were reported to accept Medicaid patients.

According to California Medicaid officials, only about 23 percent of the State's obstetricians accept Medicaid patients. The situation appears to be getting worse. According to one estimate, between 1976 and 1978, the number of Medicaid eligible women in the State aged 13 to 44 increased by about 17 percent, while the number of primary care physicians participating in Medicaid decreased by about 25 percent.

The California Medicaid program generally paid a "package" rate of $300 for prenatal care, normal delivery, and postpartum care. We were informed that obstetricians in Los Angeles charge private patients from $900 to $1,200. Obstetricians' fees for maternity care are also substantially higher than the Medicaid rate in other parts of the State.

California Medicaid officials said that, because the State Medicaid budget is limited, rates have to be kept low to enable a greater number of patients to receive care. They believe that even doubling the reimbursement rate would not entice obstetricians to participate. Delayed payment, increasing numbers of malpractice suits filed by

low-income patients, and their failure to follow prescribed treatment were also cited as reasons for obstetricians rejecting indigent patients. To further aggravate the problem, Los Angeles County health officials and a CHC manager in a rural area told us Medicaid patients get prenatal care from county clinics or the CHC and then go to the physicians for delivery. Because the Medicaid payment is generally made to whoever performs the delivery, the physician collects the entire $300.

Increasing concern by California Medicaid and MCH officials over the lack of maternity care available to low-income women in "under-served" rural areas led to the development of a pilot project--called the Obstetrical Care Pilot Program. The project is an MCH-Medicaid joint venture to develop and support obstetrical services in selected areas. Under the project, the California Department of Health Services was planning to contract with local health departments or other qualified providers to provide women eligible for Medicaid with specified maternity services, including prenatal, delivery, and postpartum services, for a "package" rate per case.

Clinic problems

Inadequate Medicaid reimbursement rates also pose a problem for clinics providing maternity or infant care. For example, the average cost of a clinical visit at the Virginia maternity and infant care project was about $34, but Medicaid's maximum reimbursement rate was $22. According to project officials, the underpayment results from Medicaid's low rate and its failure to pay for all the services provided because of its definition of preventive and clinic services. According to a California CHC manager, Medicaid payments covered only about 54 percent of the center's cost of providing care. The executive director of a CHC in Washington, D.C., cited similar problems.

Pennsylvania MCH officials supplemented their response to our questionnaire with information showing that the State's Medicaid program generally limited Medicaid reimbursement for prenatal care provided by hospital outpatient departments to five visits. Because most of the State's maternity and infant care project services were provided in this manner, the State MCH program had to expend substantial amounts of MCH funds to help cover the unreimbursed cost of caring for Medicaid patients.

In a number of instances, public health clinics are not seeking or getting reimbursement for services to eligible patients. For example, St. Louis County health officials said they were not collecting reimbursement from Medicaid for outpatient maternity services provided to eligible patients, but were developing a billing and collection system to do so. Also, St. Louis City sought Medicaid reimbursement at only one of its health centers. A city health official cited excessive paperwork and difficulty in obtaining Medicaid provider status as barriers. One maternity and infant care project in Mississippi collected only 7 percent of its 1977 revenues from Medicaid--MCH funds accounted for the rest. According to the State MCH director, county health departments only recently began to bill Medicaid.

Eligibility or coverage restrictions

In several States, Medicaid does not cover low-income women who are pregnant for the first time, who are members of intact families, or who have incomes that exceed the maximum for eligibility for Aid to Families with Dependent Children but are insufficient to pay for medical care. For example, North Carolina and Missouri Medicaid programs did not pay for prenatal care for women having their first child. They would, however, pay at least part of the delivery cost. In fiscal year 1978, North Carolina's Medicaid program paid an average of $232 for 1,531 normal deliveries that included prenatal care, but paid an average of $186 for 3,285 deliveries which did not include prenatal care. Mississippi's Medicaid program began covering first pregnancies for otherwise eligible women under 21 in 1978, but Medicaid coverage for prenatal care could not begin until the fetus was 4 months old. Legislation requiring State Medicaid programs to expand eligibility to more low-income pregnant women was proposed during the last session of the Congress, but it was not enacted. HEW is continuing to seek such legislation.

State Medicaid programs must cover persons who receive cash assistance under the Aid to Families with Dependent Children program or persons who meet certain financial and other requirements. Such persons are often referred to as the financially or categorically needy. HEW regulations prohibit States from requiring contributing payments for required medical services, such as in-patient hospital and physician services, from financially or categorically needy persons.

In addition, State Medicaid programs may cover persons who would be eligible for Medicaid based on family status, disability, or some other factor, but who have incomes that (1) exceed the maximum allowed by the program but (2) are insufficient to cover health care costs. These persons are often referred to as medically needy. States can require medically needy persons to contribute to the cost of their health care. Many low-income women not eligible for Medicaid cannot afford to pay for the high cost of obstetrical care, and many who are medically needy reportedly have difficulty making required payments, thereby forcing them to rely on publicly operated or funded services.

Missouri does not cover medically needy persons under Medicaid. However, other States, such as Mississippi, North Carolina, California, and Virginia have a "spend down" policy for covering medically needy patients whose income prevents them from qualifying as financially needy. "Spend down" allows these medically needy to qualify for Medicaid after paying part of their medical expenses. For example, in Virginia, a family's annual income of $2,900 may exceed the $2,600 income allowed by Medicaid for a 2-member family by $300; but with the "spend down," (one-half of the excess), they become eligible for Medicaid coverage once the family pays the first $150 of medical expenses during a given 6-month "spend down" period.

Low-income women often have difficulty paying even part of the cost of maternity or well baby care. For example, a health official in one California county--without a county hospital--said that private practitioners were requiring a substantial deposit before they would provide care--even to Medicaid patients. California MCH officials estimate that 150,000 women in the State giving birth each year cannot afford to pay the full cost of their maternity care. Moreover, low-income women are often too poor to fully or partially pay for health care but not poor enough to qualify for full Medicaid reimbursement.

Varying coverage of nurse-midwifery services

States vary in the manner and extent to which they cover nurse-midwifery services. For example, North Carolina's Medicaid program will pay for nurse-midwifery services, but claims must be filed through a physician's practice or a clinic. According to the director of the Mississippi Medicaid Commission, in that State the program will pay for nurse-midwifery services only when they are provided through a

State hospital or rural clinics affiliated with them. He said it will not pay for such services provided by a nurse-midwife in private practice or employed by a private physician or clinic. The services provided by the nurse-midwives at the maternity and infant care projects were not covered by Medicaid.

LACK OF SYSTEMATIC APPROACH

Lack of resources is not the only problem impeding access to prenatal and well baby care. Health officials, providers, or others in several areas, such as Washington, D.C., Missouri, and Mississippi, believe that better management of existing resources would make a significant contribution. Our findings support their contention.

Based on this work and prior GAO reports, systematic approaches for seeing that prenatal and well baby care needs are identified and met are generally lacking at the State and local level. Links among planners, service providers, or funding agencies are often lacking, as is cooperation between public health departments and the private medical community. The Federal Government, while providing substantial resources to help meet the needs of low-income persons, contributes to the lack of a systematic approach by having a multitude of diverse programs, by directly awarding project grants to local private organizations which bypass State MCH agencies, and by failing to coordinate more closely WIC and health programs.

HEW's National Guidelines for Health Planning, published in March 1978, require State and area health planning agencies to plan for obstetrical services to achieve a regionalized system of care. HEW regulations require that all health system plans developed after 1978 be consistent with the national guidelines.

Lack of links among health service providers

Health service providers, even when located in the same community, may not know what services the others are providing or whether they are serving the same patients. The lack of links among providers sometimes resulted from the lack of prenatal care patient risk assessment and referral systems designed to link patients with appropriate providers.

For example, health officials at two clinics (a county health department and a federally funded Health Underserved Rural Area grantee) visited in a rural Virginia area told us they were providing some of the same services to patients, but no attempt to coordinate these services had been made, except to exchange patient records. In the District of Columbia, there was generally little coordination between the CHCs and Department of Human Resources clinics. Two CHCs in California had no system or formal procedure for identifying high-risk pregnant women and referring them to the maternity and infant care project serving the area or to other facilities for high-risk case management.

On the other hand, the maternity and infant care projects visited in Los Angeles had risk assessment and referral arrangements with other county prenatal clinics in their areas. For example, patients screened by one project represented 30 percent of those admitted to other public prenatal clinics in the area. We noted similar arrangements among maternity and infant care projects and public clinics in other locations. We also noted that, although HEW envisions maternity and infant care projects serving high-risk maternity patients, these projects often refer high-risk cases to hospital outpatient departments for prenatal care. For example, this was the case at projects we visited in the District of Columbia, Missouri, and Mississippi.

In Mississippi, we noted that cooperation and working relationships among health care providers varied from strong to none. For example, there seemed to be a good working relationship among the family planning grantees, the CHC, and the maternity and infant care project visited that serve Hinds, Madison, and Rankin counties. On the other hand, no links or coordination existed between the CHC and public health clinic in Bolivar County, and coordination was limited between the public and private health sectors.

The Director of Obstetrics at the University of Mississippi Medical Center summed up the situation as follows:

--The most significant barriers to improving pregnancy outcome are the lack of a "system" for addressing the problem and relatively little coordination and cooperation--sometimes competition--between the public health sector and the private medical community. Although there is no question that the public health sector needs to be bolstered and improved, almost all the effort specifically directed at improving pregnancy

outcome has been through the public sector with little input or collaboration with the private sector. Regionalization has progressed slowly. A more systematic approach is needed involving (1) a long-range plan, (2) someone "in-charge," and (3) more collaborative efforts between the public and private sectors for such activities as planning, patient risk assessment, referral, followups, and data collection.

The Director of Family Health Services in Mississippi agreed that the State lacked a cohesive, integrated approach for improving pregnancy outcome and that public and private health provider activities were not coordinated.

Also, he added that he is not always aware of CHC activities, and this can result in duplication. However, he stated that the health department is working toward developing closer working relationships with private hospitals and providers.

Inasmuch as HEW provides a substantial portion of funding for public MCH services in Mississippi, it would appear that it could do more to encourage cooperative efforts between the public and private health care sectors in the State. In March 1979, we informed the director of HEW's MCH program about this problem; he agreed to look into it further.

LACK OF PATIENT MOTIVATION

Lack of motivation is another reason many women do not seek routine prenatal or well baby care. Many low-income women are "crisis-oriented" in their attitude toward health care and often do not seek care promptly, until their pregnancies are advanced or their babies get sick. Many do not see the need or lack motivation for preventive care. Unmarried mothers, particularly teenagers, frequently delay seeking prenatal care because they "deny" that they are pregnant or they want to delay confirming their pregnancy. For low-income women, these attitudes are often reinforced by such factors as long distances to clinics, long waiting times, inconvenient hours of operation, or inadequate physical conditions in public clinics. Examples follow:

--The facilities housing a North Carolina county health department--where the maternity and infant care project was located--built in the early 1950s, was in disrepair, lacked privacy for patients, and was generally unattractive. Examination rooms were divided only by pull curtains, affording little patient privacy. Supply closets were used as interview rooms. Hallways

and waiting rooms were overcrowded. (See fig. 4-2.) Health department officials stated they could not expand any clinic services until funding for additional space was available. North Carolina's ICH grant provided funding for additional space and staff. State officials told us that the need for a new facility in Halifax County has been recognized and attempts to obtain the necessary funds have been unsuccessful.

--Broken appointment rates for prenatal care at some MCH clinics in the District of Columbia were running as high as 30 to 40 percent. One CHC visited in the District was experiencing a similar broken appointment ratio for pediatric care.

--According to Mississippi's MCH director, the broken appointment rate for some infant clinics was about 50 percent, largely because women do not see the need to bring their babies to the clinic if no problems are evident. Further, he said that most health department clinics do not have enough staff to follow up on all no-shows, but where there is staff to do this, no-shows are not as great a problem.

--According to CHC officials in Kern County, California, many women do not return for infant care after their first postpartum visit for several reasons, including lack of motivation to seek preventive care.

--Several State and local health officials in Virginia cited patient apathy as a reason women and infants do not receive adequate prenatal and infant care. The pediatric team serving a rural county said they had a 25-percent patient delinquency rate because of apathy and lack of transportation. Further, public health nurses in another rural Virginia county stated that women usually know about the health department and the services. According to the nurses, these women only seek maternity services when experiencing problems or in their 7th or 8th month of pregnancy.

According to BCHS' Associate Bureau Director for Maternal and Child Health, more and better health education, information, and outreach efforts would help overcome this lack of motivation to a large extent. He recognized, however, that additional efforts to motivate persons to seek care would not totally resolve the problem because of inadequate facilities, insufficient clinic staffs, and the fact that some persons would probably not seek prenatal or well baby care regardless of efforts to motivate them.

CHAPTER 6

PROGRESS AND PROBLEMS IN PROVIDING LABOR, DELIVERY, AND INFANT INTENSIVE CARE SERVICES

In 1929, an estimated 45,000 untrained midwives in the United States delivered about 300,000 babies. Today, nearly all babies in the United States are born in hospitals and attended by trained personnel.

The development of new knowledge and technology, and the establishment of sophisticated infant intensive care units in many hospitals, has resulted in substantial reductions in infant mortality. Sick, premature, and low birth weight infants who once were believed to have little chance of survival now live and grow up normally or nearly normal.

The Federal Government, through such programs as Hill-Burton Hospital Construction, MCH, and Medicaid, has helped develop or pay for care units, thereby helping many persons gain access to them. Furthermore, the Government has promoted and even required the development of regionalized, efficient systems of care for mothers and newborns. Nevertheless, people in some locations still do not have easy access to appropriate labor and delivery services or infant intensive care units. Many areas do not have regionalized, efficient systems of perinatal care, although progress has been made.

Several factors contribute to the uneven progress that has been made, and difficult problems that persist. These include but are not limited to:

--The lack of or geographic maldistribution of physicians or facilities.

--Physician or hospital resistance to closing underused obstetrical units.

--The high cost of in-hospital obstetric and newborn care, particularly infant intensive care.

--The inability of many to afford the cost of this care and the failure of some insurance programs, including Medicaid, to always cover the full cost.

--The refusal of some physicians or hospitals to accept Medicaid or low-income patients or to refer patients to others.

--The lack of a comprehensive system for efficiently providing in-hospital maternity and infant care and the existence of dual private and public sector "systems" of care in many communities.

HEW needs to take more aggressive action to help resolve many of these problems. For example, it should urge or require State MCH agencies, health planning agencies, and State Medicaid agencies to work together along with the private medical community and other appropriate groups to hasten efforts to develop and implement systematic approaches to in-hospital care of mothers and newborn, such as regionalized care. Also, HEW could evaluate the concept of and issues surrounding elective use of out-of-hospital birthing locations, such as birthing centers. Such facilities could possibly increase access to labor and delivery services attended by trained personnel, but opinions differ widely on the safety and desirability of out-of-hospital birthing facilities, and adequate data on the subject appear lacking.

WHAT IS REGIONALIZED PERINATAL CARE?

HEW, through its MCH and health planning programs, has promoted and required the development of regionalized perinatal care as a systematic approach to providing care to mothers and newborn. "Regionalized perinatal care" is designed to assure ready access to and efficient use of labor, delivery, and infant intensive care services by better organizing and using medical knowledge, techniques, and resources to achieve a network of perinatal care services in a specified area or community. It entails the development of (1) a graded system of facilities for handling various categories of mothers and infants, (2) systems for screening pregnant women to identify risk factors, referring, and transporting mother and/or infant to the appropriate facility, (3) communication among providers, (4) data collection and followup systems, and (5) programs for training and educating personnel.

Three levels of hospitals should be established in each area. Level I hospitals would provide care for mothers and infants not expected to have complications. Level II hospitals would handle low-risk patients as well as most of the complicated obstetric problems and certain infant problems.

Level III hospitals are to serve as the hub of the system and are to be specially equipped and staffed for handling all serious cases. They would also provide leadership training, education, and assistance to the other providers in the system. Each level III hospital would serve a region having from 8,000 to 12,000 births annually. To achieve efficiency, the regionalization concept provides for consolidating or closing small, inefficient obstetric and newborn units wherever possible, considering the need to provide ready access and sensitive care.

The regionalization concept has also been endorsed or supported by several national organizations. They include the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, the American Medical Association, the National Foundation-March of Dimes, and the Robert Wood Johnson Foundation. However, some persons have cited shortcomings with the way the concept has been defined. They believe the current definition of the concept is deficient because it (1) refers only to hospitals without mention of alternatives and (2) emphasizes inpatient care without focusing on ambulatory, prenatal, or preventive services.

REGIONALIZATION STATUS

None of the States visited had achieved a regionalization of perinatal care that provides comprehensive services in all parts of the State, although regionalization efforts were underway in one or more areas of each State. It also seems that regionalized care systems for infants have progressed faster than they have for mothers, particularly as they relate to prenatal care. Also, although infant intensive care is available in many areas, residents of many rural areas often have substantial distances to travel to them. In fact, some rural areas do not have any hospitals or hospitals that provide perinatal care.

Neither HEW nor private organizations, such as the National Foundation-March of Dimes or the American College of Obstetricians and Gynecologists, we contacted could provide us with national information on the status of implementing regionalized perinatal care. Although HEW's regulations for the MCH program require that a State's program of projects for infant intensive care will be evaluated as to its progress in developing regionalized perinatal care, HEW's MCH officials had not systematically monitored State efforts and progress

in this area. HEW's Health Resources Administration has contracted for a study to obtain some information on regionalization status, but was working independently of HEW's MCH program officials.

The value of a systematic approach to perinatal care was highlighted by the Chief of Idaho's Bureau of Child Health. In his opinion, Idaho's infant mortality rate could be reduced by 25 percent if additional funds were available to establish a statewide perinatal program. Examples follow summarizing regionalization efforts in the States visited.

District of Columbia

Although several hospitals in the District of Columbia have infant intensive care units, the District did not have a perinatal care system. Also, the District's MCH program lacked a formal infant intensive care project as required by HEW's MCH program. The publicly operated hospital which served much of the District's low-income population lacked a neonatologist on the staff of its infant intensive care unit, although the District's MCH plan stated that such a specialist would be there. HEW has required the District to initiate regionalization efforts as part of its IPO project. We and HEW have recommended that the District take action on the vacant neonatologist position at the hospital. District officials said that this position was filled in July 1979, and in November 1979, they informed us that a second neonatologist had been hired.

North Carolina

North Carolina has initiated regionalized perinatal care projects in two areas and plans to eventually extend the concept to all areas in the State. For example, North Carolina started its first regionalization efforts in 1975 with a pilot project started in a five-county rural area. The State appropriated $500,000 annually for the project and $750,000 of Federal MCH funds were made available. The concept of this project was to consolidate existing obstetric beds within the area, recruit additional physicians and nurses to staff the clinics, pay for hospital and delivery cost for high-risk patients, and when necessary refer the patient with severe problems to level III hospitals at Duke University or the University of North Carolina. Preliminary results after 3 years showed a 34-percent decrease in fetal mortality in the project area, compared to a 10-percent decrease in an unregionalized control area.

California

In July 1975, the Robert Wood Johnson Foundation initiated a grant program totaling about $20 million for the development, demonstration, and evaluation of regional perinatal systems in eight areas of the United States. Three of these areas were in Los Angeles, California. According to officials of one of the Los Angeles projects, a major component of the project is to develop a regionalized data base involving all obstetric practitioners and delivery facilities in a region. Ultimately, a system will be developed so that when a woman seeks perinatal care within the region, her entire medical file is available to all practitioners and facilities within the system.

In 1976, California also established a perinatal care pilot project in Fresno to demonstrate the potential for expanding specialized services to high-risk pregnant women. The project had difficulty getting started--principally because of problems securing the participation of the private obstetricians in the area because of low Medicaid reimbursement rates. The project was scheduled to end in June 1979.

Missouri

The Neonatal Intensive Care Unit at Children's Mercy Hospital in Kansas City serves as the State's MCH infant intensive care project and a regional neonatal care center. It serves residents from six Missouri counties and two counties in Kansas--an area having about 15,000 births annually. The unit had 45 beds, and in 1977, it served 736 infants. An estimated 40 percent of the admissions were from the Kansas City metropolitan area with the remainder from other parts of the eight-county region.

One neonatologist from Children's Mercy is assigned as the attending physician at Truman Medical Center, and another acts as a consultant physician for other hospitals and provides care to newborn infants at two level II perinatal hospitals in Kansas City.

The 1977 annual report for the neonatal intensive care unit at Children's Mercy states:

> "In summary, the progress made in the NICU at Children's Mercy Hospital during 1977 has been the realization of the concept of regionalized perinatal care. This has

resulted in a slight reduction in the number of admissions, a shorter hospital stay and a higher mortality rate among a much more critically ill population of infants than in the years 1973 through 1976. Effects on the entire health service area have been substantial and resulted in a larger number of infants being cared for in level II nurseries throughout the area."

IMPEDIMENTS TO REGIONALIZATION

Several factors impede access to labor, delivery, and infant care services and full implementation of regionalization. Some are discussed below. The problems discussed in chapter 5 relating to the lack of coordination between the public and private health care sectors for prenatal and well baby care also apply to in-hospital care.

