Barriers to Implementation of a Prenatal Care Program for Low Income Women

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Abstract: By the middle of the second year of the Michigan Prenatal/Postpartum Care (PPC) program to provide pregnancy-related services to low income women who were ineligible for Medicaid or other insurance, only 25 per cent of the participating health departments were enrolling greater than 90 per cent of contracted potential clients. Using a survey of program directors and relevant state documents, we identified several barriers to successful implementation: *institutional* (program complexity, high levels of administrative concerns along with low levels of communication between local health departments and providers); *economic* (inadequate resources for provider reimbursement, outreach, transportation, high-risk pregnancies, or administrative overhead); *psychological* (servicing populations with multiple and hard to care for problems, potential discomfort of low income women with traditional providers); and *informational* (insufficient information about the program infiltrating the target community). (*Am J Public Health* 1989; 79:62–64.)

Introduction

In 1984 in Michigan, the state legislature appropriated money for a Prenatal/Postpartum Care Program (PPC) as part of an effort to combat rising infant mortality rates. This program funded local health departments to provide prenatal care for women whose incomes fell below 185 per cent of the poverty level but were ineligible for Medicaid. The PPC program became operational in some local health departments in January of 1985. Over the course of the first year, however, it became clear that the program would not meet its enrollment goals. This report analyzes barriers that slowed successful implementation of this prenatal care program and may assist other states as they attempt to implement such programs.

Methods

The Michigan PPC Program

Under the PPC program, local health departments submitted proposals to the Michigan Department of Public Health (MDPH) to provide services to women in their catchment areas. Health departments were permitted to provide PPC services directly, or to sub-contract services to local providers of their choice. None of the departments provided all services on-site. For example, while the majority of participating departments performed medical, nutritional, and psychological risk assessments on all clients, only four of the 32 departments with PPC programs provided ongoing medical services. Of the health departments that sub-contracted physician services, 69 per cent did so to practicing physicians working out of their own offices. Other providers included hospital-based clinics and residents in family practice.

The PPC program had seven components: 1) risk assessment; 2) psychosocial counseling; 3) medical services including postpartum family planning; 4) laboratory services; 5) patient education in the areas of nutrition, pregnancy, and labor and delivery; 6) local outreach; and 7) limited nutritional supplements, since most women were expected to be eligible for WIC.[1] Health departments were reimbursed $405 per case. Special or high-risk funds were allocated on a per capita basis of $48 per client. These funds could be expended for nutritional and social counseling at a rate of $10 per visit up to a total of $40. Based on Maternal and Infant Care Project risk figures, it was projected that 35 per cent of the program enrollees would be classified as high risk. Therefore, a clinic with a caseload of 100 PPC women would receive $4,800 for special services. If 35 of those women were high risk, then per capita high risk funds amount to $137 ($4800/35).

At the outset, each local department received $55 per projected client for administrative overhead and outreach; thereafter, they were reimbursed upon submission of monthly activity reports. Providers under contract were paid $250 for six or more visits plus $25 for vitamins, $50 for laboratory services, and $25 for educational services. These fees were set at the Medicaid rate by the Michigan Department of Public Health and not adjusted for community differences in costs of care.

In order to limit costs and thereby make the program more acceptable, a political decision was made not to include funds for labor and delivery. Further, although PPC women did not meet the eligibility criteria for Medicaid prenatally, it was assumed that the high cost of delivery and the addition of a new family member would result in eligibility for payment of physician and hospital costs. One free postpartum visit was, however, provided in the PPC package.

Collection of Data

Questionnaires were sent to all 32 health departments participating in the program as of February 1986, and were completed by the nurse or administrator responsible for the PPC program. While some of the barriers identified in this communication have to do with the inertia inherent in start-up of a program, many are also relevant to successful implementation. Closed and open-ended questions sought information on types of service sites; types of providers; relationships among providers, clients, and local health departments; adequacy of funding for high-risk pregnancies; outreach to clients; and, administrative overhead. The questions were designed to address problems in recruiting and retaining women in the program, as well as in providing services the program was meant to offer. Information on the projected proportion of contracted women served for year two of the program was obtained from state records. Where available, we have also utilized secondary sources that address program impediments.