Maldistribution of resources

Some rural areas of the United States have no hospitals, and in other areas the services that are available are often overburdened or underused.

--The area served by one Virginia HSA has 18 hospitals which provide obstetric services. The occupancy rate for the obstetric beds in these hospitals ranged from 15 percent for one rural hospital to 103 percent for an urban area hospital. Even though the rural hospital had a low occupancy rate, it was the only hospital for the area.

--The Missouri State Health Plan and two HSA region plans indicate that there are excess obstetric beds in the State because of the low occupancy rate in some hospitals although some areas lack such service. Specifically, the Greater St. Louis HSA plan stated that, except for the larger hospitals with obstetric services, most of the area obstetric services are currently running at low occupancies, i.e., 30 to 50 percent.

Similarly, there are other areas with insufficient obstetric beds or none at all. For example, two rural counties of eastern North Carolina with high infant mortality have no hospitals. Thus, all deliveries must be performed at hospitals in adjoining counties, in a physician's office, or at home.

All pregnant women (except under emergency conditions) are transported from one of these counties to Duke University Hospital (about 100 miles) for delivery. In 1977, one physician who delivers babies in a rural North Carolina county made 113 deliveries in his office. According to health officials, if the mother and infant have no problem after 2 hours, the physician making the office delivery sends them home.

As of September 1978, midwives lacking formal medical education and training (sometimes referred to as granny midwives) were still delivering babies in 21 Virginia counties/cities.

Economic barriers

Many obstetricians or hospitals will not accept (1) Medicaid patients for delivery because of low payment rates, paperwork, or other factors or (2) patients ineligible for Medicaid because they cannot afford to pay. As indicated, this sometimes leads to home deliveries attended by untrained persons or overcrowding of publicly supported hospitals.

Some physicians and hospitals refuse to accept patients who cannot pay

Some obstetricians will not treat a patient beyond a certain point in her pregnancy unless she has made financial arrangements to pay for the delivery. For example, an obstetrician in one rural North Carolina county will not deliver a baby unless the mother pays $275 by her 7th month of pregnancy. Similarly, the hospital in the same county requires patients to pay $500 before admission.

We were told that in another rural North Carolina hospital patients are refused admission unless they have also made a deposit with the hospital. According to health officials, nonpaying patients who present themselves at this hospital during early labor are sometimes transferred to other hospitals by ambulance, rather than being admitted. Babies are being born in emergency rooms because the hospitals will not admit the mother. State officials said that this situation varies among local areas. They said that the State has allocated some funds to local health departments to help pay for delivery and associated costs for patients ineligible for other public programs. Local health departments determine program eligibility using State guidelines.

Because some hospitals would not accept pregnant patients for delivery who could not pay, some HEW funds were used to provide prenatal care to patients who had to be delivered by granny midwives at home. For example, in 1977, the Halifax County maternity and infant care project approved 91 of the 127 granny midwife deliveries in the county that year because the local hospital would generally not accept pregnant patients for delivery who could not pay. The project could only pay hospital costs for high-risk cases.

Similarly, an NHSC obstetrician in another rural North Carolina area had to approve some of her prenatal care patients for granny midwife delivery because they could not afford the hospital cost, and the hospital would not accept patients who could not pay.

An official at one Missouri hospital we contacted said that the hospital will not admit women for delivery who cannot pay a $400 deposit. A representative from another Missouri hospital said that nonemergency obstetric patients who do not have insurance or who cannot pay will not be admitted unless they are considered of "teaching value." Those who cannot pay or who are not of "teaching value" are referred to the city hospital.

Many hospitals have received financial assistance, such as grants or loans, for construction or modernization under the Hill-Burton program. As a condition of receiving assistance under this program, HEW requires that hospitals provide care to at least some persons unable to pay for such care. Although we noted that some of the hospitals in areas visited had received financial assistance under the Hill-Burton program, our review did not include an assessment of the extent to which hospitals complied with requirements relating to providing care to low-income persons. In November 1978, the Assistant Secretary for Health told us that HEW was planning to monitor such compliance more closely.

However, even with increased monitoring and enforcement, it appears that many low-income persons would still have difficulty gaining access to in-hospital care for delivery. This is because (1) not all hospitals received financial assistance under the Hill-Burton program and (2) according to HEW, hospitals that are obligated could fulfill their annual obligations to provide specified amounts of free care early each year, leaving those needing care subsequently without access to it.

Medicaid and MCH limitations on reimbursement for labor, delivery, or infant care

Medicaid pays for a substantial number of all hospital deliveries in the United States. Although data are not available on total Medicaid expenditures for hospital delivery and infant care costs, existing data show the amount to be substantial. For example, 1977 data provided ~~to us~~ by the Commission on Professional and Hospital Activities for 1.2 million deliveries in 1,558 U.S. hospitals show that Medicaid or MCH was the expected payment source for 183,000 (or 14.9 percent). Although the Commission's data are not based on a representative sample of hospitals, they account for about 38.3 percent of all births in the Nation.

In some States, Medicaid programs pay for a significant number of all hospital deliveries in the State. For example, California Medicaid pays for an estimated 28 percent, and in the District of Columbia, Medicaid pays for more than one-third of all its residents' deliveries.

Providers often refuse to accept Medicaid patients

Physician or hospital refusal to accept Medicaid or low-income patients impedes regionalization efforts and sometimes contributes to situations where perinatal care units in public hospitals are sometimes overcrowded while such units in other hospitals are underused.

The University of Southern California Medical Center delivered about 14,000 babies in 1976--about one-fourth of all those delivered in Los Angeles that year--in a facility designed to deliver 9,000 babies annually. The hospital's infant intensive care unit caseload indicated it should have 12 beds, but it had only 4 to 6 based on availability of nurses, and the mortality rate for infants born at the hospital was increasing. The Medical Center was serving a large number of low-income undocumented aliens who were ineligible for Medicaid, Medicaid patients who could not deliver at private hospitals because of low Medicaid payment rates (even though obstetrical bed capacity was available), and poor patients from some rural counties with no public hospital. The infant intensive care unit at another Los Angeles County facility--Martin Luther King Memorial Hospital--was experiencing similar problems and could not accept referrals of infants born at other hospitals, as envisioned in the area's regionalization plan.

In 1977, residents at a Kern County, California, hospital delivered about 2,100 (or nearly one-third) of the county's 6,750 births that year. Only three obstetricians in the county accepted Medicaid patients.

Although other hospitals in the Jackson, Mississippi, area had obstetric beds available in 1976, the University of Mississippi Medical Center delivered about 4,500 babies in a facility designed to deliver only about 2,500. The center expects its obstetric patient load to increase to about 7,000 annually because two nearby county hospitals recently closed. According to the center's director of obstetrics, most Medicaid patients come to the center for delivery because private physicians practicing at other hospitals will not accept them.

The District of Columbia's Medicaid payment to an obstetrician for a normal delivery was about one-fourth the average rate paid by Washington Blue Shield for the same service. (See app. V.) According to the Chairman of the D.C. Medical Society's Committee on Maternal and Child Health, low Medicaid payment rates coupled with the high-risk nature of the pregnancies of many Medicaid-eligible women discourage many obstetricians from accepting Medicaid patients. He said that although the District's Medicaid program provides for additional payments for some complicated deliveries, paperwork requirements and lengthy delays in payment for such services further discourage acceptance of Medicaid patients.

MCH funding helps but is limited

MCH funding has helped pay and promote in-hospital delivery of high-risk women and care for premature or sick infants. For example, the total number of MCH infant intensive care projects increased from 5 in 1972 to 75 in 1978, according to our questionnaire responses. Federal MCH funding for infant intensive care projects increased from $495,000 to $7.1 million during this period. However, State programs of projects for infant intensive care often consist of only one project serving relatively few communities in the State, although projects in several States cover the entire State.

MCH programs are also limited by the available funds and number of days for which they will pay. In response to our questionnaire, State MCH directors indicated only about $10 million of their $200.4 million in 1978 Federal MCH formula grant funds and about $30 million of their funds from all

sources would be spent on inpatient hospital care, including infant intensive care projects. Five States and the District of Columbia reported no Federal MCH formula grant funding would be used for infant intensive care projects. Only eight States reported they budgeted MCH formula grant funds for inpatient care of mothers or newborn (other than their infant intensive care projects). Some additional funds for such care were expended by maternity and infant care projects or other projects, which were not specifically identified. Since States reported spending only about $2.2 million in fiscal year 1977 of their maternity and infant care project funds for inhospital care, it appears that relatively little Federal MCH project funds are used for in-hospital care.

Other Federal MCH projects such as ICH also pay for some in-hospital care, but this is also limited. The funds used for in-hospital care in these projects are not nearly enough to meet all needs in the small geographic area they serve, much less meet all the needs of a larger area or an entire State. For example, in North Carolina, the ICH project plans to use about one-fourth of its budget for inpatient hospital services for high-risk patients. However, the ICH plan identified the need for more funds for in-hospital deliveries as a gap in service availability for the project.

All of the States reviewed spent little or nothing for inpatient hospital care except Virginia, which reported using about $1.2 million (or 27 percent) of its 1978 Federal MCH formula grant on in-hospital care. Also, Virginia reported using more Federal MCH funds for in-hospital care than any of the other States responding to our questionnaire. According to one Virginia health official, it is not unusual for the State to spend $50,000 per infant, and in one case spent $100,000.

North Carolina officials told us that the State has allocated some of its funds for about 3 years to help pay delivery and associated cost for certain low-income persons. They said that $500,000 will be available for this in fiscal year 1980, but in general, funds will never be available to meet all the needs.

Limited coverage

MCH programs generally only pay in-hospital costs for high-risk cases. Also, some States limit the number of days or total amount for which MCH will pay for in-hospital care. For example, Virginia's MCH program will generally

only pay for up to 30 days for in-hospital care. Since Medicaid and MCH funding for in-hospital care is limited, States, local governments, or hospitals must absorb the costs not covered by these programs, insurance, or patients. The following example illustrates the problem.

Missouri Medicaid reimburses for a maximum of about $220 per day for in-hospital infant intensive care, but as with other in-hospital care, it will only pay for a maximum of 21 days for each admission. Thus, the maximum Medicaid payment would be $4,620 per patient. In 1977, the hospital's cost for caring for the 736 infants in intensive care was $3,953,208, or an average of $5,371 per patient. The average length of patient stay was 14.5 days, resulting in an average daily cost of about $370 per patient.

A sample of infants recently requiring infant intensive care at the hospital follows:

Table 6-1

Examples of Infant Intensive Care Cases

Hospital total care cost	Days in unit	Average daily cost
$46,640	108	$ 431.85
44,059	65	677.83
30,057	83	362.13
14,866	54	275.30
16,339	54	302.57
8,140	34	239.41
12,324	45	273.87
28,684	26	1,103.23
17,536	11	1,594.18
12,296	36	341.56

According to the hospital's controller, Medicaid and private insurance each provide about 30 percent of the costs of operating the neonatal intensive care unit. The hospital receives no payment for another 30 percent of the unit's costs because of patients inability to pay. The remaining 10 percent comes from miscellaneous sources, such as MCH or the State's special high-risk payment program. About $99,000 was requested from MCH for the perinatal intensive care unit for fiscal year 1979.

State high-risk programs

Several States have special high-risk projects--in addition to Federal MCH activities--that pay for obstetric and infant in-hospital costs. However, these project funds are usually very limited and unable to pay for all patients who need it, but cannot pay. Missouri's program was developed to prevent mental retardation by identifying high-risk mothers and infants and paying for their care, including in-hospital cost. Because of limited funding, the program only covers six obstetric conditions and one pediatric condition; funding is insufficient to pay for the care of all those who are eligible.

Similarly, the North Carolina perinatal pilot project is limited by the funds it has available to cover high-risk patients. In 1976, the project followed and provided care to only 250 high-risk mothers out of an anticipated 500 in two special maternity clinics. Additionally, out of an estimated 800 mother-infant pairs who needed their medical bills paid, the project paid for only 435 of an authorized 537 pairs.

OTHER PROBLEMS OR ISSUES

Several other factors impede access to labor, delivery, and infant care services or implementation of regionalization plans. They include lack of transportation for mother and/or infant to an appropriate facility, physician resistance to closing small, inefficient, but convenient, obstetric and newborn services, and some physician reluctance to refer patients to another hospital. Also, some persons have questioned the belief that hospitals are always the preferred or the only safe location for childbirth.

Transportation

Some areas seem to have been able to develop adequate transportation arrangements for high-risk women or infants, but others have not.

The North Carolina infant intensive care unit at Bowman Gray Baptist Hospital serves a 19-county area of northwestern North Carolina. According to project officials, most of the infants transported to the unit from these counties were carried by normal ambulance vehicles, which lacked specialized

equipment needed for the infants, even though their condition was critical enough to warrant moving them to an infant intensive care unit. In May 1978, the unit began using a portable infant transport unit that is adaptable to a normal rescue squad vehicle. They transport infants from only six hospitals in the service area closest to Bowman Gray. According to project officials, transportation from all hospitals in the area in this unit is not possible because one unit cannot cover the entire 19-county area, and resources are not available to purchase additional units. They stated that infants from all other hospitals in the service area are still being transported by normal ambulance and rescue squad vehicles.

Kern County, California, has one infant intensive care unit. However, California's Crippled Children's program will not pay for the cost of care at the unit for patient's eligible because it has not approved the facility for such payment. Therefore, infants eligible for care under the Crippled Children's program must be transported to an approved facility in Los Angeles or Fresno. The director of one CHC in Kern county believes that some infants have died or been permanently damaged as a result of delays in care resulting from transportation, although no studies of the situation have been done. In contrast, King's Daughters Hospital officials in Norfolk, Virginia, said that the transport vehicle they use is fully equipped with all the equipment needed to transport and treat infants. This vehicle goes to any hospital in the service area to pick up infants and transports them to King's Daughters. The vehicle was purchased and given to King's Daughters by the March of Dimes.

Physician resistance

Health officials in Los Angeles said that some physicians are reluctant to refer women or infants to other facilities or hospitals. For example, some California physicians were reportedly reluctant to refer patients to county facilities serving as a regional center because of overcrowding or other factors. Also, some were reportedly reluctant to refer Medicaid patients elsewhere because they would not receive payment for prenatal care because the Medicaid package payment is usually made to the physician who performs the delivery.

Elective use of alternate birthing facilities

The discussion in this chapter on barriers to access to labor and delivery services is based on the premise that the hospital is the preferred and safest location for childbirth. This belief was expressed in a June 1978 position statement on the development of family-centered maternity/newborn care in hospitals by the Interprofessional Task Force on Health Care of Women and Children. The task force consisted of representatives from several medical professional organizations, such as the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Nurses' Association. In addition, those organizations that formulated and promoted the concept of regionalized perinatal care and HEW, in its National Guidelines for Health Planning (42 C.F.R. 121.203), refer only to hospitals when discussing the facility components of a regionalized system of care.

However, there has been growing interest among women (expecting normal, uncomplicated births) to choose to have their babies outside of hospitals in such places as the home or in special childbirth centers. In the last few years, there has been a small but steady increase in the proportion of reported births occurring outside of hospitals. Consumers and some health professionals have been challenging the belief that hospitals are the preferred or only safe location for normal births. They point to studies showing that out-of-hospital births for low-risk women are at least as safe as hospital births and to reasons why some women are choosing other locations. These include (1) disenchantment with the hospital environment, (2) fear of excessive use of technological intervention in the childbirth process, such as use of electronic fetal monitors or performance of cesarean section, (3) preference for a family-centered childbirth at home or in a home-like atmosphere, and (4) lower costs associated with out-of-hospital births.

In November 1979, BCHS established an ad hoc committee to develop a position paper on implementation of the alternate birthing facility concept in BCHS. According to a BCHS official, BCHS provides financial support to two facilities--one in Texas and the other in California--which provide labor and delivery services outside of hospitals. BCHS believes that this concept has potential, particularly for migrants and low-income persons, because (1) the costs are substantially lower than for in-hospital births, (2) more persons can be provided with both prenatal and labor

and delivery services, (3) more effective use could be made of nurse-midwives, and (4) it would enhance the concept of screening women for risk status early in pregnancy and managing the pregnancy accordingly. BCHS expects the committee to complete its paper by May 1980.

In commenting on the increase in out-of-hospital births, a representative from the American College of Obstetricians and Gynecologists said that data reported by a number of State health departments indicate that (1) out-of-hospital births are not always as safe as in-hospital births, (2) many women who have out-of-hospital births are not low risk, and (3) many births occurring outside of hospitals are attended by untrained personnel.

Because our review did not include an assessment of the advantages, disadvantages, safety, costs, or implications of out-of-hospital births, we are not in a position to make formal recommendations on this issue. In our report "Evaluating Benefits and Risks of Obstetric Practices--More Coordinated Federal and Private Efforts Needed," we recommended several steps HEW should take regarding research on obstetric practices. In carrying out this recommendation, HEW could look further into the out-of-hospital birth question as it affects national policy, particularly its safety, risks, and costs and possible effect on hospitals, regionalization of perinatal care, health planning, and pregnancy outcome.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Federal programs have helped increase access to health care for many persons and have contributed much to the Nation's progress in improving pregnancy outcome. However, many lack ready access to adequate health care or fail to effectively use services which are available. Persons in several areas continue to experience poor pregnancy outcomes, and nonwhites generally experience poorer pregnancy outcomes than whites.

The Federal Government, principally HEW, has recognized these problems and has taken several steps to help resolve them. These efforts are well-intentioned and should lead to further improvements in pregnancy outcome. However, the Federal Government could further enhance its efforts along with those of State and local governments and many private, nonprofit organizations by developing a more systematic approach to the problem and by improving the structure or management of several programs, which can or do affect pregnancy outcome.

Some of the ways the Federal Government can enhance its efforts are by:

--Developing specific national goals for pregnancy outcome using other indicators, such as low birth weight or prematurity, in addition to infant mortality.

--Reducing the large number and wide variety of prorams administered by different agencies which often operate independently of one another and fund identical, similar, or related activities.

--Seeing that programs that can affect pregnancy outcome give appropriate attention to it.

--Giving State MCH agencies a role to play in HEW's award of project grants to private, nonprofit organizations and doing more to link improved pregnancy outcome efforts by public and private health care sectors, including enhancing efforts to develop and implement regionalized perinatal care systems.

--Strengthening the management of the MCH program and giving State MCH programs more flexibility.

--Ensuring that (1) Medicaid reimbursement rates for obstetrical and well baby care are sufficient to encourage private providers to accept Medicaid patients, (2) more low-income women become eligible for Medicaid, and (3) States include coverage of at least HEW-specified minimum prenatal care services under their Medicaid programs.

--Strengthening efforts through the NHSC program or by other means to improve access to obstetrical and well baby care in areas lacking health professionals.

--Informing and educating the public and health care providers to help eliminate apathy and negative attitudes and to promote effective use of health care services.

--Monitoring more aggressively agency and grantee efforts and compliance with program requirements and evaluating the effectiveness of various programs in improving pregnancy outcome.

RECOMMENDATIONS TO THE CONGRESS

We recommend that the Congress:

1. Over the long run and to the extent possible consolidate Federal programs funding similar types of activities, which are principally directed toward health care for women, infants, or children into one MCH program. We believe that candidates for consolidation include those administered by HEW's Public Health Service, such as the MCH, Family Planning, Adolescent Pregnancy, Sudden Infant Death Syndrome, and genetic disease screening and counseling programs.

2. In those cases where consolidation is not feasible or will take a long time to accomplish, amend the programs affecting improved pregnancy outcome, such as those identifed above and health-related programs like WIC, to require the administering agencies at the Federal, State, and local levels to coordinate their activities. Activities to be coordinated should include program planning, funding, implementation, reporting, and monitoring.

3. Provide funding for a major nationwide education and information campaign on the benefits and importance of early and adequate prenatal care and prevention or delay of high-risk pregnancies.

4. Designate one agency or official to be responsible for taking the lead in coordinating and focusing Federal efforts for improving pregnancy outcome. We believe that this official should be HEW's Assistant Secretary for Health.

5. Revitalize the MCH program by: strengthening the management role and ability of State MCH agencies; giving States more flexibility consistent with national policy, goals, or guidelines in using MCH funds; and directing HEW to monitor more closely MCH activities and use of funds and to take corrective action when State MCH agencies are not complying with requirements or making satisfactory progress toward achieving program goals. More specifically, we recommend that the Congress require:

   (a) State MCH agencies to formulate comprehensive multiyear, statewide plans, in consultation with interested public and private organizations and consumers, aimed at improving pregnancy outcome. For the State as a whole and for various subareas, this plan would (1) identify and prioritize unmet needs, (2) identify available resources, and the ability or inability of these resources to meet unmet needs, including specific services needed and the most appropriate way to meet these needs (e.g., through MCH, CHC, NHSC, or private physicians), (3) set specific and measurable goals and objectives, (4) specify and prioritize specific steps or actions needed and planned to meet unsatisfied needs, and (5) help coordinate efforts among providers in local areas. These plans should specify the extent to which federally funded projects, such as MCH-supported clinics, CHCs, NHSC sites, family planning clinics, Appalachian health projects, or WIC grantees, are meeting improved pregnancy outcome needs in their areas, additional efforts needed by these projects, and where additional projects should be placed so as to be consistent with State plans to provide

additional resources. (As we are calling for in recommendation #5 to the Secretary of HEW, HEW and private organizations could then use these plans to formulate their strategies to assist State MCH efforts.) HEW should be directed to specify the types of needs each State plan should address and to identify national priorities, such as prenatal care, to which States must give particular attention.

(b) State MCH agencies to use their funding in accordance with the needs and priorities identified in their plans. States should be required to continue funding program of project activities only to the extent they meet current needs and priorities. Some MCH funds should be available for HEW to grant, as an incentive, to States for areas having particularly difficult problems and/or to States doing exceptionally well.

(c) State MCH agencies to collect and report such information to HEW as it determines necessary to monitor use of MCH funds and evaluate program performance. HEW should be given authority to withhold all or part of State MCH funds if States do not submit acceptable plans or reports, or do not use their MCH funds properly.

(d) HEW to report the results of Federal efforts to help improve pregnancy outcome, including those of State MCH agencies, to the Congress.

6. Direct HEW to identify those Federal programs, which directly affect, or have the greatest potential for affecting, pregnancy outcome and require through legislation that agencies administering these programs give State MCH agencies an opportunity (1) to review and comment on applications or plans required prior to funding award and (2) to participate, to the extent practical, in monitoring and evaluation activities.

7. Earmark funds that could be used for assisting or promoting family life education programs with a view toward strengthening the family relationship. Federal assistance could include: (a) information

and education efforts to motivate persons to use family planning services and to convince parents and community organizations of the need for and importance of family life education in the prevention of adolescent pregnancy, (b) financial and technical assistance to communities wishing to develop or implement family life education programs, (c) providing funds to help train teachers, parents, or others how to teach family life education, and (d) evaluating program effectiveness and disseminating information.

8. Amend title X of the Public Health Service Act to require that (a) some priority be given to providing family planning services to low-income women who have a high risk of poor pregnancy outcome, including adolescents, and (b) one organization be designated to plan, coordinate, and oversee the provision of federally subsidized family planning services in each State and local area.

9. Increase Federal training funds for nurse-midwifery.

10. Require States to extend Medicaid eligibility for prenatal and labor and delivery care for low-income pregnant women regardless of family status.

11. Require State Medicaid programs to at least cover those prenatal care and labor and delivery services identified by HEW as essential. As an incentive to States, authorize HEW to increase the Federal financial participation rate under Medicaid for prenatal care. The Congress could also allow States to use part of their MCH funding to match Federal Medicaid funds to increase the amount of funds available for prenatal care.

12. Direct HEW to give higher priority to improving pregnancy outcome in project grant programs such as CHC or NHSC.

13. Consider making more Federal funding available, in decreasing order of importance, for (a) prenatal care, (b) preventing adolescent pregnancy, and (c) health education, which State MCH directors indicated were their three highest priorities for using additional funds to improve pregnancy outcome.

14. Clarify section 334 of the Public Health Service Act to specifically include State and local governments among those eligible for cost reimbursement waivers for NHSC personnel who will provide new or additional services.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary:

1. Direct the Assistant Secretary for Health to formulate specific national goals for improving pregnancy outcome. Goals should cover such indicators as infant mortality, fetal deaths, low birth weight, prematurity, and unplanned pregnancies terminated by abortions. Goals for preventing high-risk pregnancies should also be considered, as should goals for adequate prenatal care.

2. Direct the Assistant Secretary for Health to consider the feasibility of formulating specific national goals for alleviating infant morbidity or birth defects, and for providing adequate well baby care to infants during their first year of life. The feasibility assessment should consider the costs and benefits of developing and implementing an information system for collecting data on morbidity and receipt of well baby care.

3. Designate one official to be responsible for planning, ~~coordinating, promoting, and evaluating HEW efforts~~ to improve pregnancy outcome. We believe that the Assistant Secretary for Health should be given this responsibility. One official should also be responsible for overseeing all departmental efforts relating to adolescent pregnancy, and more aggressive efforts should be made to integrate activities of HEW's health, family planning, and educational programs. Steps should be taken to ensure coordinated efforts with the Department of Education when it becomes operational.

4. Direct that State MCH agencies be given an opportunity to comment during HEW's project grant review process ~~for those cases in which the grants do or can affect~~ pregnancy outcome. As a minimum, the following programs should be included: CHC, NHSC, Migrant Health, title X Family Planning, Health Underserved Rural Areas, Appalachian Health, and adolescent pregnancy.

5. Require that relevant HEW component agencies, under the leadership of the Assistant Secretary for Health and in collaboration with other Federal agencies, develop a comprehensive plan for each State, specifying how Federal resources should be integrated and used to improve pregnancy outcome, based on State needs assessments, plans, and priorities as called for in congressional recommendation 5(a). The Family Planning, CHC, adolescent pregnancy, and NHSC programs, as a minimum, should be an integral component of the plan for each State. These plans should serve as the major part of application for funding under relevant programs. HEW should work with Agriculture to see that WIC is included in the plan.

6. Develop a strategy for integrating MCH, CHC, NHSC, and other resources with public health department and private organization efforts to increase health care capacity for disadvantaged persons, to avoid unnecessary duplication or competition for patients. For example, one aspect of the strategy could be to rely on CHCs to provide prenatal and well baby care where they exist and use MCH project grant funds in locations not having or eligible for CHCs. Exceptions could be made in unusual circumstances. Through such a strategy HEW could give even higher priority to areas having significant problems and take more aggressive action to see that such grantees have adequate programs to provide family planning, prenatal, perinatal, and well baby care, as already required. MCH funds could then be used to assist areas (a) ineligible for capacity building programs, (b) not likely to receive such programs for a number of years, or (c) having unusual problems.

7. Inform public and private health care organizations and school officials at the local level, through State MCH agencies, health planning agencies, professional organizations, or by other means, of Federal or private resources that can be used to help improve pregnancy outcome. Funding sources for such items as prenatal care, health education, family planning, well baby care, facility construction or improvement, and transportation should be included.

8. Define what constitutes satisfactory progress in improving pregnancy outcome and monitor States' performance against this definition. Assist those States which are not progressing satisfactorily.

9. Specify how and to what extent States are to give priority to using MCH funds in rural areas and require States to report information necessary to determine compliance.

10. Define the essential elements and develop milestones so that State progress in developing regionalized perinatal health services can be evaluated and monitor progress made and problems encountered by States in developing and implementing such systems, giving appropriate emphasis to regionalized ambulatory, as well as inpatient, care. See that efforts made by the Health Resources Administration to regionalize perinatal care are coordinated with BCHS activities under the MCH program.

11. Consider what incentives would be appropriate to encourage and assist States to hasten efforts to regionalize perinatal care and integrate public and private health care sectors and make appropriate recommendations to the Congress. One possibility is to offer a higher Medicaid reimbursement rate for MCH services or more MCH funds to those States having acceptable regionalization plans and making satisfactory (to be defined by HEW) progress toward implementation. Federal funds for health care facility construction, expansion, or renovation could be tied to regionalization progress.

12. Direct the Assistant Secretary for Health to consider what the Federal Government should or can do to help poor persons gain access to in-hospital obstetrical or infant care in cases where hospitals, which are not obligated under Federal programs or have already met their obligations to provide some care to persons who can not pay, refuse to accept such patients. Expanding Medicaid coverage and increasing Medicaid reimbursement rates should help. Providing additional funding for in-hospital care of non-Medicaid eligible persons under the MCH program is one alternative. Evaluating the concept of and issues surrounding out-of-hospital births is another action that could be taken.

13. Enforce requirements for CHCs to provide prenatal care, perinatal care, family planning, and well baby care and provide assistance that such grantees may need to comply. See that CHCs serve adolescents as part of their basic provision of services.

14. Consider the feasibility of seeking additional MCH funds earmarked specifically for prenatal care until sufficient resources are available through the CHC program or from other sources to cover all areas having significant pregnancy outcome problems with adequate comprehensive health care capacity.

15. Work with professional organizations, such as the American College of Obstetricians and Gynecologists, State medical societies, the American Academy of Pediatrics, and the American Academy of Family Physicians, to see what steps can be taken to encourage more private physicians to accept Medicaid patients or low-income patients not eligible for Medicaid. Collaborative efforts should also be made to determine whether the practice of obstetrician/gynecologists to discontinue providing obstetrical services is or is likely to become a significant national or regional problem, and if so, determine what actions are appropriate for dealing with the problem.

16. Require or request health planning agencies, as part of their periodic planning process, to assess the extent to which physician refusal to accept Medicaid or other low-income patients, particularly obstetric and pediatric patients, is a problem in their areas and suggest specific measures for alleviating the problem. Steps could include (a) requesting designation of the area as a health manpower shortage area if it does not otherwise meet the criteria, (b) giving higher priority to the area for NHSC personnel, (c) working with the State Medicaid agency or State legislature to increase Medicaid fees, reduce paperwork or claim processing time, or (d) working with medical societies or other professional organizations to convince physicians of the need to help provide health care to poor persons.

17. Launch a major, nationwide information and education campaign, in conjunction with private organizations, such as the National Foundation-March of Dimes, on the benefits and importance of early and adequate prenatal care and preventing or favorably timing high-risk pregnancies. Tell the public, as part of this campaign, what health authorities believe to be the most critical and common high-risk conditions.

18. Periodically determine whether State Medicaid fee structures, ~~particularly for obstetrical and pediatric care,~~ comply with HEW regulations requiring that they be designed to enlist the participation of a sufficient number of providers so that eligible persons can receive such care at least to the extent it is available to the general population. In those cases where fee structures are inadequate, take appropriate action to remedy the situation. In those cases where factors other than the fee structure, such as paperwork requirements or payment delays, significantly contribute to lack of physician participation, see, in conjunction with health planning agencies, what arrangements can be worked out with the States to overcome the problem.

19. Encourage greater use of nurse-midwife/obstetrician teams, help ~~eliminate barriers which preclude~~ nurse-midwives from practicing in hospitals, and provide additional training funds for nurse-midwives by giving such training higher priority for use of existing funds and/or seeking additional funds from the Congress. Also, consider doing more to encourage and assist in efforts to use obstetrical, pediatric, or other types of nurse practitioners who can help increase access to or improve the quality of MCH care.

20. Identify, in conjunction with State MCH agencies and interested private organizations, what HEW will consider minimally acceptable prenatal care in Federal assistance programs in terms of timing of initiation of prenatal care, number of visits, and services to be provided, at least for normal, noncomplicated pregnancies.

21. Develop a mechanism for getting NHSC personnel into areas experiencing significant pregnancy outcome problems lacking health care professionals or such professionals willing to serve poor persons and lacking a CHC or other community organization besides a governmental agency willing or able to sponsor a CHC or NHSC site. Alternatively, HEW could request approval from the Office of Management and Budget to give State or local health departments cost reimbursement waivers for NHSC personnel who provide new or additional services in communities to help improve pregnancy outcome.

22. Instruct regional office staffs to see that applications for capacity building grants and family planning grants specifically address improved pregnancy outcome and discuss unmet needs, specific goals, objectives, and activities proposed to meet these needs and closely monitor regional office performance.

23. If the Congress gives a priority to low-income, high-risk persons in the title X Family Planning program as we recommend, see that grantees and applicants describe adequate measures for (a) identifying high-risk women early, (b) making them aware of the risks of ill-timed pregnancy, and (c) motivating women through more aggressive information, education, and outreach efforts to seek and effectively use family planning services.

24. Hasten efforts to develop a mechanism for determining the extent to which family planning clinics serve women with high risk of poor pregnancy outcome for reasons other than age. Indicators might include the numbers or proportion of women in geographic areas (a) who give birth two times within a 17-month period, (b) who have previous premature births or fetal deaths, (c) who have abortions, (d) who have had four or more previous pregnancies, or (e) who become pregnant and have low educational attainment.

25. Consider whether it would be possible and desirable for the Federal Government to act concerning State restrictions against providing family planning services to minors without parental consent and, if so, what steps would be appropriate, particularly in view of rising concern over Government interference in the family relationship.

26. Require family planning grant applicants to describe what steps they are planning or taking to assure confidentiality through such factors as clinic location, array of services offered (only family planning versus comprehensive), notifying clients of appointments, lab results, missed appointments, and billings and assessing effectiveness of these during site visits.

27. Direct HEW's Office for Civil Rights to step-up monitoring and enforcement of regulations prohibiting school systems receiving Federal financial assistance from discriminating against pregnant students.

28. Work with the States, through the National Center for Health Statistics, to evaluate the accuracy of reported infant mortality statistics to determine whether the underreporting noted in one State by the Center for Disease Control exists elsewhere.

CHAPTER 8

COMMENTS BY FEDERAL AND STATE AGENCIES AND PRIVATE ORGANIZATIONS AND OUR EVALUATION

We received written comments on a draft of this report from HEW, the Department of Agriculture, health or human resources agencies in the States visited, except California, the American College of Obstetricians and Gynecologists, the American College of Nurse-Midwives, the American Academy of Pediatrics, and the National Foundation-March of Dimes. These agencies and organizations generally concurred in our findings and recommendations. Their general comments are summarized below. We have considered the technical comments made by these organizations and have made changes in this report where appropriate.

HEW

General comments

In its general comments, HEW pointed out some significant actions it has taken to address many of the problems discussed in the report. These included (1) a department-wide effort to better coordinate its health service delivery and health care financing programs, (2) including universal maternal and infant care under the Administration's national health insurance proposal, and (3) extending Medicaid coverage to more pregnant women under the Administration's legislative proposal for the Child Health Assurance program.

Problems and issues not discussed or mentioned too briefly

HEW pointed out several problems and issues relating to improved pregnancy outcome that it believed were discussed too briefly or not at all in our report. We acknowledge HEW's concerns about these issues and problems and did not intend to imply that they were unimportant by not focusing on them in our report. We did not look at all problems and issues affecting pregnancy outcome. We limited our review to selected problems impeding access to health care for women at risk of poor pregnancy outcome. Some aspects of the problems and issues of concern to HEW are discussed in other GAO reports.

The problems and issues that HEW said were either not discussed or discussed too briefly and references to other GAO reports, where applicable, that deal with these follow:

--The general health and well-being of reproductive age males and females and adverse physical, mental, and social outcomes that can result from pregnancy. Our February 6, 1979, report to the Congress, "Early Childhood and Family Development Programs Improve the Quality of Life for Low-Income Families" (HRD-79-40), discusses the benefits that early childhood and family development programs provide, the extent that such programs were serving those in need, the effect of HEW-sponsored child and family development programs, and the potential benefits and costs of these programs.

--Excessive technological intervention during childbirth and the increasing proportion of women choosing to give birth at home or in childbirth centers outside of hospitals. Our September 24, 1979, report to the Congress, "Evaluating Benefits and Risks of Obstetric Practices--More Coordinated Federal and Private Efforts Needed" (HRD-79-85) and an accompanying staff study issued at the same time, "A Review of Research Literature and Federal Involvement Relating to Selected Obstetric Practices" (HRD-79-85A) discuss several issues and problems relating to some medical practices used during childbirth, including use of electronic fetal monitoring devices and performance of cesarean sections. Neither the report nor the staff study discuss the issue of out-of-hospital births by choice, but we have added a brief discussion of this issue to this report and modified HEW recommendation #12 in recognition of HEW's concern.

--Prospects for preventing birth defects through (1) prenatal diagnosis of potential problems, (2) childhood immunizations, and (3) preventing or treating sexually transmitted diseases. Our October 3, 1977, report to the Congress, "Preventing Mental Retardation--More Can Be Done" (HRD-77-37) discusses several additional steps that could be taken to prevent mental retardation through prenatal diagnosis and immunizations as well as by improved screening efforts. Causes of mental retardation discussed in the report include metabolic disorders, chromosome abnormalities, rubella and measles, lead poisoning, and Rh hemolytic disease.

--Research needs and efforts, particularly by the National Institute of Child Health and Human Development, in such areas as improved methods of fertility control, fetal research, and evaluation of technology frequently used during prenatal and intrapartum care. The latter area is discussed in our report and staff study on obstetric practices mentioned above.

--More emphasis on the role of health education, particularly as it might influence the behavior of already-pregnant women in the use of drugs, alcohol, and tobacco and in the practice of better nutrition and attention to women's occupational exposures to toxic chemicals and physical hazards. Our February 27, 1979, report, "The Special Supplemental Food Program for Women, Infants, and Children (WIC)--How Can It Work Better?" (CED-79-55) discusses nutrition education in more detail.

--The role of abortion in pregnancy outcome.

HEW also said that it had recently published reports which discuss many issues relating to pregnancy outcome that should be mentioned in our report. These documents were the Surgeon General's report "Healthy People" and a series of draft working papers on health promotion and disease prevention, which set forth potential approaches for dealing with problems concerning pregnancy and infancy, family planning, and sexually transmissible diseases.

Matters needing clarification

HEW said that (1) our report discussed education solely in the context of motivating persons to practice contraception and (2) the necessary distinction between family planning education, which provides the means for women to freely choose a contraceptive method, and family life and sex education, which encompass a far broader set of goals and objectives, has not been adequately made. Chapter 4 briefly discusses the exclusion or superficial coverage of more comprehensive health education at family planning clinics and in schools, and chapter 5 also discusses broader aspects of health education in relation to prenatal and well baby care. We recognize HEW's concern over the distinction between family planning education and family life and sex education. Where we refer to family life and sex education, we intended

to refer to the broader set of goals and objectives cited by HEW, not just family planning information.

HEW said that the report focuses attention on adolescents without fully considering the needs of all other high-risk groups. It said that while adolescent pregnancy must be counted as a most serious problem, older women account for a larger share of adverse pregnancy outcome and that efforts to reduce infant mortality often overlook women over 35 years of age. We agree that our report emphasizes the problems relating to adolescent pregnancy. We focused on adolescents because HEW and the Congress have identified them as a serious national problem and because HEW and State MCH directors have given the problem of adolescent pregnancy a high priority. However, the report also discusses other women, such as older women, women who experienced problems with previous pregnancies, and women who have an Rh negative blood type, who could be high risk for adverse pregnancy outcome. Our recommendations focus on high-risk persons in general, and are not limited to adolescents. Our report, "Preventing Mental Retardation--More Can Be Done," discusses in more detail specific problems and needs relating to several categories of women--other than adolescents--who have a high risk for adverse pregnancy outome.

HEW said that to give priority--under the existing title X program--to the prevention of high-risk pregnancy and to assume a more aggressive stance in motivating such women to seek and effectively use family planning services would present a moral dilemma and be at variance with the statutory language and intent. Title X mandates that the program serve all those who need and voluntarily desire services, giving priority to low-income women. Therefore, to the extent that HEW emphasizes any high-risk groups, it may be forced to deemphasize services for other women who also need family planning.

In our draft report, we proposed that the Congress amend title X of the Public Health Service Act to require that priority be given to providing family planning services to women having high risk for poor pregnancy outcome, including adolescents. We modified this proposal to clarify our intent that the Congress require that at least some priority be given to low-income women who would be at risk of poor pregnancy outcome. We did not intend that the entire title X program be focused on this group.

Comments on recommendations

HEW generally concurred in our recommendations to it and described actions planned or underway which address them. We modified four of our recommendations to HEW as a result of its comments or comments by others.

In our draft report, we proposed that HEW define in its MCH regulations what constitutes satisfactory progress in improving pregnancy outcome. HEW said that it agreed with the intent of this proposal, but that criteria for measuring progress did not need to be incorporated in regulations. We agree with HEW and modified our recommendation (HEW recommendation #8) accordingly.

Another proposal in our draft report was that HEW give State MCH agencies a formal role in its grant review process for those cases in which the grants do or can affect pregnancy outcome. HEW said that it would fund six to eight demonstration projects in fiscal year 1980 to test and develop a mechanism for ensuring that State MCH agencies have concurrent review and are involved in approving State health plans. In making our proposal, we did not intend that State MCH agencies necessarily be given approval or denial authority. Therefore, to preclude possible misinterpretation, we modified our recommendation (HEW recommendation #4) to clarify our intent that as a minimum, HEW consider comments of State MCH agencies during its grant review process.

In our draft report, we proposed that HEW take steps to facilitate greater use of nurse-midwife-obstetrician teams. HEW concurred with our proposal. In addition, HEW stated that it will consider increasing support for obstetrical and pediatric nurse practitioners who can help meet certain ambulatory care needs. The American Academy of Pediatrics and Missouri also cited the need for other types of nursing personnel in addition to nurse-midwives. Therefore, we modified our recommendation (HEW recommendation #19) to include other types of nursing personnel.

In our draft report, we suggested that HEW consider reevaluating its cost reimbursement waiver policy under the NHSC program. In its comments, HEW said that it still believes that the Office of Management and Budget has prohibited it from giving cost reimbursement waivers to State and local governments for NHSC personnel. Therefore, we revised our report and are recommending (HEW recommendation #21) that HEW, as one alternative, request approval

from the Office of Management and Budget to give such waivers in certain situations.