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Institutional Barriers

Based on responses of program nurses and administrators, several institutional barriers to success of the PPC program were identified. First, 69 per cent of local health departments cited provider unwillingness to participate as a primary reason for under-enrollment of PPC clientele. One reason often cited for provider unwillingness to participate was program complexity. Administrative concerns, combined with low reimbursement rates, serve as a barrier to provider participation that was also described by the Perinatal Association of Michigan.[2] In a review of the PPC program, the Michigan Department of Public Health also noted provider concern with complexity of standards.[3]

It also was clear that most contacts between departments and providers (which took place once a month on average) centered around billing and clerical issues rather than client or program content issues. Lack of substantive communication may limit the degree to which health departments and providers can work together to provide consistent and quality care for the population they serve.

Other potential institutional barriers are suggested by the fact that local health departments were more likely to meet their enrollment targets for the PPC program if they provided services on-site rather than through an off-site provider. For all but one of the 14 services that made up the seven components of the program, departments which provided the services on-site were more likely to approach enrollment targets than were those with sub-contracted or off-site services. For example, 38 per cent (8/21) of the departments providing nutritional services on-site reached at least 90 per cent of their enrollment targets, in contrast to 0 per cent (0/11) of the departments providing those services at another location. Similarly, 46 per cent of those offering family planning services on-site reached their enrollment goals, in contrast to only 11 per cent (2/19) of those sub-contracting family planning services. As shown in Table 1, health department size was not related to the likelihood of reaching at least 90 per cent of the enrollment target.

Transportation was cited as a problem for clients by local health departments in both rural and urban areas, a finding consistent with other reports.[4] Provision of some, if not all, services on-site is likely to minimize transportation problems.

Evidence from other studies[4] also suggests that the existence of multiple services at one site leads to increased participation across service boundaries. It is not unreasonable to assume that non-pregnant clients who use health department services like WIC (women, infants and children) or family planning are more likely to learn of the PPC program when it shares facilities with those programs. These women are then more likely to inform their pregnant friends about its availability.[2]

TABLE 1—Relationship between Number of Contracted Clients and Per Cent of Enrollment Goal Achieved

	Per Cent of Enrollment Goal		
Number of Contracted Clients	<50	51–89	>90
<100	1	5	2
101–199	3	7	3
>200	3	5	3

X^2=.77, p=.94 (Note the small cell sizes.)

Economic Barriers

As mentioned earlier, many local health departments felt a major obstacle to the implementation of the PPC program was recruitment of providers. Concern over malpractice costs may have been heightened because of caring for a population that is perceived to increase the risk of malpractice suits. In a survey of Michigan members of the American College of Obstetrics and Gynecology, Block[5] reported that 48.7 per cent of those surveyed said they avoid high-risk patients in an effort to compensate for the high costs of liability insurance.

Low reimbursement rates not only limited participation by providers, but indirectly affected clients to the extent that providers raised their rates to cover uncompensated care. Some physicians resorted to charging PPC clients a fee that was applied to labor and delivery.[5] Hospitals also began to cap the number of PPC clients that they would accept because of the uncertainty over payment for hospital services.[3]

Economic factors also impeded program operation. Most health departments agreed that funds were not adequate for outreach (65 per cent), transportation (74 per cent), high-risk services (76 per cent), or administrative overhead (84 per cent).