DEPARTMENT OF AGRICULTURE

General comments

Agriculture made several comments on matters discussed in our draft report. It generally agreed with our finding that Federal efforts to improve pregnancy outcome need to be better coordinated and that a problem exists in getting both health services and WIC benefits in some areas. However, Agriculture expressed concern about the perspective in which problems with the WIC program were discussed in our draft report.

Agriculture said that:

--The inadequate health services for WIC participants cited in the report are not representative of the WIC program. WIC agencies have used a variety of arrangements with existing health care providers, including HEW grantees, community health providers, and private physicians. Although the data indicate that further improvement is needed, the WIC participant in the vast majority of areas has good health services available at the critical time of pregnancy and early growth.

--Federal efforts to improve pregnancy outcome do need improved coordination. Agriculture has taken and intends to continue taking action to strengthen the relationship between health care and WIC. HEW and Agriculture regional office personnel have identified barriers to coordinating WIC and BCHS projects. In July 1979, Agriculture issued new WIC regulations which put stronger emphasis on coordination with existing health services and HEW-funded clinics and which push WIC projects more in the direction of serving as an adjunct to health care. For example, Agriculture regulations now require State WIC agencies to submit plans for coordinating program operations with health programs. Also, in October 1979, Agriculture began a large-scale evaluation of WIC which will include an assessment of the coordination of WIC and health care services. Agriculture and HEW will be evaluating ways to reduce barriers to the relationship between WIC and health care and to better serve the target populations.

--State and local WIC program administrators have tried to coordinate with HEW programs wherever possible. Given the great variations in the availability of health services in the United States, local communities frequently have had to find alternative means to ensure health care availability to WIC participants. Many areas have both a high priority for WIC and an inadequately developed health network. In some rural areas, WIC has drawn health care services for low-income women and children into areas for the first time.

--Many low-income women lack access to WIC because program funds are limited, and most States are not able to serve all persons in need.

It is true that our samples of WIC participants were not designed to be projected to the entire Nation. Instead, our approach was to identify what we believed to be basic problems with the management controls over the program and determine if they were isolated examples or systemic weaknesses requiring nationwide corrective actions. Our prior report on the WIC program clearly shows that, despite the fact that most WIC participants seemed to be receiving health services, systemic management problems resulted in a number of participants in some locations not receiving needed services and some participants in other locations having to arrange health services on their own instead of receiving them through the local WIC agency. We concluded that, based on our findings and WIC's authorizing legislation, the program should have a closer link to health services.

Although WIC can stimulate the expansion of health care services in areas where such services are lacking or inadequate, this does not always happen. WIC provides neither the health personnel for this expansion nor the funds to pay for it. Moreover, we believe that closer coordination between WIC and health program administrators, especially for medically underserved areas, will help maximize WIC's potential for helping to improve pregnancy outcome.

Comments on recommendations

Although we did not make any recommendations directly to Agriculture, several of our recommendations to the Congress and HEW involve Agriculture programs. Agriculture commented on three of our proposals.

Requiring closer coordination among programs

Agriculture agreed with our proposal that the Congress require that health-related programs like WIC that affect pregnancy outcome be better coordinated at the Federal, State, and local levels (congressional recommendation #2). As previously indicated, Agriculture said that efforts toward closer coordination were already underway. However, Agriculture said that coordination may not always be possible in areas most in need of WIC. It said that in some cases an area that a State WIC agency identified as most in need of WIC expansion may not be targeted for HEW funds and that WIC funds should be provided to these high priority areas with health care being provided through whatever alternative facilities are available.

It appears that Agriculture misinterpreted our intent. In making our proposal, we did not intend to imply that WIC should be placed only in those areas served by an HEW health program. We believe that WIC programs should be placed in those areas in need where adequate and appropriate health services are available to WIC participants regardless of the source of funding for the health care. However, it is in those areas most in need of WIC that lack adequate or appropriate health care or where WIC recipients do or would lack access to such care where we believe health and WIC program administrators need most to coordinate their planning and other activities. Furthermore, HEW and other health agencies may be able to help WIC program administrators to find alternative sources of health care when they do not have funds targeted for medically underserved areas where WIC is operating or planned.

Designate an organization or official to facilitate coordination

Agriculture said that although Federal efforts to improve pregnancy outcome need improved coordination, it was not convinced that our proposal that the Congress name one agency or official to take the lead in coordinating and focusing efforts (congressional recommendation #4) is the necessary solution to coordination problems. Agriculture said that coordination means better communication and improved efforts to see that efforts are complementary, not duplicative.

We recognize Agriculture's concern and agree that naming someone to be the lead in itself will not result in improvement. However, because several Federal agencies administer programs affecting pregnancy outcome, we believe that someone needs to serve as the catalyst in promoting better communications and more coordinated efforts. We did not intend that this person be given authority to direct other agencies' activities. We believe our recommendation is appropriate and would help facilitate the actions Agriculture believes are necessary.

Developing a plan for each State

With respect to our proposal that HEW collaborate with other Federal agencies, including Agriculture, to develop a comprehensive plan for each State specifying how Federal resources should be integrated to improve pregnancy outcome (HEW recommendation #5), Agriculture said that such action which included the WIC program could be valuable for many State agencies.

STATES

Comments received from the District of Columbia, North Carolina, Mississippi, and Missouri are summarized below. Virginia said it concurred in our findings. A representative from the California Department of Health Services said that his department had no comments.

North Carolina

North Carolina described several actions it took or was taking to deal with problems in the State. It said that:

--It was obtaining information to prepare a comprehensive MCH plan, although it had no Federal guidelines showing what a plan should contain.

--A recent review of all NHSC placements in the State was made, and cooperative efforts were beginning.

--Coordination with health planning agencies was improving, although there is too little contact between the agencies writing plans about MCH and the MCH agency.

--A task force is developing a viable school health program, but this will take time to implement and will depend on resources available.

--Progress has been made in reducing the number of granny midwife deliveries. Also, State funding for local health departments to pay for the cost of delivery and associated costs has increased, and the State is expanding services now provided in two counties under the IPO initiative to the rest of the State.

--Attempts are being made to establish a viable infant transport system, but problems continue to hamper these efforts.

In addition, North Carolina said that the lack of prenatal clinics in many areas is not primarily an MCH funding problem. It said that in various areas: (1) facilities are not available, (2) some private physicians do not support health departments having clinics, (3) there are no private physicians or nurse practitioners, or (4) private physicians are too busy.

Also, North Carolina said that although it concurs in the concept of operating health clinics by appointment, successful implementation of the concept has varied. In some instances, over half the patients did not come. The State also said that extra waiting is experienced by persons living in remote areas who depend on others for transportation, and waiting is not peculiar to health department patients.

Mississippi

The Mississippi State Board of Health highlighted several problems discussed in our draft report that it believed were particularly applicable to the State or were significant problems. These included:

--The failure of HEW urban and rural health initiative grantees and CHCs to integrate their activities with those of other organized programs in the State.

--The overlap and confusion in responsibilities between State MCH and health planning agencies.

--Failure of some CHCs to emphasize prenatal care, family planning, and other services aimed at improving pregnancy outcome.

--Burdens placed on HEW grantees resulting from the multiplicity of funding sources.

--The significant number of low-income women who, by reason of marriage, are not eligible for Medicaid, but who have financial and other needs as great as those who are.

--The need for strengthening the public health system and improving coordination between it and the private sector.

--The lack of motivation by many to seek private care, even when they have access to such care.

Mississippi also expressed concern about the Government's policy to generally not give waivers to State and local government for repayment of the cost of NHSC personnel, which, in the State's opinion, frustrates efforts to expand cost-effective preventive services for the high-risk population.

Regarding WIC, Mississippi said that the program will serve all the counties in the State within the next year, provided funds are available. Mississippi also said that it provides MCH services in every county even though little or no MCH funds are budgeted for some. We modified our report accordingly.

Missouri

The Missouri Division of Health said that:

--One of the major obstacles to expanding prenatal clinics is the difficulty in getting area physicians to participate. Changes in Medicaid that could encourage wider participation by private physicians and other health care providers, such as increasing reimbursement rates, would decrease the number of women and infants who are not being served. The problem is illustrated in the Bootheel area, where before 1973, and the introduction of Medicaid, prenatal care clinics existed in five of the six counties and were staffed by physicians and others. With the onset of Medicaid payments to private physicians, these clinics closed. Currently, private physicians in the area are reluctant to accept Medicaid patients because of low reimbursement rates.

--The MCH funding formula is not realistic today, and there needs to be a mechanism to ensure incentive to reduce perinatal mortality and morbidity.

--The State plans to develop a realistic MCH plan.

--In Missouri, parental consent for receipt of family planning services is such a deterrent to the adolescent that even informed, mature, and responsible teenagers who choose to be sexually active are at a disadvantage to adequately protect themselves from an unwanted, ill-timed pregnancy. Also, many persons oppose family planning and family life education programs.

--The use of nurse-midwives and pediatric nurse practitioners is obstructed by several problems, including their legal status as health providers, lack of uniform standards for their training and certification, and their small numbers.

--All MCH-funded programs need to be coordinated to have an effective mechanism for improving pregnancy outcome.

--The need for qualified NHSC personnel, particularly in rural areas, is clearly illustrated by the difficulty the State has faced in trying to recruit key staff for its Boothe:el IPO project. Missouri has not received any NHSC personnel for this project.

District of Columbia

The District of Columbia's Department of Human Resources said that:

--Static funding for the MCH program of projects and inflation resulted in a reduction of MCH staff and services during the last several years. This trend was reversed during fiscal year 1979, when the District initiated concerted action to reduce its infant mortality rate, including steps to coordinate and increase services for mothers and infants. These efforts have reduced or eliminated many of the problems identified in our report. For example, outreach and followup for broken maternity appointments have increased, and the waiting period for a maternity appointment has been reduced to less than 2 weeks in all but one clinic, and an additional neonatologist has been hired for D.C. General Hospital.

--Additional funds are needed for in-hospital care for selected patients who cannot pay for such service. This problem has been of particular concern in the District.

PRIVATE ORGANIZATIONS

We received written comments on our draft report from the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American College of Nurse-Midwives, and the National Foundation-March of Dimes. A summary of their comments follows:

American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists emphasized the need for better management, coordination, and evaluation of MCH efforts, including having someone designated to oversee all programs providing health services to women and children. In addition, the College said that it has worked with the Health Care Financing Administration to develop a recommended minimum package of obstetrical benefits that State Medicaid plans should provide. It said it would continue to work with other professional groups, the Congress, and Federal agencies to increase physician participation in Medicaid and related programs. The College said that it was working with the National Center for Health Statistics to develop uniform acceptable definitions for pregnancy outcome terminology, such as perinatal mortality.

The College took exception to the measure of inadequate prenatal care used in our report, saying that accepting delay in seeking prenatal care until the third trimester is not a medically acceptable suggestion. It was not our intent to suggest that this be a standard of care. As we noted in our report, this measure is frequently used by others as a rough indicator, and we used it because a uniform, generally accepted standard could not be obtained. Moreover, we recommended that HEW, in conjunction with interested private organizations, define what it considers minimally acceptable prenatal care, including timing of initiation of care.

American Academy of Pediatrics

The Academy said that many of our findings and recommendations are identical or similar to those contained in a report it recently prepared summarizing its findings during

evaluations of several State MCH efforts under contract with HEW. The Academy identified several actions it believed warrant high priority by the Congress and Federal agencies. These included:

--Increased emphasis on early, high-quality prenatal care, particularly for high-risk women, including more effective use of nurse-midwives and obstetrical nurses.

--Improved regionalization of inpatient perinatal care and infant transportation.

--Better integration of health and WIC programs.

--Strengthened management of State MCH programs.

American College of Nurse-Midwives

The Nurse-Midwives identified several obstacles to increasing their supply and use, including the high cost of training, the need for more opportunity to obtain clinical experience and supervision, and incomplete coverage under Medicaid programs. They also said that nurse-midwives can help fill a gap by serving those persons who other providers have refused to serve.

National Foundation-March of Dimes

The Foundation stated that reports from its chapters throughout the Nation reinforce the problems identified in our report, including duplicative efforts, examples of pregnant women being unable to obtain needed services and shortcomings in Medicaid. In addition, the Foundation expressed concern about deficiencies in administration of MCH programs at State and local health departments and at the Federal level. The Foundation said that since the transfer of MCH program responsibility from the Children's Bureau to the Public Health Service (in 1969), Federal program performance has deteriorated. The Foundation urged action by the Congress and HEW to correct this. The Foundation also suggested increased Federal support for educating and training health professionals in schools of public health to improve administrative expertise in MCH programs.

The Foundation suggested, and we agreed, to specify two additional medical professional organizations to HEW recommendation #15 and said that it would be pleased to help HEW launch a major public education effort as proposed in HEW recommendation #17.

BUDGETED USE OF FEDERAL MATERNAL AND CHILD HEALTH

FORMULA GRANT FUNDS BY STATE--FISCAL YEAR 1978

Percent of total MCH	Local health departments	State or private contractor	Activities other than program of projects: In-hospital care	Research	Training	General administration	Other	Sub-total	Percent of total MCH	Total MCH
64.9	$ 440,000	$ 483,281	$ -	$ -	$ 28,207	$ 349,595	$ 387,060	$ 1,688,143	35.1	$ 4,807,268
72.0	-	9,600	-	-	1,900	12,000	83,000	106,500	28.0	380,200
36.9	804,824	-	-	-	160,866	735,064	305,832	2,006,586	63.1	3,180,901
46.2	1,107,600	-	-	-	-	169,000	387,300	1,659,100	53.9	3,080,400
49.0	1,716,355	761,307	349,448	-	504,397	1,727,540	678,965	5,738,012	51.0	11,254,203
78.5	261,359	-	-	-	1,500	278,436	221,567	762,862	21.5	3,554,659
62.3	14,000	177,295	-	-	-	211,761	220,317	623,373	37.2	1,674,012
38.0	807,382	-	-	-	2,000	230,000	-	539,382	62.0	869,282
70.9	163,503	1,061,168	-	11,140	2,573	405,237	-	1,643,621	29.1	5,650,431
76.8	977,834	101,378	-	-	100,000	-	281,600	1,460,812	23.2	6,297,410
60.2	1,719,317	393,759	35,080	32,628	(a)	298,006	99,863	2,578,653	39.8	6,476,053
86.2	-	-	-	-	-	64,296	85,912	150,208	13.8	1,087,320
67.4	237,840	-	-	-	8,850	76,500	61,665	384,855	32.6	1,181,847
40.4	2,190,487	-	25,000	-	-	-	29,656	2,245,143	59.6	3,766,399
58.0	458,349	517,236	-	-	2,957	38,341	229,086	1,245,969	42.0	2,969,480
55.2	382,741	-	-	-	-	158,866	382,287	823,894	44.8	1,838,237
34.4	1,293,945	340,726	(a)	10,000	61,000	565,513	919,068	3,190,252	65.6	4,860,198
6.8	-	4,909,141	-	-	25,000	291,653	-	5,225,794	93.2	5,606,425
48.2	-	500,000	-	-	-	250,000	-	750,000	51.8	1,447,000
85.3	1,015,000	-	-	-	-	-	-	1,015,000	14.7	6,924,932
77.6	1,432	210,598	-	500	349	786,089	76,791	1,075,759	22.4	4,793,097
70.5	1,146,433	-	-	-	-	1,092,400	-	2,238,833	29.5	7,586,233
86.0	75,000	32,700	-	-	16,187	259,995	39,786	423,668	14.0	3,036,262
26.0	1,236,320	1,492,688	189,144	-	39,321	339,960	-	3,297,433	74.0	4,456,906
51.9	659,000	913,000	-	-	7,500	145,000	392,300	2,117,800	48.1	4,397,076
39.0	147,090	102,583	-	-	-	375,869	148,196	773,738	61.0	1,267,960
77.0	92,759	108,235	-	-	-	87,903	138,443	427,340	23.0	1,860,220
47.9	11,880	-	-	-	-	-	212,167	224,047	52.1	429,791
86.8	-	-	-	-	-	-	100,000	100,000	13.2	759,000
40.7	534,879	635,602	-	-	-	747,071	141,909	2,059,461	59.3	3,475,146
62.3	250,000	124,013	-	-	-	27,471	87,766	489,250	37.7	1,299,429
75.0	1,800,000	-	-	-	-	2,018,241	991,398	4,809,639	25.0	19,230,467
16.2	3,454,530	251,636	-	15,052	(a)	1,842,675	-	5,563,893	83.8	6,638,695
30.1	174,969	220,773	-	-	500	54,658	-	450,900	69.9	644,900
50.2	2,455,058	-	-	-	-	1,509,000	-	3,964,058	49.8	7,960,502
52.2	793,394	149,715	-	-	15,000	285,000	-	1,243,109	47.8	2,602,000
38.8	718,118	154,212	-	-	-	186,742	514,016	1,573,088	61.2	2,571,356
61.1	-	1,205,000	-	-	43,195	972,972	1,392,501	3,613,668	38.9	9,292,751
32.7	152,000	-	-	-	-	-	301,183	453,183	67.3	673,183
28.4	583,466	1,259,179	351,617	-	-	1,164,962	211,367	3,570,591	71.6	4,985,462
74.9	22,600	42,699	-	-	-	98,825	-	164,124	25.1	654,375
34.0	758,690	2,010,260	95,940	-	-	240,140	-	3,105,030	66.0	4,707,280
40.0	1,787,761	2,478,257	(a)	(a)	(a)	913,170	1,789,577	6,968,765	60.0	11,620,397
65.8	280,119	-	-	-	-	295,207	-	575,326	34.2	1,684,592
100.0	-	-	-	-	(c)	(c)	-	-	-	423,927
46.0	-	468,593	1,203,780	-	32,319	(a)	889,597	2,594,289	54.0	4,806,000
47.8	998,000	318,000	-	-	-	166,000	-	1,482,000	52.2	2,840,000
40.6	-	529,387	675,232	-	-	288,162	267,692	1,760,473	59.4	2,965,558
44.5	575,500	849,300	-	-	96,200	1,000,000	424,000	2,945,000	55.5	5,309,900
22.5	6,255	58,283	-	-	-	-	301,838	366,376	77.5	472,876
53.9	$31,700,989	$22,869,604	$2,925,241	$69,320	$1,149,821	$20,759,320	$12,793,705	$92,268,000	46.1	$200,351,998

APPENDIX I

State	Program or projects: Maternity and infant care	Infant intensive care	Family planning	Dental	Children and youth	Sub-total
Alabama	$1,410,877	$ 200,000	$ 80,000	$ 125,000	$ 1,303,248	$ 3,119,125
Alaska	41,500	67,000	120,700	15,000	29,500	273,700
Arizona	285,112	103,611	360,005	57,244	368,343	1,174,315
Arkansas	510,300	221,000	-	57,000	633,000	1,421,300
California	1,770,789	372,683	47,254	27,897	3,297,568	5,516,191
Colorado	370,225	92,502	94,000	7,250	2,227,820	2,791,797
Connecticut	428,000	51,610	28,043	22,486	520,500	1,050,639
Delware	50,600	50,000	14,300	57,000	158,000	329,900
District of Columbia	2,448,308	-	115,000	-	1,443,502	4,006,810
Florida	3,176,598	100,000	100,000	110,000	1,350,000	4,836,598
Georgia	2,517,859	884,196	-	84,765	410,580	3,897,400
Hawaii	535,165	25,000	31,700	11,000	334,247	937,112
Idaho	554,829	70,000	121,591	25,572	25,000	796,992
Illinois (note d)						
Indiana	510,312	266,459	387,832	25,500	331,153	1,521,256
Iowa	739,692	192,532	134,542	103,603	553,142	1,723,511
Kansas	119,285	122,061	120,000	51,997	601,000	1,014,343
Kentucky	482,471	356,475	40,000	66,000	725,000	1,669,946
Louisiana	121,981	147,402	329	12,519	98,400	380,631
Maine	270,000	115,000	-	140,000	172,000	697,000
Maryland	1,144,400	18,000	162,132	98,000	4,487,400	5,909,932
Massachusetts	1,563,685	72,324	97,843	78,000	1,905,486	3,717,338
Michigan	901,600	-	781,200	95,000	3,569,600	5,347,400
Minnesota	2,103,062	35,132	114,728	44,169	315,503	2,612,594
Mississippi	424,051	179,312	52,728	65,280	438,102	1,159,473
Missouri	543,549	38,985	392,700	69,382	1,175,660	2,280,276
Montana	103,000	20,000	31,222	35,000	305,000	494,222
Nebraska	350,000	61,477	71,403	75,000	875,000	1,432,880
Nevada	131,800	10,657	10,000	-	53,287	205,744
New Hampshire	205,000	55,000	15,000	101,000	283,000	659,000
New Jersey	708,000	-	278,139	121,000	308,546	1,415,685
New Mexico	593,516	66,583	57,278	41,952	50,850	810,179
New York	6,520,564	212,486	(a)	190,000	7,497,778	14,420,828
North Carolina	593,309	-	31,364	60,277	389,852	1,074,802
North Dakota	30,000	16,000	65,000	20,750	62,250	194,000
Ohio	2,767,407	184,539	100,000	81,863	862,635	3,996,444
Oklahoma	102,485	15,000	760,000	71,466	409,940	1,358,891
Oregon	375,000	275,000	82,331	60,836	205,101	998,268
Pennsylvania	2,077,785	119,740	396,000	151,762	2,933,796	5,679,083
Rhode Island	190,000	-	-	-	30,000	220,000
South Carolina	500,000	150,125	160,000	96,547	508,199	1,414,871
South Dakota	95,084	187,145	-	14,972	193,050	490,251
Tennessee	397,450	197,240	216,000	140,690	650,870	1,602,250
Texas	1,610,865	153,000	300,911	85,000	2,501,856	4,651,632
Utah	363,362	281,457	145,924	45,536	272,987	1,109,266
Vermont	64,603	36,542	2,130	0	320,652	423,927
Virginia	483,000	97,777	182,605	102,000	1,346,329	2,211,711
Washington	283,000	212,000	210,000	108,000	545,000	1,358,000
West Virginia	675,081	160,000	-	80,000	290,004	1,202,085
Wisconsin	200,000	768,500	528,400	218,000	650,000	2,364,900
Wyoming	-	-	b/106,500	-	-	106,500
Sub-total	$42,444,561	$7,121,552	$7,146,824	$3,351,315	$48,019,736	$108,083,998
Total						

Source: Questionnaires from States.

a/Amount included in other column(s).

b/Includes $12,000 for dental health.

c/Amount not specified.

d/Illinois has not returned questionnaire.

1976 VITAL STATISTICS FOR THE UNITED STATES AND SELECTED STATES

State	Number of live births	Infant deaths		Fetal deaths		Low birth weight		Prematurity		Number of abortions
		Number	Rate	Number	Rate	Number	Rate	Number	Rate	
United States	3,167,788	48,265	15.2	33,111	10.5	229,375	7.3	176,415	8.8	1,179,300
California	332,256	4,129	12.4	3,051	9.2	20,469	6.2	22,321	8.2	190,800
District of Columbia	9,700	245	25.3	163	16.8	1,163	12.0	924	13.1	14,200
Mississippi	42,943	924	21.5	698	16.3	3,875	9.0	3,746	11.8	4,200
Missouri	68,879	1,053	15.3	679	9.9	5,002	7.3	4,714	8.7	16,900
North Carolina	80,594	1,434	17.8	1,010	12.5	6,650	8.3	6,795	10.4	23,600
Virginia	70,038	1,140	16.3	977	13.0	5,274	7.5	Not reported		31,500

APPENDIX II

APPENDIX III

COMPOSITE LIST OF MATERNAL

PREGNANCY RISK FACTORS

Patient less than 15 or more than 35 years of age. (Some say less than 17 and more than 40.)

High parity.

One (some say two or more) or more previous premature labors or history of low birth weight infants (less than 2,500 grams).

Excessively large previous infants (greater than 4,000 grams).

Previous Cesarean section or uterine operations.

Previous significant dystocia.

Two or more previous abortions.

Previous stillbirth or neonatal loss.

Suspected or actual previous incompetent cervix.

Medical indication for termination in previous pregnancy.

Previously diagnosed abnormalities of the genital tract.

Previous history of need for special neonatal care.

Previous infant with a known or suspected genetic or family or other congenital disorder.

Previous severe emotional problems associated with previous pregnancy or delivery.

Primary or secondary infertility of more than 2 years duration.

Chronic medical disease; e.g., heart disease, neurological, endocrine, or metabolic disorders.

Maternal diabetes mellitus.

Psychiatric disorder.

APPENDIX III

Marked nutritional abnormality (obesity, abnormal stature, low weight for height, etc.).

Malignancy.

Unresponding urinary tract infections.

Abnormal cervico-vaginal cytologic study.

Suspected ectopic pregnancy.

Suspected missed abortion or trophoblastic disease.

Severe hyperemesis.

Exposure to known teratogens (radiation, infection, chemicals, etc.).

Positive serologic test for syphilis.

Pregnancies complicated by medical disease (endocrine, renal, cardiac, hypertensive, etc.).

Anemia not responsive to iron therapy.

Drug addiction including alcoholism.

Rh isoimmunization (or positive irregular antibody screen).

Severe, unresponding infection.

Third trimester uterine bleeding.

Toxemia of all classes.

Polyhydramnios or oligohydramnios.

Prenatal fetal demise.

Thrombo-embolic disease.

Multiple pregnancy.

Need for fetal maturation studies.

Inappropriate fetal growth for gestational age (too small or too large).

APPENDIX III

Persistent abnormal presentation.

Postdate pregnancy.

Premature rupture of membranes.

Premature labor.

Induction of labor.

Tumor or other obstruction of birth canal.

Suspected feto-pelvic disproportion.

Active genital herpes.

Abnormal glucose tolerance test.

Severe preeclampsia and eclampsia.

Severe isoimmune disease.

Unexplained previous perinatal death.

Labor at less than 34 weeks gestation.

Anticipated severe neonatal infection.

Anticipated need for neonatal surgery.

Serious cardio-respiratory disease.

Serious renal disease.

Severe hemoglobinopathy.

Nonwhite.

Unwed and without male support.

Low income and uneducated.

Over or underweight.

Subsequent pregnancy in less than 1 year.

APPENDIX IV

CLASSIFICATION OF FEDERAL MCH FORMULA GRANT STATE BUDGET ITEMS IN TERMS OF THEIR LIKELIHOOD OF EXTENDING SERVICES TO IMPROVE PREGNANCY OUTCOME FISCAL YEAR 1978

	Amount (millions)	Percent
Appear most likely to extend services:		
Maternity and infant care projects	$ 42.4	
Infant intensive care projects	7.1	
Family planning projects	7.1	
Local health department support	31.7	
State employee or private contractor support	22.9	
In-hospital care	2.9	
Other	4.6	
Total	$118.7	59.3
Generally not targeted at this objective, but appears to have some direct effect:		
Children and youth projects	$ 48.0	
Other	4.7	
Total	$ 52.7	26.3
Appear to have no direct effect:		
Dental projects	$ 3.4	
General administration	20.8	
Research	.1	
Training	1.1	
Other	3.5	
Total	$ 28.9	14.4
Grand total	$200.3	100.0

STATE MEDICAID RATES FOR PHYSICIANS COMPARED TO GOING RATES FOR PRENATAL AND DELIVERY CARE

State	State Medicaid rate limits: Prenatal care	Delivery	Total OB care	Estimated market rate of OB care in State (note a)	Blue Shield plan rate average actual 1977
United States	-	-	-	-	$413
California	-	-	b/$300	c/$900-$1,200	516
District of Columbia	d/$163	$150	313	600-1,000	616
Mississippi	90	135	225	450-500	332
Missouri	55	e/193-220	e/248-275	300-750	f/364-g/375
North Carolina	47	246	293	h/375-450	350
Virginia	100	150	250	i/350-550	401

a/Estimated rates provided by various health officials.

b/Global fee paid for all services.

c/Los Angeles, California.

d/Assumed receipt of 12 prenatal visits at $20 for first visit and $13 for subsequent visits.

e/Different rates according to whether physician is a GP or Obstetrician.

f/St. Louis Blue Shield plan.

g/Kansas City Blue Shield plan.

h/Range represents rural area (Halifax Co.) to urban (Raleigh).

i/Range represents rural area (Greensville Co.) to urban (Norfolk/Virginia Beach).

APPENDIX V

APPENDIX VI

EXTENT TO WHICH STATE MCH DIRECTORS WOULD USE ADDITIONAL MCH FUNDS TO IMPROVE PREGNANCY OUTCOME FROM QUESTIONNAIRE RESULTS

Activity	Very great extent	Sub-stantial extent	Total
Additional prenatal care	29	16	45
Prevent unplanned teenage pregnancy	27	15	42
Additional health education	11	22	33
Improve data collection and analysis	17	15	32
Improve management of MCH program	9	13	22
Additional or improved well baby care	8	14	22
More nutritional counseling and/or supplemental foods for more mothers and infants	7	10	17
Additional infant intensive care services	4	13	17
Additional in-hospital care of mothers for labor and delivery	7	9	16
Provide genetic counseling	6	10	16
Additional or more compre-hensive family planning services	6	6	12

APPENDIX VII

IMPROVED PREGNANCY OUTCOME AND IMPROVED CHILD HEALTH PROJECT FUNDING FISCAL YEAR 1978 (note a)

State or territory	IPO MCH funding	IPO No. of NHSC personnel	ICH MCH funding	ICH Title X funding
District of Columbia	$ 350,000	7	$ -	$ -
Pennsylvania	400,000	-	-	-
Virginia	400,000	-	-	-
West Virginia	400,000	8	-	-
Alabama	400,000	11	$ 300,000	94,688
Florida	400,000	10		
Georgia	400,000	11	300,000	59,672
Kentucky	400,000	-	-	-
Mississippi	400,000	16	b/600,000	b/190,406
North Carolina	400,000	22	300,000	68,255
South Carolina	400,000	30	300,000	80,269
Tennessee	400,000	8	-	-
Illinois	240,000	10	-	-
Michigan	158,428	-	-	-
Arkansas	264,323	6	-	-
Louisiana	400,000	4	-	-
New Mexico	393,302	-	-	-
Oklahoma	400,000	-	-	-
Texas	400,000	-	-	-
Missouri	400,000	-	-	-
North Dakota	-	-	92,529	57,171
South Dakota	400,000	13	207,471	37,829
Wyoming	363,276	-	-	-
Nevada	400,000	-	-	-
Idaho	-	-	158,950	23,220
Washington	-	-	159,475	34,380
Puerto Rico	400,000	-	-	-
	$8,969,329	156	$2,418,425	$645,890

a/NHSC data are as of 4/79.

b/Received two ICH grants.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

REFER TO:

OFFICE OF THE INSPECTOR GENERAL

NOV 19 1979

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Enhancing Federal Efforts To Improve Pregnancy Outcome: Better Management and More Resources Needed." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan Mitchell
for Richard B. Lowe III
Acting Inspector General

Enclosure

APPENDIX VIII

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "ENHANCING FEDERAL EFFORTS TO IMPROVE PREGNANCY OUTCOME: BETTER MANAGEMENT AND MORE RESOURCES NEEDED."

GENERAL COMMENTS

The Department is pleased to offer its comments on this draft report, and it agrees with the need to improve pregnancy outcome and to enhance efforts in this vital area. The inherent value of improved pregnancy outcome to women, the children they bear, and to society at large cannot be overestimated, and we commend the GAO for focusing attention on this issue. The Department has taken several significant steps to address many of the problems raised by the GAO:

1. The PHS/HCFA Child Health Strategy -- a Department-wide effort to improve coordination between PHS service delivery programs and HCFA financing programs. This administrative initiative has important implications for improving access to pregnancy related care for low-income women.

2. The universal maternal and infant care component of the Administration's national health insurance plan now under consideration by the Congress. This special provision makes complete prenatal and delivery services financially available to every woman in this nation: all employed women, or spouses of fulltime employed workers, are covered under the plan's employer mandate; all other women are eligible for fully subsidized pregnancy-related care. All services to pregnant women are provided at no cost sharing to the patient.

3. The Administration's Child Health Assurance Program (CHAP) legislation. This proposal, originally submitted in April of 1977, and resubmitted in the 96th Congress, has been reported out by both the Senate Finance Committee and the House Interstate and Foreign Commerce Committee. CHAP provides a significant step toward the broader entitlement offered under our national health insurance bill -- the Administration's proposal would extend Medicaid coverage to an additional 100,000 needy pregnant women and almost 2 million low-income children under 18.

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However, we have several concerns about the report and related issues. The problems of and solutions to poor pregnancy outcome are discussed almost exclusively in terms of infant outcome. We urge that, in addition to infant outcome the central issue of women's physical and emotional health be addressed.

Women who do not have adequate health care are, in essence, vulnerable to problems of pregnancy and its aftermath; so, too, are their children. High-risk women are even more vulnerable. A woman's state of health is directly related to her effectiveness as a parent, reflecting in large measure her ability to attend to her children's needs and her family's needs as well as her own. To the extent that we attend to all aspects of women's health needs, we focus, at one and the same time, on improving pregnancy outcome. The two are inseparable.

The report says little of the adverse physical, mental and social outcomes in women that can be set in motion by pregnancy. Among them: maternal mortality; immediate maternal morbidity; decreased longevity due to pregnancy-caused chronic illness (e.g. chronic hypertensive disease following pregnancy toxemia); morbidity associated with the increasing rate of Cesarean section; post-partum depression; negative social health outcomes, including marital dysfunction, family disruption, and divorce; and negative mental health outcomes which can affect parent-child bonding and interpersonal relations. In addition, the report does not discuss the issue of excessive technological intervention and the currently increasing proportion of pregnant women who are electing to give birth at home or in childbirth centers outside of hospitals. They do so, in many instances, in order to avoid hospital practices and procedures which they believe are unnecessary and possibly dangerous and which interfere with their enjoyment of childbirth. We advise that the public health issues surrounding the use of these newer technologies and the choice of birth settings are critically important to the improvement of pregnancy outcome.

There is a tendency in the report to focus attention on adolescents, without fully considering the needs of all other high-risk groups. This can only redound to the detriment of low-income women and older women. While adolescent pregnancy must be counted as a most serious problem, it should also be recognized that older women account for a larger share of adverse pregnancy outcome and that efforts to reduce infant mortality often overlook women over 35.

We are concerned that the health promotion/disease prevention potential in improving pregnancy outcome is not as fully addressed as we think it could be. When discussed, the approaches could present some difficult problems:

1. To give priority, under the Title X program, to the prevention of high-risk pregnancy and to assume a more aggressive stance in motivating such women to seek and effectively use family planning services would present both a moral dilemma and be at variance with the statutory language and intent. We must keep clearly in mind the Title X mandates: (1) to serve all those who need and desire such services, giving priority to low income women, and (2) that they be provided through voluntary choice. From the inception of the Federal family planning program, in concept and practice, individuals have been free to decide on the number and spacing of their children, and just as free to seek help in overcoming problems of infertility. To the extent, therefore, that we emphasize any high-risk groups, we may be forced to deemphasize services for other women who also need family planning.

   While we agree with the importance of family planning as a preventive measure and with the opportunities presented by Title X and other Federal programs to address this need, a broader programmatic approach is advisable.

2. Education, an important preventive measure, is discussed solely in the context of motivating individuals to practice contraception. The necessary distinction between family planning education, which provides the means for women to freely choose a method of contraception, and family life and sex education, which encompass a far broader set of goals and objectives, has not been adequately drawn. We agree with the need to develop comprehensive family life and sex education courses and programs in both formal and non-formal education settings. Our basic objective is to provide young people, their parents, and the community at large with tested and proven approaches, materials, and methods, and with relevant and accurate information that will assist them in developing values that promote healthful decisions and responsible relations with others and with society. Based on research findings in this area, we are acting as a catalyst to support innovative approaches, including the development and demonstration of model programs

and curricula for students, parents and the community at large. The role of health education, particularly as it might influence the behavior of already-pregnant women in the use of drugs, alcohol, and tobacco, and in the practice of better nutrition, needs more emphasis. The occupational exposures to toxic chemicals and physical hazards which can increase the frequency of stillbirths, spontaneous abortions, and sterility also require attention.

3. Other measures to prevent adverse infant outcomes are not discussed. The importance of preventing first pregnancies in very young women is dismissed lightly. The role of sexually-transmitted infections and childhood diseases that can be prevented by immunization are not mentioned. The prospects for preventing birth defects through prenatal diagnosis and the problems of the subsequent therapeutic measures are also omitted. In addition, there is little effort to analyze the role which abortion may play with regard to pregnancy outcome.

4. The Surgeon General's Report, Healthy People, which addresses many of the issues relating to pregnancy outcome is not mentioned. The recently published PHS prevention strategies includes potential approaches in Pregnancy and Infancy, Family Planning, and Sexually Transmissible Diseases which should be considered in our efforts.

We believe that improved pregnancy outcome is a function of research, as well as of effective program management and services delivery. We regret that the report omits any discussion of our current fundamental and applied reproductive research efforts in the National Institute of Child Health and Human Development. Clearly, the research needs in such areas as improved methods of fertility control, fetal research, and evaluation of technology frequently used during prenatal and intrapartum care will be critical to our success in improving pregnancy outcome. In addition, the very relevant activities in the Family Planning Evaluation Division at Center for Disease Control should be described.

The report repeatedly emphasizes the need for closer integration and coordination of the Department's programs. Yet several agencies that comprise the network of pregnancy-related programs and services are either unmentioned or their contributions are too briefly discusse

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There are related programs in the Social Security Administration and the Office of Human Development Services which are named but not described. Involved but unmentioned offices within the Public Health Service include the Office of Population Affairs in the Office of the Assistant Secretary for Health and the Food and Drug Administration.

Finally, the report makes serious recommendation about HEW's organization as it concerns pregnancy outcome. We believe it will be important to consider not only the fetus, the newborn, and the infant, but also the reproductive age male and female both before and after they have become parents. Such an organizational structure would need to deal with all aspects of human reproduction and would need to consider the full scope of HEW activities including not only conventional services, but also preventive services, social services, education, and research.

APPENDIX VIII

COMMENTS ON RECOMMENDATIONS

GAO RECOMMENDATION 1.

We recommend that the Secretary of HEW direct the Assistant Secretary for Health to formulate specific goals for improving pregnancy outcome. Goals should cover such indicators as infant mortality, fetal deaths, low birth weight, prematurity, and unplanned pregnancies terminated by abortions. Goals for preventing high-risk pregnancies should also be considered as should goals for adequate prenatal care.

DEPARTMENT COMMENT

We concur. The Health Services Administration (HSA) distributes biennially its Child Health Objectives for State Title V agencies. These objectives address some of the suggested indicators; for example, infant mortality and onset of prenatal care were included in the Objectives for fiscal year 1979-1980. In addition, indices have been defined for program activity areas including pregnancy identification, maternal risk, infant risk and out-of-hospital deliveries.

National goals for 1980 relative to reducing infant, perinatal, and maternal mortality, for increasing the proportion of pregnant women who receive prenatal care starting in the first trimester and who receive safe, attended intrapartum care, to reducing the rate of low-weight birth, for reducing unintended births especially among medically and socially high-risk groups, and to reducing the need for induced abortions, were developed for HEW in draft form by a working conference of experts in Atlanta in June 1979. The report which includes these goals is currently being circulated to individuals and organizations with special competence and interest in this area for constructive comments on which final versions of the objectives will be based.

National and community level goals relative to maternal and infant morbidity and mortality, unwanted pregnancies, prenatal, intrapartum and postpartum services, and reduction in high-risk pregnancies were established in a collaboration effort by HEW, the U.S. Conference of City Health Offices, the National Association of County Health Officials, the Association of State and Territorial Health Officials and the American Public Health Association, were published by HEW in October 1979.

The HSA will establish a process to develop and set forth national goals specific to each State. The process will ensure the appropriate involvement of the National Center for Health Statistics, State maternal and child health agencies, State health planning and development agencies.

GAO RECOMMENDATION 2.

We recommend that the Secretary of HEW direct the Assistant Secretary for Health to consider the feasibility of formulating specific national goals for infant morbidity or birth defects and for providing adequate well-baby care to infants during their first year of life. The feasibility assessment should include an assessment of the costs and benefits of developing and implementing an information system for collecting data on morbidity and receipt of well-baby care.

DEPARTMENT COMMENT

We concur. The Assistant Secretary for Health will direct the HSA to determine the feasibility of collecting and using morbidity data, as indicated in the recommendation above, by July 1, 1980. It will be important to include maternal morbidity measures, as well as those relating to infant morbidity.

Potential predictors of infant and maternal morbidity include low birth weight, low gestational age, labor complications, birth injuries and malformations.

The planning effort described in recommendation #1 will consider morbidity data and birth defects in this process.

GAO RECOMMENDATION 3.

We recommend that the Secretary of HEW designate one official to be responsible for planning, promoting, and evaluating HEW efforts to improve pregnancy outcome. We believe that the Assistant Secretary for Health should be given this responsibility. One official should also be made reponsible for overseeing all departmental efforts relating to adolescent pregnancy, and more aggressive efforts should be made to integrate activities of HEW's health, family, planning, and educational programs.

DEPARTMENT COMMENT

We concur. The Assistant Secretary for Health does, in fact, have the responsibility for planning, promoting, and evaluating HEW's effort to improve pregnancy outcomes, including efforts relative to adolescent pregnancy. Two officials are primarily responsible for assisting him: the Deputy Assistant Secretary for Population Affairs, and the Director, Office of Adolescent Pregnancy Programs. We concur with the recommendation that more aggressive efforts should be made to integrate activities of HEW's health, family planning, and educational programs and we have these efforts underway.

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GAO RECOMMENDATION 4.