Informational Barriers

Sixty-five per cent of the health departments reported that insufficient funds had been allocated for outreach and advertising; 44 per cent felt that inadequate advertising was a primary reason for under-enrollment of clients. In addition, most advertising consisted of the least effective forms such as flyers and posters (71 per cent) in contrast to radio (37 per cent) and television (34 per cent). Given the overall inadequacy of resources for outreach, promotions directed at specific cultural and ethnic groups were particularly limited. Evidence that increased resources specifically for outreach and education are critical comes from studies showing that women who are less educated are less likely to get adequate prenatal care,[2,6] and that potential program recipients identify lack of knowledge about where to go for care as an important impediment to seeking out services.

Possible Psychological Barriers

Provider unwillingness to participate may have reflected a psychological barrier in that the population to be served was more likely to have multiple problems that often are not amenable to physicians' traditional, medically based interventions.

The better enrollment of clients by local health departments with on-site services suggests that health departments present a more comfortable atmosphere for low income women than private physicians' offices, with staff that may be more in touch with and responsive to the needs of this population. Women who receive initial services in such an atmosphere may be more likely to stay in the program and/or pass on news of PPC to friends in similar circumstances. Also, with services on-site, perhaps staff become more invested in the program and put more effort into recruitment and retention of clients than do the staff of health departments that contract services out to other providers.

Stigma associated with public programs represents yet another potential psychological impediment for clients. In a

separate analysis,* the needs assessment performed by the health department indicated that 17.1 per cent of the women in the PPC target group reported they were "unlikely" to use a free public service and an additional 14.6 per cent said they "might" use such services.

Conclusions

The Michigan Department of Public Health implemented the Prenatal/Postpartum Care program with unusual speed following the recommendations of a statewide task force and appropriations by the legislature. Although administrative delays associated with the establishment of such a far-reaching program may have contributed to the inability of the PPC program to reach its service goals, we have described additional substantive barriers that must be addressed.

From an institutional perspective, departments that were able to provide many of the program services on-site seemed to be more effective in enrolling and retaining clients than departments that sub-contracted those services to individual providers. This finding has particular relevance to recent enhancements in Medicaid. Specifically, increases in covered services may not affect maternal and infant health unless these efforts are at least well coordinated, if not provided at single sites.

Economically, resources seemed insufficient to attract both clients and providers. Furthermore, additional funding was needed to assure that enrolled clients received all of the services (e.g., high-risk care and labor and delivery) necessary for truly comprehensive care. Since programs such as the PPC are vulnerable to budget cuts, failure to preserve or increase funding for this complex array of services is likely to exacerbate this economic barrier. Finally, the psychological barriers that may have impeded implementation are not unique to the PPC program, and require attention in many similar public programs.

The barriers we identified were largely predictable during the design of the program, but political and budgetary considerations** created constraints that affected program implementation. While additional funding may have ameliorated many of these barriers, numerous demands on the public health budget precluded extensive funding. It is important to note, however, that the selective provision of additional resources for a few components of the program may have enhanced its overall effectiveness. For example, since transportation is a known barrier to care and the provision of different services at different sites is likely to exacerbate that problem, funds for transportation could have been allocated to those departments which were obliged to use multiple sites to provide services. Moreover, asking providers to serve a population that they may have been unaccustomed to serving while at the same time increasing their perceived exposure to malpractice as well as expecting those providers to persuade their hospitals potentially to absorb the costs of labor and delivery created an insurmountable combination of barriers. Funds for labor and delivery may have facilitated recruitment of physicians by removing the need for them to make demands on their hospitals.

The Michigan Department of Public Health has recently made efforts to overcome these barriers:

- the 1988 budget includes funds to pay physician providers for labor and delivery;
- statewide media promotion of the program has begun;
- a second task force on infant mortality, called by the Director of the Department of Public Health in July of 1986,[8] has recommended a comprehensive series of strategies to focus on the problem of infant mortality, instead of focusing on a particular segment of the population.

The most important measure of the program will be the degree to which participation improves pregnancy outcomes. Although evaluation of the effect of the program is still pending, attempts to increase enrollments and improve the content and quality of care should prove beneficial to this group of women in need.

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