We recommend that the Secretary of HEW direct that State MCH agencies be made a formal part of HEW's project grant review process for those cases in which the grants do or can affect pregnancy outcome. As a minimum, the following programs should be included: CHC, NHSC, Migrant Health, Title X Family Planning, Health Underserved Rural Areas, Appalachian Health, and adolescent pregnancy.

DEPARTMENT COMMENT

We concur with limitations. The Improved Child Health Program formally links Title X, Title V, National Health Service Corps, and primary care projects in the funding process, in which the MCH agency serves a primary function.

As GAO pointed out, to involve all State agencies in the grant review process would merely add additional administrative requirements or may in some instances be inappropriate. The HSA will fund 6-8 demonstration projects in fiscal year 1980 which will provide a process for testing and developing a mechanism for insuring that State MCH agencies have concurrent review and are involved in the process of approving State health plans.

GAO RECOMMENATION 5.

We recommend that the Secretary of HEW require that relevant HEW component agencies, under the leadership of the Assistant Secretary for Health and in collaboration with other Federal agencies, develop a comprehensive plan for each State specifying how Federal resources should be integrated and used to improve pregnancy outcome, based on State needs assessments, plans, and priorities as called for in congressional recommendation 5(a). The Family Planning, Community Health Centers, Adolescent Pregnancy Program, and the National Health Service Corp programs, as a minimum, should be an integral component of the plan for each State. These plans should serve as the major part of application for funding under relevant programs. The DHEW should work with the Department of Agriculture to see that the WIC program is included in the plan.

DEPARTMENT COMMENT

We concur. The HSA will explore mechanisms to foster development of a comprehensive plan by each State which will strive to integrate Federal resources (as described in congressional recommendation 5(a)) and as part of the efforts outlined in recommendation #4. These efforts will consider necessary administrative steps to enhance the sharing of information about related programs between agencies at the Central and Regional HEW Office levels. The Public Health Service and the Office of the Assistant Secretary for Planning and Evaluation have undertaken jointly an indepth review of Title V in order to identify ways to improve the MCH program. A report on the findings is now being drafted.

GAO RECOMMENDATION 6.

We recommend that the Secretary of HEW develop a strategy for use of MCH, CHC, NHSC, and other resources which sets forth the circumstances under which various Federal programs should be used to assist public health departments and private organizations to increase health care capacity for disadvantaged persons to avoid unnecessary duplication or competition for patients. For example, one aspect of the strategy could be to rely on CHCs to provide prenatal and well-baby care where they exist and use MCH project grant funds in locations not having or eligible for CHCs. Exceptions could be made in unusual circumstances. Through such a strategy, HEW could give even higher priority to areas having significant problems and take more aggressive action to see that such grantees have adequate programs to provide family planning, prenatal, perinatal, and well-baby care, as already required. The MCH funds could then be used to assist areas (a) ineligible for capacity building programs, (b) not likely to receive such programs for a number of years, or (c) having unusual problems.

DEPARTMENT COMMENT

We concur. Five to six demonstration Projects with States are being developed in 1980 by the HSA. They are designed to assure access to organized systems of health care for low-income and high-risk mothers and children. The integration of resources constitutes a critical element of these approaches. For example, where multiple resources are available, primary care is provided by CHCs and migrants. A strategy will be developed, based on the results of these demonstration projects.

GAO RECOMMENDATION 7.

We recommend that the Secretary of HEW inform public and private health care organizations and school officials at the local level, through State MCH agencies, health planning agencies, professional organizations, or by other means, of Federal or private resources that can be used to help improve pregnancy outcome. Funding sources for such items as prenatal care, health education, family planning, well-baby care, facility construction or improvement, and transportation should be included.

DEPARTMENT COMMENT

We concur. As indicated in the answer to recommendation #1, the HSA will assess the feasibility of formulating national goals. As part of this process local HSAs, schools, community boards, media and publications will be considered along with other outreach activities to assure this recommendation is carried out.

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GAO RECOMMENDATION 8.

We recommend that the Secretary of HEW define in its regulations what constitutes satisfactory progress in improving pregnancy outcome, routinely monitor and evaluate the extent to which States make satisfactory progress and otherwise implement MCH activities, and assist States which do not.

DEPARTMENT COMMENT

We concur with the intent of this recommendation. However, we do not agree with the specific recommendation to incorporate within MCH regulations. This GAO report contains many process changes in the management of Federal programs related to improving pregnancy outcome. We will evaluate the effects of such changes on outcome, using predetermined criteria of degree, or rate of improvement in outcome. Such criteria of acceptable, or unacceptable performance, will be defined in BCHS established funding criteria. All States will be required to meet these criteria to be funded by October 1, 1980.

The IPO and ICH programs have emphasized the importance of setting measurable objectives, and have assisted States and areas which exhibit evidence of relatively slow progress toward improving pregnancy outcome.

GAO RECOMMENDATION 9.

We recommend that the Secretary of HEW specify how and to what extent States are to give priority to using MCH funds in rural areas and require States to report information necessary to determine compliance.

DEPARTMENT COMMENT

We concur. Programs must be directed toward location where the greatest number of people are in need. Frequently, these areas are rural, and, therefore, receive special priorities as evidenced by the IPO programs.

Such support however, is directed at solving specific problems. It is difficult to institute special reporting requirements beyond those required as part of the grant process.

GAO RECOMMENDATION 10.

We recommend that the Secretary of HEW define what is considered essential elements and develop milestones so that State progress in developing regionalized perinatal health services can be evaluated, and monitor progress made and problems encountered by States in developing and implementing such systems, giving appropriate emphasis to regionalized ambulatory, as well as inpatient care. See that efforts made by the Health Resources Administration that relate to regionalized perinatal care are coordinated with BCHS activities under the MCH program.

DEPARTMENT COMMENT

We concur. A definition of essential elements of a perinatal care system to improve assessment of the status of regionalization is available. Agreement on the most desirable sequence with which the elements are developed ("milestones") will prove difficult in practice. However, the HSA will develop guidelines in 1980 to include elements which will be acceptable.

Many State MCH plans include a perinatal regionalization sub-plan. The IPO program required the development of such regionalization sub-plans in States approved for support. The IPO program also highlighted the ambulatory care aspect of regionalized perinatal care.

The Office of Population Affairs will take the initiative to insure that BCHS and HRA efforts are coordinated.

GAO RECOMMENDATION 11.

We recommend that the Secretary of HEW consider what incentives would be appropriate to encourage and assist States to hasten efforts to regionalize perinatal care and integrate public and private health care sectors and make appropriate recommendations to the Congress. One possibility is to offer a higher Medicaid reimbursement rate for maternal and child health services or more MCH funds to those States having acceptable regionalization plans and making satisfactory (to be defined by HEW) implementation progress. Federal funds for health care facility construction, expansion, or renovation could be tied to the regionalization progress.

DEPARTMENT COMMENT

We concur. Incentives would probably be helpful in promoting regionalization. However, the incentives should be based on evidence of effectiveness, not only the establishment of a regionalized system having the specified components. In FY 1980, the HSA will explore the methods to encourage and assist States in these efforts within the context of its other efforts which have been addressed previously.

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The Assistant Secretary for Health will request the Health Care Financing Administration and Health Resources Administration explore ways to provide such incentives.

GAO RECOMMENDATION 12.

We recommend that the Secretary of HEW consider what the Federal Government should or can do to help poor persons gain access to in-hospital obstetrical or infant care in cases where hospitals, which are not obligated under Federal programs or have already met their obligations to provide some care to persons who cannot pay, refuse to accept such patients. Expanding Medicaid coverage and increasing Medicaid reimbursement rates should help. Providing additional funding for in-hospital care of non-Medicaid-eligible persons under the MCH program is an alternative.

DEPARTMENT COMMENT

We concur.

The HSA has been working with HCFA on this and similar issues of providing payment for care. The Administration's efforts on the Child Health Assistance Program and National Health Insurance evidence similar efforts pending before Congress. Before providing additional funding it is necessary to consider the impact of these efforts as well as the unmet needs of the 1980's. Providing additional funding for in-hospital care of non-Medicaid-eligible persons under the MCH program is not a viable alternative. The MCH program provides direct patient care on an individual, preauthorized basis, as opposed to Medicaid which is primarily a bill payor.

GAO RECOMMENDATION 13.

We recommend that the Secretary of HEW enforce requirements for CHCs to provide prenatal care, perinatal care, family planning, and well-baby care and provide assistance that may be needed by such grantees to comply.

See that CHCs serve adolescents as part of their basic provision of services.

DEPARTMENT COMMENT

We concur. This recommendation is now a criteria for grant approval for funding of all Primary Care Projects including CHCs. Final issuance of the Funding Criteria containing these factors will be issued in November 1979.

GAO RECOMMENDATION 14.

We recommend that the Secretary of HEW consider the feasibility of seeking additional MCH funds earmarked specifically for prenatal care until sufficient resources are available through the CHC program or from other sources to cover all areas having significant pregnancy outcome problems with adequate comprehensive health care capacity.

DEPARTMENT COMMENT

We concur. If additional funds can be made available under present budget constraints, such action as earmarked for prenatal services, particularly in underserved areas, is a feasible method of developing and distributing resources. Additional efforts in 1980 will be considered in light of national goals and objectives. It should be stressed that aside from increased funding, we will attempt to find ways by which prenatal services can be increased through more efficient and effective use of current MCH funds by States.

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GAO RECOMMENDATION 15.

We recommend that the Secretary of HEW work with professional organizations, such as the American College of Obstetricians and Gynecologists and State medical societies, to see what steps can be taken to encourage more private physicians to accept Medicaid patients or low-income patients not eligible for Medicaid. Collaborative efforts should also be made to determine whether the practice of obstetricians/gynecologists to discontinue providing obstetrical services is or is likely to become a significant national or regional problem, and, if so, to determine what actions are appropriate for dealing with the problem.

DEPARTMENT COMMENT

We concur. The HSA has excellent working relationships with ACOG and State Medical societies. The PHS and HCFA will explore in 1980 with these professional organizations the outlook and barriers to future development of services for low-income families.

GAO RECOMMENDATION 16.

We recommend that the Secretary of HEW require or request health planning agencies, as part of their periodic planning process, to assess the extent to which physicians refusal to accept Medicaid or other low-income patients, particularly obstetric and pediatric patients, is a problem in their areas and to suggest specific measures for alleviating the problem. Steps could include (a) requesting designation of the area as a health manpower shortage area if it does not otherwise meet the criteria, (b) giving higher priority to the area for NHSC personnel, (c) working with the State Medicaid agency or State legislature to increase Medicaid fees, reduce paperwork or claim-processing time, or (d) working with medical societies or other professional organizations to convince physicians of the need to help provide health care to poor persons.

DEPARTMENT COMMENT

Several sets of guidelines have been issued by the HRA during the last year which address the problems of access to care, particularly special barriers to primary health service such as a pattern of failure to serve Medicaid eligibles or other medically indigent

individuals. It is expected that these access barriers will be considered in a Health Systems Agency's periodic planning process and that when problems are isolated that remedial action (e.g., recommendations for designation for NHSC support and consultation with appropriate State agencies) will be initiated. The HRA will evaluate the need for additional specific guidance to the agencies to foster sufficient attention to this fundamental problem of access. The HRA and the HSA will work jointly during 1980 to devise the most effective mechanism to assure that service barriers to the poor are identified and that steps are undertaken to alleviate these barriers to the extent possible.

GAO RECOMMENDATION 17.

We recommend that the Secretary of HEW launch a major, nationwide information and education campaign, in conjunction with private organizations, such as the National Foundation March of Dimes, on the benefits and importance of early and adequate prenatal care and preventing or favorably timing high-risk pregnancies. Tell the public, as part of this campaign, what health authorities believe to be the most critical and common high-risk conditions.

DEPARTMENT COMMENT

We concur. It is important that the public be made aware of the benefits and importance of early, adequate prenatal care and of preventing or favorably timing high-risk pregnancies. DHEW under the leadership of the Office of the Assistant Secretary for Health will develop and implement a plan in FY 1980 to increase public awareness in this area.

GAO RECOMMENDATION 18.

We recommend that the Secretary of HEW periodically determine whether State Medicaid fee structures, particularly for obstetrical and pediatric care, comply with HEW regulations requiring that they be designed to enlist the participation of a sufficient number of providers so that eligible persons can receive such care at least to the extent it is available to the general population. In those cases where fee structures are inadequate, take appropriate action to remedy the situation. In those cases where factors other than the fee structure, such as paperwork requirements or payment delays,

significantly contribute to lack of physician participation, see, in conjunction with health planning agencies, what arrangements can be worked out with the States to overcome the problem.

DEPARTMENT COMMENT

We concur. The Assistant Secretary for Health will establish a working group of representatives of HSA and HCFA to determine the best methodology for implementing this recommendation. This group will be formed by December 1, 1979. It should be noted that a Department-wide working group already exists under the PHS/HCFA Child Health Strategy to establish ways to raise Medicaid reimbursement levels for services to children provided in federally funded primary care centers and to enlist better physician participation.

GAO RECOMMENDATION 19.

We recommend that the Secretary of HEW encourage greater use of nurse-midwife obstetrician teams, help eliminate barriers which preclude nurse-midwives from practicing in hospitals, and provide additional training funds for nurse-midwives, by giving such training higher priority for use of existing funds and/or seeking additional funds from Congress.

DEPARTMENT COMMENT

We concur. Better training and practice opportunities are needed for nurse-midwives. Title V training funds are currently used to support schools of nurse-midwifery, as noted in the GAO report.

Consideration will be given to increased support for obstetrical and pediatric nurse practitioners, who may meet certain ambulatory care needs without needing to achieve physician acceptance for hospital practice.

The Assistant Secretary for Health will request the Deputy Assistant Secretary for Population Affairs to convene a working group of HEW operating agencies to develop by March 1980 a plan to promote greater use of nurse-midwives.

GAO RECOMMENDATION 20.

We recommend that the Secretary of HEW identify, in conjunction with State MCH agencies and interested private organizations, what HEW will consider minimally acceptable prenatal care in Federal assistance programs in terms of timing of initiation of prenatal care, number of visits, and services to be provided, at least for normal, non-complicated pregnancies.

DEPARTMENT COMMENT

We concur. The MCH's staff site visit health care facilities using standards which have been developed by national professional organizations such as the American College of Obstetricians and Gynecologists. Standards for ambulatory maternity and infant care can be developed and distributed to all Federal projects providing such care. Such uniform standards should reduce some of the wide variation in content of services as described in the GAO report.

GAO RECOMMENDATION 21.

We recommend that the Secretary of HEW develop a mechanism for getting NHSC personnel into areas experiencing significant pregnancy outcome problems, lacking health care professionals or such professionals willing to serve poor persons, and lacking a CHC or other community organization besides a governmental agency willing or able to sponsor a CHC or NHSC site. Alternatively, HEW could re-evaluate its policy which generally excludes State and local governments from eligibility for a cost reimbursement waiver under the NHSC program.

DEPARTMENT COMMENT

We concur. The HSA has developed a working priority system for assigning NHSC personnel. For example, IPOs and CHCs are given priority. We are taking a number of steps to link IPOs with CHCs and other grant supported projects so that IPOs, through coordinated efforts, may benefit from the NHSC program.

With regard to the waiver question, the OMB has determined that the Department not support waivers of reimbursement for NHSC personnel assigned to carry out traditional State functions.

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GAO RECOMMENDATION 22.

We recommend that the Secretary of HEW instruct regional office staffs to see that applications for capacity building grants and family planning grants specifically address improved pregnancy outcome and discuss unmet needs, specific goals, objectives, and activities proposed to meet these needs, and closely monitor regional office performance.

DEPARTMENT COMMENT

We concur. The State plans will be provided to prospective grantees so that applications can be designated to be consistent with them.

MCH State program reviews are already addressing this problem. State planning agencies and State health agencies are identifying situations and areas which can be integrated. We plan to continue this process. In addition to our efforts under the IPO programs mentioned previously, the program priorities and funding criteria used by the Regional Office in reviewing grant proposals, include the elements identified by GAO and are revised yearly. HSA will issue the next guidance in November 1979.

OPA will follow up with HSA to see that this recommendation is carried out.

GAO RECOMMENDATION 23.

We recommend that the Secretary of HEW, if the Congress gives priority to high-risk persons in the Title X Family Planning program as we recommend, see that grantees and applicants describe adequate measures for: (a) identifying high-risk women early; (b) making them aware of the risks of ill-timed pregnancy; and (c) motivating women through more aggressive information, education, and outreach efforts to seek and effectively use family planning services.

DEPARTMENT COMMENT

If Congress changes the Title X legislation the Department will develop mechanisms to identify, motivate, educate, and track women who would represent high-risk pregnancies if they became pregnant. The educational component of this effort shall include information on the nature and availability of high-risk maternity and infant care.

GAO RECOMMENDATION 24.

We recommend that the Secretary of HEW hasten efforts to develop a mechanism for determining the extent to which family planning clinics serve women at high risk of poor pregnancy outcome for reasons other than age. Indicators might include numbers or rates of women in geographic areas (a) giving birth two times within a 17 month period, (b) having previous premature births or fetal deaths, (c) who have abortions, (d) who have had four or more pregnancies, or (e) become pregnant and have low educational attainment.

DEPARTMENT COMMENT

We concur. Program Guidelines for Title V and X address these same areas. We believe that postpartum consultation is the time to address these items. The HSA will initiate efforts in 1980 to ascertain the degree to which high-risk women are being given appropriate consultation and follow-up.

GAO RECOMMENDATION 25.

We recommend that the Secretary of HEW consider whether it would be possible and desirable for the Federal Government to act concerning State restrictions against providing family planning services to minors without parental consent and, if so, what steps would be appropriate, particularly in view of rising concern over Government interference in the family relationship.

DEPARTMENT COMMENT

We concur. The Assistant Secretary for Health will request the advice of the Office of General Counsel as to the extent to which regulations governing these programs may be structured to ameliorate such restrictions. In concert with that advice the Department will consider the possibility and desirability of action concerning any identified, inappropriate State provisions on family planning services to minors.

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GAO RECOMMENDATION 26.

We recommend that the Secretary of HEW require family planning grant applications to describe what steps they are planning or taking to assure confidentiality through such factors as clinic location, array of services offered (only family planning versus comprehensive), notifying clients of appointments, lab results, missed appointments, and billings, and assessing effectiveness of these during site visits.

DEPARTMENT COMMENT

We concur. Confidentiality should be assured in the provision of all health services. Breaks in confidentiality may limit the utilization of any type of service, not only family planning.

Most HEW program regulations including family planning contain language similar to the following which addresses the subject of confidentiality. Each recipient of a grant ...must hold confidential all information obtained by its personnel about participants in the project related to their examination and care and may not divulge it without the individual's authorization, unless it is required by law or is necessary to provide service to the individual or in compelling circumstances to protect the health or safety of an individual. HSA will require applicants to describe in their grant application their plans to assure confidentiality. HSA will also continue to advise projects that various practices, in addition to the release of information, may impact on confidentiality.

GAO RECOMMENDATION 27.

We recommend that the Secretary of HEW direct HEW's Office of Civil Rights to step-up monitoring and enforcement of regulations prohibiting school systems receiving Federal financial assistance from discriminating against pregnant students.

DEPARTMENT COMMENT

We concur. Section 86.40(b) of the Department's regulations implementing Title IX of the Education Amendments of 1972 prohibits school districts from excluding pregnant students from the regular education program and from requiring these students to attend special programs for pregnant students. Although only a few complaints alleging discrimination in this area have been received

by OCR, we are aware of the seriousness of the school dropout rate among pregnant teenagers and recognize the problems they face. Complaints received to date have been investigated and resolved. Where violations have been identified, school districts have been required to return pregnant students to the regular program if they have either been excluded from the program or involuntarily isolated in a special program.

OCR will make every effort to include a question on pregnant pupils on the 1980 Elementary and Secondary Civil Rights Survey that would help to identify school districts where these Title IX violations are occurring. The survey samples thousands of school districts across the country and schools are required by law to respond. Data from the Survey are used to identify possible civil rights violations, to select HEW recipient institutions for review, and to help in documenting compliance reviews and complaint investigations.

GAO RECOMMENDATION 28.

We recommend that the Secretary of HEW work with States, through the National Center for Health Statistics, to evaluate the accuracy of reported infant mortality statistics to determine whether the under-reporting noted in one State by the Center for Disease Control exists elsewhere.

DEPARTMENT COMMENT

We concur. The recommendation coincides with two ongoing efforts of NCHS: 1) a continuing program through working with registration officials in each State to maintain a high level of accuracy in our vital registration system throughout the U.S.; 2) a planned national study of infant mortality which involves matching infant death certificates of infants born in 1980 with their birth certificates in each State. The results of this matching study will enable NCHS to identify States in which possible underregistration of infant deaths may occur. This study is currently in the planning phase. Discussions with State officials will begin in fiscal year 1980. The NCHS believes that the reporting of infant deaths is quite complete in the United States as a whole. Although the NCHS is generally confident with the State registration procedure, the national study they are planning will help to identify any State with possible registration problems.

APPENDIX VIII

TECHNICAL COMMENTS

It is stated that the Federal government has never made a comprehensive study of the status of family life education in the schools. The Department has just completed an extensive survey, under contract, which was identified where programs are being taught, assessed the effectiveness of these programs and the approaches that have been effective in gaining the acceptance and support of parents, school boards, religious groups, and other community organizations. Entitled "An Analysis of U.S. Sex Education Programs and Evaluation Methods" the survey includes programs encompassing family life education as well. This is one of the projects, as noted in the report, that the Center for Disease Control planned to fund in fiscal year 1979.

Legal abortions in the United States have been increasing, but it is not known if illegal abortions have been increasing. We suggest that "legal" be inserted before "abortions" under the subhead, "Increased incidence of abortions."

APPENDIX IX

UNITED STATES DEPARTMENT OF AGRICULTURE
FOOD AND NUTRITION SERVICE

WASHINGTON, DC 20250

November 19, 1979

Mr. Henry Eschwege, Director
Community and Economic Development Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Eschwege:

We appreciate this opportunity to comment on the draft GAO report, "Enhancing Federal Efforts to Improve Pregnancy Outcome: Better Management and More Resources Needed."

We would like to offer two general observations before commenting on specific recommendations and statements contained in the report.

First, new WIC regulations which were issued in July 1979 put a stronger emphasis on coordination with existing health services, including HEW-funded clinics. Priority for local grantees is given to agencies which are able to provide both health and administrative services directly. However, areas where there is not a well-defined health network are not penalized. Rather, the WIC project is required to set up more formal health linkages to ensure the availability of health services. The new regulations push WIC projects more in the direction of serving as an adjunct to health care.

Second, the report points out that in many areas of the U.S., HEW health services and clinics are inadequate. WIC has the potential to act as a magnet to draw health services into such areas. Where possible, WIC tries to coordinate with health care, including HEW services; but it can also serve the important function of stimulating the expansion of health care services in areas where existing services are inadequate.

GAO RECOMMENDATIONS

The following are our comments on several GAO recommendations.

GAO recommendation: "In those cases where consolidation is not feasible or will take a long time to accomplish, legislate that programs such as those identified above and health-related programs like WIC, affecting improved pregnancy outcome, be better coordinated at the Federal, State, and local levels. Activities to be coordinated should include program planning, funding, implementation reporting and monitoring."

International Year of the Child 1979

APPENDIX IX

USDA comment: Certainly, USDA and HEW programs should coordinate whenever possible and efforts towards closer coordination are already underway. HEW and USDA have been working together to develop a Nutritional Status Monitoring System (NSMS). One component of the NSMS is an assessment of Federal nutrition programs which includes objectives for evaluating each component of WIC. This joint HEW/USDA project is one example of efforts to review programs systematically and avoid duplication of efforts.

However, coordination may not always be possible in areas most in need of WIC services. In some cases, an area a State agency identified as most in need of WIC expansion may not be targeted for HEW funds. We believe WIC funds should be provided to these high priority areas and that health care should be provided through whatever alternative health facilities are available. To fail to expand WIC to areas in need simply because they are not being served by HEW health programs would not be sound policy. This is particularly true of a number of poor, rural areas.

GAO recommendation: Designate one agency official to be responsible for taking the lead in coordinating and focusing Federal efforts for improving pregnancy outcome. We believe that this official should be HEW's Assistant Secretary for Health.

USDA comment: The effect of this recommendation on the WIC Program is unclear. Certainly, Federal efforts on pregnancy outcome do need improved coordination. However, we are not convinced that naming one official to be "in charge" is the necessary solution to coordination problems. We believe that coordination means better communication between USDA and HEW and improved efforts to assure that the Departments are working toward common goals in a manner that is complementary, not duplicative.

GAO recommendation: "Require that relevant HEW component agencies, under the leadership of the Assistant Secretary for Health and in collaboration with other Federal agencies, develop a comprehensive plan for each State specifying how Federal resources should be integrated and used to improve pregnancy outcome, based on State needs assessments, plans, and priorities as called for in congressional recommendation 5(a). The Family Planning, CHC, adolescent pregnancy, and NHSC programs, as a minimum, should be an integral component of the plan for each State. These plans should serve as the major part of application for funding under relevant programs. HEW should work with Agriculture to see that the WIC Program is included in the plan."

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USDA comment: State agencies are now required to submit annually WIC State Plans of Program Operations and Administration and funds are granted only upon USDA's approval of these State Plans. These Plans must outline objectives for implementation and administration of all aspects of WIC Program operations for the coming fiscal year and are used as a vehicle to measure Program performance during the fiscal year.

USDA does not require and has not advocated a stringent format for State Plans. The State agency is encouraged to use other planning documents which may have been developed for other purposes. For example, if the State agency prepares a document for submission to the State government or HEW and that submission addresses requirements in the WIC Program regulations, a copy of that document could be included in the WIC State agency Plan of Operation and Administration.

To integrate Federal programs successfully, State plans should be formulated in coherent and comprehensive ways. We believe that for many State agencies, including the WIC Program in a comprehensive plan for integrating Federal resources to improve pregnancy outcome could be valuable.

COMMENTS ON OTHER STATEMENTS IN THE GAO REPORT

Page 34 - "Although the Congress intended the WIC Program to be an adjunct to health care, Agriculture has administered the program independently in some instances of BCHS programs to build health care capacity, and planning for health service delivery and WIC have not been coordinated."

The WIC Program has always been intended to serve as an adjunct to existing health care. Unfortunately, given the great variations in the availability of health services in the United States, local communities have had to find alternative means to ensure health care availability to WIC participants. Delivery of WIC benefits in a number of underserved rural and urban areas has been achieved through various arrangements with CAP agencies, welfare agencies and referrals from private physicians. In this way, the target population has been reached despite gaps in public health care.

Recently, USDA has taken several steps to ensure that WIC is more closely tied to health care. Under USDA regulations, State agencies must develop an annual Affirmative Action Plan which ranks areas of the State according to need for the Program. The State agency must take action to encourage the neediest one-third of areas unserved or

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partially served to implement or expand Program operations within the following year. Wherever possible, State and local WIC Program administrators have tried to coordinate with DHEW Programs. However, in many areas there is both a high priority for WIC and an inadequately developed health network. As was stated in response to the GAO Report, WIC -- How Can It Work Better?, "areas with greatest need for WIC are more likely to be medically underserved. WIC has acted as a magnet in some rural areas that has drawn health care services for low-income women and children into these areas for the first time."

During the past year, USDA has made an effort to identify the reasons why the WIC Program is not more closely allied with existing DHEW facilities. DHEW and the WIC Program Regional Offices prepared a report on barriers to coordinating WIC and DHEW's Bureau of Community Health Services (BCHS) health facilities. The report shows that some BCHS units currently do not provide health services which are required in conjunction with WIC, such as pediatric or prenatal services; many BCHS facilities have not made applications to the appropriate State agency for WIC; and of those that have applied, many are either located in areas with low affirmative action status in the State, or are located in an area already operating a WIC Program. USDA and DHEW will be evaluating ways to reduce these barriers and better serve the target populations.

Page 76 - "HEW and Agriculture lack a formal procedure for seeing that low-income women and infants in areas experiencing the most severe pregnancy outcome problems have access to both health services and supplemental foods."

There has always been a requirement in the WIC regulations that sponsors be able to make health services available. This fact is in part reflected in the data from the recent GAO report on improving the WIC Program, which found that 88 percent of WIC participants surveyed were receiving health care. Additionally, some proportion of the 12 percent for whom no records of direct health care were found may well have been receiving health care at a non-WIC facility. The most recent WIC regulations further strengthen the WIC health care linkage in a variety of ways.

In addition, our regulations now require that as part of their State plans, State agencies submit plans to coordinate program operations with special counseling services and other programs. This coordination must include services such as family planning, prenatal and well child care, alcohol and drug abuse counseling, and coordination with HEW's Early and Periodic Screening, Diagnosis and Treatment Program (Title XIX of the Social Security Act).

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The inadequate health services cited are certainly not representative of the WIC Program. In areas across the country, State and local level agencies have made great strides in bringing WIC into unserved areas through a variety of arrangements with existing health care providers including DHEW programs, community health services and private physicians. As previously stated, there have been instances where the WIC Program has acted as a magnet and has drawn health care services for low-income women and children into areas for the first time. In the vast majority of areas, the WIC participant has good health services available at the critical time of pregnancy and early growth.

USDA's intention has been and continues to be one of strengthening the relationship between health care and the delivery of WIC Program benefits. On October 1, 1979, we began a large-scale evaluation of the WIC Program. One aspect of this evaluation will be an assessment of the extent to which WIC is coordinated with health care services, the ways in which it is coordinated and the extent to which this coordination affects pregnancy outcomes.

Page 140 - GAO states that in a recent WIC Program review it found that a number of women and infants participating in the WIC Program in three States -- Illinois, New York and Washington -- were not receiving prenatal or pediatric care.

Our comment in response to this earlier GAO review is still relevant:

> GAO's own data demonstrate that 88 percent of the participants surveyed by GAO were receiving health care. Additionally, some proportion of the 12 percent for whom no records of health care were located may have been receiving such care at facilities not associated directly with WIC. Finally, about half of the 12 percent for whom health care records were not located were participants at a clinic in Washington where the entire medical staff had resigned in an extremely unusual occurrence. If those persons in Washington who had previously received health services were included in the group who received health services, GAO's data indicate that 93 percent of the participants receive health care. This data indicates that, while further improvement is needed, a good job was generally being done in the clinics GAO visited in providing health care to WIC participants.

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Page 145 - "Many low-income women or infants lacked access to WIC."

Many low-income women or infants lack access to WIC because program funds are limited and most States are not able to serve all persons in need of program benefits.

Sincerely,

ROBERT GREENSTEIN
Administrator

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN RESOURCES
WASHINGTON, D. C. 20004

OFFICE OF THE DIRECTOR

REPLY TO
415 12TH STREET, N. W
WASHINGTON D C 20004

NOV 30 1979

Mr. Allen R. Voss
Director
General Government Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Voss:

I appreciate you affording me the opportunity to comment on your proposed report to the Congress "Enhancing Federal Efforts to Improve Pregnancy Outcome."

This most comprehensive report points out several issues and problems which we have tried to address in the District of Columbia. Particularly we have been concerned with the issue of unimpeded access to appropriate medical care regardless of ability to pay especially as it relates to in-hospital care. As you point out the MCH Title V funds are provided mostly for ambulatory services. Additional funds would be needed to cover for selected in-patient care cost.

Your report states: "MCH funds have not been sufficient to enable States to extend services to all those in need ...." In actual fact, MCH funds have not been sufficient to continue services at the same level because of static funding of program of project grants and the inflationary trends. By receiving the same grant in FY 1980 as in FY 1973 we lost in purchasing power 36.6%. The loss has resulted in a reduction of staff and services, including out-reach staff and in-patient care.

The trend in reduction of services to mothers and children was reversed in FY 79 when Mayor Marion Barry announced his commitment to lower the high infant mortality rate in the District of Columbia. As a result many steps were taken to coordinate and increase services for mothers and infants. These efforts have resulted in reducing or eliminating many of the deficiencies identified in your report. For

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instance outreach and follow-up for broken maternity appointments have increased and the waiting period for a maternity appointment has been reduced to less than two weeks in all but one clinic. D.C. General Hospital appointed a second neonatologist to the newborn nursery in addition to the one neonatologist hired as part of the intensive infant care project. We would like to see these increased State efforts matched by increased support by the Federal Government.

In view of actual loss of purchasing power of MCH static grant funds, Medicaid has been providing for care for many of the mothers and infants MCH no longer could serve. In reviewing the State Medicaid rates it should be pointed out that these rates do not include any ancillary services such as lab test, pharmaceuticals and special procedures (sonograms etc.).

I would like to commend you on a very thorough analysis of the problem. Your recommendations are appropriate and realistic. Nevertheless care should be taken, that the thrust to improve pregnancy outcome does not set back MCH programs which are not directly targeted to this effort.

Sincerely,

Albert P. Russo
Director

Enclosure

APPENDIX XI

STATE OF NORTH CAROLINA

JAMES B. HUNT, JR.
GOVERNOR

DEPARTMENT OF HUMAN RESOURCES

Division of Health Services

HUGH H. TILSON, M.D.
DIRECTOR

SARAH T. MORROW, M.D., M.P.H.
SECRETARY

P. O. Box 2091 Raleigh 27602

October 15, 1979

Mr. Gregory J. Ahart, Director
United States General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Ahart:

Thank you for allowing us to review the draft of your report to the Congress, "Enhancing Federal Efforts to Improve Pregnancy Outcome: Better Management and More Resources Needed."

The report contains a wealth of information. Although some of the shortcomings and needs are well-known, basically, we agree with the information and recommendations contained in your cover summary. The following are comments pertaining to statements made about projects and areas in North Carolina in an attempt to clarify or amplify what was written plus some general comments:

Page 43, Services Extension Has Been Limited

We do not question statistics about prenatal clinics but wish to state that this is not primarily a Maternal and Child Health funding problem. In some areas, facilities are not available; some private physicians do not support health departments having the clinics. In other cases, there are no private physicians or nurse practitioners to staff the clinics and, often, private physicians are too busy. In Halifax County, there have been funds to support delivery and allied services of approved Maternity and Infant Care Project patients and their infants. The statement is applicable if a person is not eligible under Project criteria.

Page 52, Better MCH Plans

We concur that better planning is needed. We are currently obtaining information to write a comprehensive Maternal and Child Health Plan. As far as can be determined, there are no federal guidelines as to what a plan should contain or its format. When we queried the Regional Office about this they referred us to a state with a "fairly good" plan. Allied to this problem is the need to

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coordinate the various plans within the state which contain information about Maternal and Child Health and still meet the needs of the federal government. We agree in general with the statement made about the allocation of Maternal and Child Health funds; we are attempting to do this. It should be noted that North Carolina has an Improved Pregnancy Outcome Project operational in two counties and is expanding its services statewide in conjunction with the Perinatal Care Program.

Page 55, NHSC Placements

This situation has been improved. A recent review was made of all National Health Service Corp placements in North Carolina with appropriate agency personnel, and full cooperation between other programs is beginning to take place.

Page 80, Coordination With Health Planning Agencies

We concur with the statements, although we are improving in this area. There are many agencies and others writing plans about maternal and child health with too little contact with the agency having the primary responsibility.

Page 97, Limited Resources

The statement about Halifax and Northampton Counties was true at that time. The Improved Child Health Project proved to be the impetus needed to get some improvement in the resources available.

Page 110, Linkage with Schools

Progress has been made, and a task force is working toward a viable School Health Program. This will take time to implement and will depend on resources available.

Page 116, Confidentiality

We concur with the statement, and this is true in other areas of the state. Although a number of county health departments have new or expanded facilities, the situation as described is not unique.

Page 141, North Carolina Maternity Care

Please see comments concerning information on page 43.

Page 142, Limited Hours of Operation

We concur with the statement that clinics are "full to overflowing;" however, the people who wrote this report were aware of a number of factors which limit night and weekend clinics. Money for extra staff or funds to pay for overtime has to be considered; this situation is not just applicable to the health department patient.

Page 144, Clinic Appointments

We concur with the statement and concept. This has been tried with varying degrees of success. In some instances, appointments have been made and staff was available, but over one-half of the patients did not show up. In more remote areas, people depend on others for transportation which causes extra hours of waiting for services. However, waiting is not peculiar to health departments only.

Page 179, County Facilities in North Carolina

Improvement has been made in this facility (Halifax County) and every attempt has been made by the state and local health officials to provide funds for a new health facility; at present, funds are not available. The Improved Child Health Grant did provide funds for the rental of additional space and staff. This county has one of the largest patient loads in the state and undoubtedly needs a new health facility as much as any in the state (and possibly country).

Page 191, Ability of Patients to Pay for Care

No comment other than that the situation varies. Through the use of a delivery fund program the last two years, the state has allocated funds to local health departments to provide assistance for delivery and allied costs. These funds are intended to be used for those patients not eligible for other public programs but who do not have the financial resources to meet their needs. Determination of eligibility is made by local health departments using guidelines furnished by the state.

Page 192, Granny Midwife Deliveries

Progress is being made in reducing the number of deliveries and the number of granny midwives. Statistics for 1978 indicate a total of 57 deliveries by midwives or "others."

Page 199, More Funds for Hospital Deliveries

By law, the Improved Child Health Project cannot use more than 25 percent of its budget for hospital care. Some MCH funds were allocated to the Project to assist in this area but, in general, funds will never be available to meet all the needs. It should be noted that state funds amounting to $350,000 were available in the last two years to provide support for delivery and associated costs. This year (FY 1979-80), the amount will be $500,000.

Page 202, Limited Funding - Perinatal Care Project

We concur with the statements, although it should be noted that 1976 was the first year of the project. Funding played an important part, but billing was delayed to the extent that only 435 of an authorized 537 pairs were paid.

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Page 203, Transportation - Intensive Infant Care Project

This statement is true. We are attempting to establish a viable transportation system, but there are still problems. Funds were available in the amount of $20,000 during FY 1978-79 for a private company to transport patients, but they were not totally spent. The company does not wish to participate in the program this year.

It is hoped that these comments will be valuable. If we can be of further assistance, please let us know.

Sincerely,

Hugh M. Tilson, M.D.
Director

cc: Lewis L. Bock, M.D.
Jimmie L. Rhyne, M.D.

APPENDIX XII

MISSISSIPPI
STATE BOARD OF HEALTH
2423 NORTH STATE STREET, P. O. BOX 1700
JACKSON, MISSISSIPPI 39205

ALTON B. COBB, M.D., M.P.H.
STATE HEALTH OFFICER

October 30, 1979

Mr. Gregory J. Ahart, Director
Human Resources Division
U. S. General Accounting Office
Washington, D.C. 20548

Attention: Mr. Bernie Ungar

Dear Mr. Ahart:

Enclosed is the copy of a draft of your proposed report to the Congress, "Enhancing Federal Efforts to Improve Pregnancy Outcome: Better Management and More Resources Needed," which you sent for my review and comment.

The report is generally accurate and identifies some key problems relating to adequate services for improved pregnancy outcome. The following are some specific comments relating to the report.

1. Page 31 - As stated on page 31, the actual purpose for the Urban and Rural Health Initiatives was to improve access to primary health care by integrating existing project grant programs. Somehow the outcome has not satisfied the goal; that is, the projects, at least in this state, are not integrating existing grant programs but generally represent independent small clinics staffed by nurse practitioners with little or no relationship to other organized programs aimed at improving the health of mothers and children.

2. Page 43 - The comment is made that in 1978 Mississippi provided no MCH funding for twelve counties and small amounts of funds for several others.

   The actual amount of MCH funding by county in Mississippi may not match precisely the MCH activities; that is, we do provide MCH services in every county despite the fact that a few counties have little or no MCH funds budgeted.

   ADDITIONAL COMMENT: We are presently developing a time reporting system which will permit the more precise budgeting of funds to match actual activities.

APPENDIX XII

3. Page 54 - Comment is made in the first paragraph that the director of the MCH agency in one state did not view her agency as having the role of planner, coordinator, or evaluator of statewide activities to improve pregnancy outcome.

   I would raise the question as to how the state MCH director may be expected to fulfill these roles in light of Public Law 93-641 - Health Planning.

4. Page 55 - Comment concerning the lack of coordination between HEW funded CHCs and MCH activities in Virginia is also applicable to Mississippi.

   Reference to positions of the District of Columbia Department of Human Resources are also applicable to Mississippi.

5. Page 58 - References to the HEW review of MCH programs - Such a review has just been completed in Mississippi and, in our view, was a fair and very complete evaluation of program activities.

6. Page 59 - Paragraph 1, item 3 - Reference to linkages between state MCH agencies and other health care providers, including federally funded projects. This is not being done effectively in Mississippi.

7. Page 65 - References to BCHS policy on placement of National Health Service Corps personnel - The policy apparently does not satisfy the intent of the law and, in my view, is frustrating efforts to expand cost-effective preventive services for high risk population and is emphasizing much less cost-effective primary care services for small segments of the population.

8. Page 68 - Our experience confirms the finding that few of the 330 type projects emphasize pernatal care, family planning and other services directed at improving pregnancy outcome.

9. Page 72 - Problems created by multiple funding sources. We concur with this finding.

10. Page 111 - Reference to comments on linkage between family planning providers and the school system.

    We concur with this finding but are doing our best to address this problem.

11. Page 142 - Reference to Mississippi's MCH budget. As stated above, this does not mean that MCH services were not available and actually provided in all counties. It would have been preferable to look at program performance reports rather than budgeted amounts.

12. Page 145 - First paragraph, reference to environmental health problems and insufficient funding to correct the problems.

    There exists a discretionary provision in the statutory authority for 330 projects in that they will permit the use of funds to deal with such problems, but formula grant programs are not given this discretion.

13. Page 145 - WIC - The reason for Jackson County, Mississippi, not participating in WIC is misstated. This county has not qualified to date under the state's established priority system.

    All counties in the state will be served by WIC within the next year, provided funds are available.

14. The comments pertaining to restricted medicaid eligibility are generally applicable to Mississippi; that is, there are significant numbers of low income women who, by reason of marriage, are not eligible for medicaid whose financial and other need problems are as great as those who are eligible.

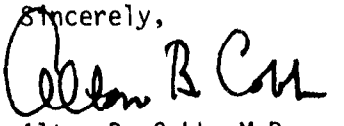
15. Page 177 - Comments on maternity care and pregnancy outcome in Mississippi. I question whether there exists the competition as described between the public sector and the private medical community.

    In Mississippi over one-third of maternity patients receive their prenatal care through the public health system. It is our opinion that strengthening this system and its coordination with the private sector is the only practical answer to dealing with this matter in our state.

    The simple fact of life is that even with adequate financial resources many lack personal motivation to seek private care. The simple availability of a health insurance card will not assure adequate care for the population at risk.

16. Page 206 - Conclusions and Recommendations. We would generally concur with the conclusions and recommendations.

Sincerely,



Alton B. Cobb, M.D.

ABC:hvf
Enclosure

cc: Terry Beck, Acting Chief
Bureau of Family Health Services

APPENDIX XIII

JOSEPH P. TEASDALE
GOVERNOR

MISSOURI
DEPARTMENT OF SOCIAL SERVICES

DIVISION OF HEALTH
BROADWAY STATE OFFICE BUILDING
P. O. BOX 570
JEFFERSON CITY
65101

October 31, 1979

DAVID R. FREEMAN
DIRECTOR
DEPARTMENT OF SOCIAL SERVICES

Mr. Joseph B. Reichart
Interim Director
Missouri Division of Health
P.O. Box 570
Jefferson City, Missouri 65102

Dear Mr. Reichart:

Enclosed are the comments from the IPO staff regarding the GAO report "Enhancing Federal Efforts to Improve Pregnancy Outcome: Better Management and More Resources Needed".

This report is of such depth and scope, a deeper analysis would have been helpful had time permitted. It does raise some interesting points. It also points out some of the difficulties that the Division has no control over, i.e. federal and state financing, legislation mandates, etc.

We hope that some of our comments may be useful to you in answering the GAO's request.

Sincerely,

Patrick H. Knowles
Perinatal Coordinator
Improved Pregnancy Outcome Program

PHK:bb

enclosure

cc: Edward Washington, M.D.
IPO Team:
Liz Sappington, M.Ed.
Jean Kitchen, R.N.
Doris McGuire, R.D.
Patrick Knowles, M.P.H.

APPENDIX XIII

Comments on:
Enhancing Federal Efforts to Improve Pregnancy Outcome-Better Management & More Resources Needed

Chapter 1: Introduction

The GAO Report very accurately describes the barriers inherent in trying to improve pregnancy outcome. We have experienced and/or are cognizant of these barriers in attempting to implement the IPO and other MCH Programs here in Missouri.

In Chapter 1, nine high risk areas for infant mortality rates out of 115 were listed. Are these counties with high percentages of infant deaths, if not, what are the geographic designations of these nine areas?

Chapter 2: Many Federal Programs Affect Pregnancy Outcome.

We were aware of the many federally funded programs available as listed in Chapter Two, most of which are operational in Missouri and the remainder we were cognizant of prior to this report.

Chapter 3: Federal Efforts to Improve Pregnancy Outcome Hampered by Structural, Managerial and Financial Problems.

Medicaid restrictions impede services extension:

In reference to the statement on page 43 which states 5 out of 6 counties in the Bootheel did not have public prenatal care clinics, we offer the following comment: Previous to 1973 and the introduction of Title XIX there were prenatal clinics in 5 of the 6 counties in the Bootheel of Missouri staffed by physicians, nurse midwives, granny midwives and county health nurses. With the onset of Medicaid payments to private physicians these prenatal clinics closed. The current problems in that area arise from the fact that private physicians are reluctant to handle Title XIX patients because of low reimbursement rates in Missouri. Changes in Medicaid that would encourage wider participation by private physicians and other health care providers would decrease the number of women and infants who are not being served. One of the major obstacles we have found to expanding prenatal clinics in the Bootheel and initiating prenatal clinics in Poplar Bluff is the difficulty in getting participation by the area physicians.* Increasing the Medicaid program would be helpful in accomplishing this needed cooperation.
*See references on pages 167 and 200.

Limited funding:

The pattern of funding is based on a formula that is 45 years old and is not realistic in todays society.

There is a need to have a mechanism of funding to insure the incentive to reduce perinatal morbidity and mortality.

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Better MCH Plans are Needed:

We understand the state is in the process of hiring a consultant firm to develop a statewide MCH Plan and will develop a plan that is realistic, measurable and obtainable.

Family Life Education:

We are concerned that Family Life Education efforts on the national, state and local levels will possibly suffer a setback as a result of the Office of Education becoming a separate Department from H.E.W.

Chapter 4: Efforts to Prevent or to Favorably Time High Risk Pregnancies Need to be Enhanced.

In view of the fact that teenage pregnancy is synonomous with high risk pregnancy, providing adequate family planning services becomes an even greater consideration.

In Missouri, parental consent for receipt of Family Planning Services is such a deterrent to the adolescent that even informed, mature and responsible teenagers who choose to be sexually active are at a disadvantage to adequately protect themselves from an unwanted, ill-timed pregnancy. Until we as professionals, and parents admit that adolescent sexuality is a "fact of life" and start treating the adolescents as a young adult; and quit waiting until and unless they prove that they have been sexually active by presenting an unwanted high risk pregnancy, to afford them rights and responsibilities of an adult, we must face the dilemma that we are responsible for a lack of response to a medical (and emotional) need by a legitimate minority group in our state.

Chapter 5: Prenatal and Well Baby Care - Services are not always Available or Accessible.

It is encouraging to note that the recently appointed Regional Health Administrator for Region VII has set regional priorities for programs that are prevention oriented such as Family Planning, Prenatal Care and other prevention programs. This attitude is in keeping with Missouri Governor Joseph P. Teasdale's interest in expanding prenatal care services in areas of need in the State. The Division of Health is currently involved in the establishment of a perinatal clinic in conjunction with the IPO Program and the Governor's Rural Health Initiative.

Chapter 6: Progress and Problems in Providing Labor, Delivery and Infant Intensive Care Services.

The utilization of nurse-midwives and pediatric nurse practitioners to provide care is obstructed by their legal status as health care providers, need for physician supervision, lack of uniform standards for their training and certification and small numbers available to meet the needs. Family planning or family living services to adolescents faces many barriers. A significant majority of the population is opposed to these programs, especially those provided through the schools. Effective educational pro-

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grams and changes in attitudes of the population will promote progress in the future.

Chapter 7: Conclusions and Recommendations.

The section on conclusions and recommendations summarized by pointing out that much has been done to improve pregnancy outcome but that many lack ready access to adequate health care and fail to use services which are available. Persons in several areas continue to experience poor pregnancy outcomes and non-whites generally experience poorer pregnancy outcomes than whites. Nine ways were suggested whereby the Federal Government can enhance its efforts to solve this problem and we would agree they would have a positive effect.

Recommendations were made to the Congress (14 recommendations) and to the Secretary of HEW (28 recommendations). The recommendation that Federal programs funding similar types of activities be consolidated into one Maternal and Child Health Program and where not possible then better coordination between agencies at all levels is a theme common to all Federal Reviews recently and which is difficult to disagree with but equally difficult to accomplish. Changes suggested in the management and programs of state MCH agencies would require greater indepth study before making specific comments.

Coordination of all MCH funded programs seems to be the most logical step to take and needs to be done to have an effective mechanism for improving pregnancy outcome. If Health and Human Resources could mandate coordination, this would help tremendously.

Because of the difficulties in recruiting qualified personnel, the need for qualified Corps people is certainly evident particularly in rural areas. For example, in the Bootheel the IPO Project has not been able to attract a Clinical Director and other key professional staff for its program. This is after an extensive recruiting effort has been made. You will note that on Appendix VII there are 156 Corps personnel assigned to IPO Projects among the various states, but Missouri has not received any.

In reviewing this entire draft, the following questions were generated:

1. Has a feasibility study been done or proposed to ascertain if consolidation of All MCH Programs can be done, and if so, how?

2. Is coordination a reasonable alternative to consolidation, or would coordination efforts exist only on paper?

3. Has anyone taken a look at the MCH system in Maine and/or Hawaii to discover the reasons behind their superior statistics? And how does our system differ from theirs?

4. Who is responsible for grouping ABORTION as an infant MORBIDITY factor on page 2?

In closing, we feel that this is an important, well written document that deserves thoughtful study and contains many positive recommendations.

APPENDIX XIV

COMMONWEALTH of VIRGINIA

JAMES B KENLEY M D
COMMISSIONER

Department of Health
Richmond, Va. 23219

October 11, 1979

Gregory J. Ahart, Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

My staff has reviewed the draft report on "Enhancing Federal Efforts to Improve Pregnancy Outcome: Better Management and More Resources Needed."

Their comments are all favorable and supportive of the content and recommendations. In particular, the areas of overlapping of services, duplication of effort and restrictive government agency mandates were again emphasized.

They felt that their input has been very well documented in the report. Should you desire further information or supportive documentation, we will be pleased to cooperate with your staff.

Thank you for giving us the opportunity to comment.

Sincerely,

James B. Kenley M.D.

James B. Kenley, M.D.
State Health Commissioner

APPENDIX XV

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

444 North Capitol Street, Suite 408 • Washington, D.C. 20001 • Telephone (202) 638-4860

November 13, 1979

Gregory J. Ahart
Director
United State General Accounting Office
Human Resources Division
Washington, DC 20548

Dear Mr. Ahart:

The American College of Obstetricians and Gynecologists appreciates the opportunity to review this GAO draft report, "Enhancing Federal Efforts to Improve Pregnancy Outcome: Better Management and More Resources Needed".

The report's title and certainly text suggests a course of action that the ACOG has long felt necessary; that is improved coordination of the multitude of health and service programs for mothers and children into one jurisdiction or central office. The office, if managed at a deputy assistant secretary for health level and appropriated sufficient funding and resources, could be expected to implement the individual programs according to their original intent and thus enhance the total federal health effort for women and children. Our recommendation, which has repeatedly been offered in Congress as a proposal to revise Title V of the Social Security Act affecting maternal and child health programs, is supported by both the American Medical Association and American Academy of Pediatrics.

The Select Panel for the Promotion of Child Health has in the past several months undertaken an effort to study duplication in these very programs and is committed to outlining for Congress a plan for the federal government. The GAO report will certainly be of assistance to them as they proceed in meeting their charge. We are hopeful that their recommendations will include a proposal to upgrade within DHHS an office for maternal and child health with adequate and assured funding sufficient to retain staff and improve program function. It is clear to ACOG that the majority of the recommendations contained in the GAO report are well founded and if implemented would serve to increase the number of people served by existing maternal and child health programs as well as improve upon the quality of services provided. Unmistakably, several of the goals of the GAO recommendations are intended to cut unnecessary waste and

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duplication as well as eliminate barriers which inhibit access to services for many individuals. Efforts ongoing in Congress such as the proposed Child Health Assurance Program will move several of the GAO recommendations to reality. We are pleased that the GAO report can and will serve as guidelines and reference for all who are participating in efforts to improve federal policies, programs and services for women and children.

Specific points that we would like to raise and priorities we would suggest with respect to the GAO draft are as follows:

1) In both recommendations to Congress and the Secretary, the GAO has highlighted the significant need for an appropriate government official, possibly the Assistant Secretary for Health, to assume responsibility and accountability for all federal health programs serving women and children. Along with this recommendation, the GAO has recommended that jurisdiction for all of these programs (including Maternal and Child Health, Family Planning, Adolescent Pregnancy, Sudden Infant Death, and genetic disease screening and counseling programs) be placed in one office under the direction of the Assistant Secretary of Health. We concur wholeheartedly with the intent and wisdom of such a reorganization, however, we feel that the Secretary of DHHS or the Congress, if required, should reorganize the administrative structure of these programs to the extent that a Deputy Assistant Secretary level position would be created and a physician appointed as Deputy Assistant Secretary to oversee all programs providing health services to women and children. Clearly, health programs providing maternal and child health services assist to assure the continued good health of the individual. Placing this office, responsible for managing and implementing these programs, in an administrative position close to the Secretary will increase the likelihood that they will receive the resources and review necessary for improving and continuing their contribution to the health status of all people in this country.

2) With respect to recommendations supporting a tightening at the federal level of the Maternal and Child Health Title V mandate, the ACOG can only restate our position encouraging the return of the administrative authority to DHHS to guide the management and planning of state maternal and child health programs, to evaluate the effectiveness of state programs and to review their compliance with national goals and guidelines. To do so, the Office of Maternal and Child Health or an appropriate office established to carry out these programs, would instruct and advise states on developing their state plans, monitor their efforts to implement state plans, and require states to carry out ongoing evaluation of their effectiveness in meeting state goals. An evaluation at the federal level of all state's maternal and child health programs would be required of the central administrative office in order to assure appropriate coordination and

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assimilation of MCH programs into a comprehensive national plan for women and children.

3) GAO recommends that action be taken to eliminate categorical eligibility requirements which exist in some state Medicaid plans and which inhibit access to services for many income-eligible individuals. As well, the GAO encourages state Medicaid programs to determine fee schedules for health care professionals at levels which would serve to encourage their participation in the Medicaid program. The ACOG has repeatedly supported both actions and has worked with Congress when such proposals have been presented. The College has also worked with HCFA to prepare a recommended minimum package of obstetrical benefits that state Medicaid plans should at least provide to their beneficiaries. We will continue to cooperate with other professional groups, Congress and federal agencies to increase physician participation in Titles XVIII, XIX, V, X and other programs to improve and expand services to underserved and populations in need of health care.

4) Within the text of the GAO report, the issue of initiation of prenatal care is addressed and the statement made that "in this report, prenatal care is considered adequate when it is initiated before the third trimester, except when specifically noted otherwise." The ACOG disagrees with this statement finding it accepting of delay in seeking care until the third trimester which we feel is not a medically acceptable suggestion.

5) As with all reports, surveys, and research which relv upon infant mortality statistics to determine the health status of the nation or a community, confusion arises when uniform terminology is not utilized in data collection. The ACOG is working with the National Center on Health Statistics to develop uniform acceptable definitions for perinatal mortality, neonatal mortality, and postneonatal mortality in order to eliminate this problem. For purposes of data collection on infant mortality, information should always be broken down into these component states of development which, in fact, have their own identifiable and associated risks.

Again, we appreciate the opportunity to review this document and look forward to working further with the General Accounting Office on this and other projects where we can be of assistance.

Sincerely yours,

Ervin E. Nichols

Ervin E. Nichols, M.D., FACOG
Director - Practice Activities

EEN/ddw

APPENDIX XVI

American
Academy of
Pediatrics

P.O. Box 1034
1801 Hinman Avenue
Evanston, Illinois 60204
Phone (312) 869 4255
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November 13, 1979

Mr. Gregory J. Ahart
Director, Human Resources Division
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Ahart:

The Academy generally concurs with the findings and recommendations in your draft report "Enhancing Federal Efforts to Improve Pregnancy Outcome: Better Management and More Resources Needed." We have sent under separate cover a copy of our report summarizing findings and recommendations resulting from Academy-sponsored visits to twenty-four States, the District of Columbia and Puerto Rico. These visits were made under contract with HEW to help it implement its Improved Pregnancy Outcome project grant initiative.

Many of the findings and recommendations in our summary report are identical or similar to those in your draft. Although there are many areas in which the Federal Government can enhance efforts to improve pregnancy outcome, there are a number which we believe the Congress and Federal agencies should assign high priority. These are:

--Increased emphasis on early, high-quality prenatal care, particularly for high-risk women, which should reduce the number of infants needing specialized, expensive inpatient care. More effective use of nurse-midwives and obstetrical nurses in rural and manpower poor areas could help accomplish this objective.

--Improved regionalization of inpatient perinatal care and infant transportation.

--Better integration of health and WIC programs at the Federal and State level.

--Better access to family planning services, especially for teenagers.

--Strengthened management of State MCH programs.

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--Development of a uniform definition of the high-risk population by Federal and State programs, such as MCH, Family Planning, and WIC.

We would appreciate the opportunity to comment on your draft report and would be pleased to provide further assistance to you or other Federal agencies undertaking efforts to reduce infant mortality and morbidity.

Sincerely,

Robert G. Frazier, M.D.

JPC:mk

APPENDIX XVII

AMERICAN COLLEGE OF NURSE-MIDWIVES

1012 Fourteenth Street, N.W., Suite 801, Washington, D. C. 20005 202/347-5445

October 12, 1979

Mr. Bernie Ungar
United States General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Sir:

I have read with great interest the draft report of September, 1979. Since I am currently trying to complete constructive comments for the Federal Trade Commission along these same lines, I found it refreshing to see two governmental department's interests coincide.

I would agree that more nurse-midwives need to be trained, so that the percentage of actual care-givers and potential educators increase. This does take a great deal of money for several reasons:

1. Being a full-time, unemployed student without financial support is impossible.
2. Commuting to existing programs by married candidates might be more realistic.
3. Collaboration between existing academic (theory) programs and the clinical experience sites might be possible, with adequate funding, until more programs with more clinical placement sites are available.
4. The adequate, in person, supervision required to produce a safe, beginning practitioner reduces the teacher/student ratio, increases the costs and need for more faculty. This is necessary if we are to prevent malpractice from disabling nurse-midwives also.

Funding also has been limited to students enrolled in academic degree programs; since the greatest need is in areas with resource pools of predominantly non-degree nurses, this further limits the training of staff level nurse-midwives. It may also drain off candidates to urban areas from which the candidates may not return.

Support for inclusion under all states Medicaid programs would certainly go a long way in enabling nurse-midwives to support themselves, a physician backup and a patient population's needs.

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There are many problems in health care today which must be addressed. Thanks to your efforts, those of maternal-child health are being dealt with. Opposition to our proliferation is inevitable since we are a competing force in some minds. This really is not correct, however. It can be documented that other care-givers refuse services or see to it that other care-givers cannot provide care in many areas of our country still. Face to face dialogues between groups could go far in fostering understanding. If we each function collaboratively within our areas of expertise, with adequate time to enjoy what we are doing, the need to be at odds may resolve. More precisely though, citizens have a right to health care; those who wish to give it and are qualified can no longer be interferred with by those refusing to be responsible to the citizenry.

I will send a copy of my response to the Federal Trade Commission.

Sincerely,

Bonnie J. Stickles, M.S.N., C.N.M.
Chairperson, Professional Affairs Committee

BJS/bb

APPENDIX XVIII

THE NATIONAL FOUNDATION
MARCH OF DIMES 1275 MAMARONECK AVENUE, WHITE PLAINS, NEW YORK 10605 • 914 428-7100

FRANKLIN D. ROOSEVELT, FOUNDER
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VICE PRESIDENT FOR MEDICAL SERVICES

November 21, 1979

Mr. Gregory J. Ahart
Director, Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

I regret the delay in giving you this written reaction to your draft of the report "Enhancing Federal Efforts to Improve Pregnancy Outcome: Better Management and More Resources Needed." I wish to compliment you and your staff on the comprehensiveness of the report, which is all the more commendable considering the complexity of the subject.

Viewed from the national perspective here at our Headquarters, reports from our Chapters all over the United States have reinforced and augmented the items identified in your report, and we have noted many corroborative instances of duplication of efforts but, more sadly, many examples of pregnant women being unable to secure needed services. The conclusions drawn from your sample of regions would seem totally applicable to the whole United States.

We are particularly disturbed by the lack of interaction and relationship between the Title V (Maternal and Child Health) and the Title XIX (Medical Assistance or Medicaid) programs at the federal and state levels. We were pleased to see your discussion of this problem and of others related to the shortcomings of Medicaid, for example, the low rates for reimbursement of providers and the ineligibility of undocumented aliens for services.

It must be accepted that the level of competence and creativity in the administration of maternal and child health programs in state and local health departments is deficient. Furthermore, since the

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transfer of Title V responsibility from the Children's Bureau to the Public Health Service, the performance at the federal level has deteriorated. The staff in HHS regional offices has been decimated and maternal and child health has been relegated to a status of subsidiary priority. These conditions can be corrected only by action at the highest levels in Congress and in HHS.

Deficiencies in administrative expertise in maternal and child health programs can be lessened by increased federal support for the education and training of health professionals in schools of public health. Recent years have seen a decline in this support and a reduction in the number of prepared professionals graduating each year.

We agree with the 14 specific recommendations to the Congress and the 28 detailed recommendations to the Secretary of HHS. Under No. 15 of the latter, we would suggest that the American Academy of Pediatrics be included together with the American Academy of Family Physicians. Under 17, we would be pleased to cooperate in the role suggested in education of the public.

Pending action of the Congress based on the recommendations listed in your report, and moves by the Secretary of HHS in response to your recommendations, we at the March of Dimes Birth Defects Foundation will continue to work toward improving the outcome of pregnancy, including convening coalitions of concerned groups and individual citizens to voice the problems and solutions so well identified and expressed in your report. We will be happy to collaborate or react further in this matter as you progress.

Sincerely,

Arthur J. Salisbury, M.D.

(102030)

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