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Right Start in Michigan and Its Great Start Collaboratives 2013: Trends in Maternal and Infant Well-Being





This report reviews eight indicators at birth to assess the extent of differences by race/ethnicity in Michigan and among its 54 Great Start Collaboratives, which are based primarily in Intermediate School Districts. Following are the eight indicators:

- Teen births
- Repeat teen births (teen already a parent)
- Nonmarital births
- Births to mothers without high school diploma/GED
- Late or no prenatal care
- Smoking during pregnancy
- Low-birthweight babies (less than 5.5 pounds)
- Preterm births (less than 37 weeks gestation)

From the very beginning of life, children experience vastly different circumstances. Public policy can ease or exacerbate these disparities. The sustained public health and education campaign to reduce teen pregnancy and birth shows the success of such focus over the past two decades. By 2011, the state's teen birth rate was half of what it was in 1990. In other areas of maternal and infant well-being, Michigan has not seen such progress.

ACKNOWLEDGEMENTS

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Data Source: Unless otherwise noted, all data come from the Michigan Department of Community Health, Vital Statistics and Health Data Development Section.

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This report reviews eight key indicators at birth to assess the extent of differences by race/ethnicity in Michigan and among its 54 Great Start Collaboratives, which are based primarily in Intermediate School Districts.[1] For example, babies in the St. Joseph GSC were six times more likely to be born to a mother without a high school education than those in the Livingston GSC.

Efforts to improve the lives of young children include many local partners who are active in these collaboratives and now coordinated through leaders across three key state departments (Education, Community Health, Human Services) including the recently created Office of Great Start in the Michigan Department of Education. This report examines the well-being of children in each of the collaboratives at the very outset of life—reviewing six characteristics of their mothers and two measures of infant health at birth.

Many state policymakers have realized the importance of investment in early care and education by supporting preschool for 4-year-olds, but a similar emphasis must be placed on making sure more children have the "right start." The key factors of maternal and infant well-being reviewed in this analysis have been well-documented as risks to short-term, as well as long-term, outcomes such as high school graduation.

HOW DOES MICHIGAN COMPARE WITH OTHER STATES?

As Michigan policymakers debate how to improve educational outcomes by investing more in early childhood, these birth indicators show some of the challenges. On the five Right Start measures where Michigan can be compared with all 50 states, Michigan attains its best ranking for its relatively low percentage of teen births to those who were already mothers (17%).[2] The Michigan rate tied for 20th place with Minnesota. While this is Michigan's best ranking in maternal/infant health measures, it is Minnesota's worst: it ranks in the top 10 among the 50 states for the other four measures.

Michigan's worst ranking (31st) was for its percentage of preterm births with 12% of babies being born too soon. Babies born too soon face higher risks than babies born at term of multiple physical conditions that will compromise their health, education and employment potential.

Michigan compares poorly with other states on key Right Start measures.

Indicator	Rank among the 50 states	% of Live Births
Births to Teens (under 20 years old)	30	10%
Births to Teens who were already Mothers (% teen births)	**20**	17%
Births to Unmarried Women	28	42%
Low Birthweight Babies	30	8.4%
Preterm Births	**31**	12%

Notes: Based on 2010 data with 1being the best ranking.
Source: Kids Count Data Center

The number of births rose only among women with some college.

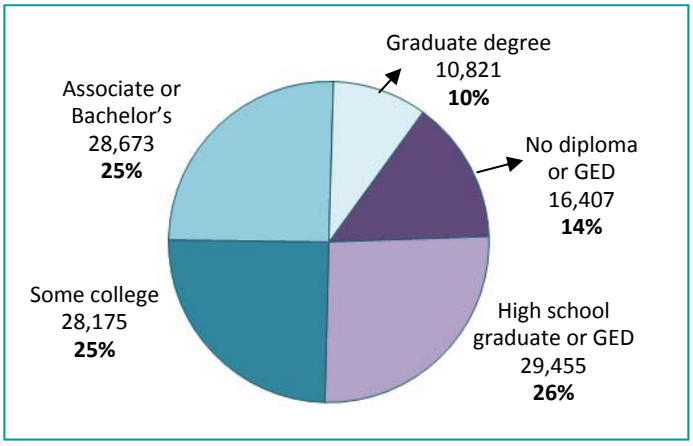
WHAT ARE THE TRENDS IN MATERNAL AND INFANT WELL-BEING IN MICHIGAN?

Fewer babies are being born to Michigan women. Overall the number of births in Michigan continued to fall between 2005 and 2011—from 129,000 to 115,000.[3] Of the 54 GSCs only two—Wexford-Missaukee and Marquette-Alger—experienced any increase in the number of births. Even at that, their numbers went up by only 1% and 4%, respectively. Lapeer and Tuscola counties sustained the largest decrease (19%)—almost double the state decline of 11%. (See Appendix A.)

Between 2008 and 2011, the decline in births occurred mostly among women with the lowest levels of education—3,600 fewer births among women with less than a high school education and 2,800 fewer among high school graduates.[4] The number of births rose only among women with some college. In 2011 the majority of Michigan mothers of newborns had some post-secondary education; one-third had a postsecondary degree. Since maternal education is a critical factor in assuring better health and educational outcomes for children, this is a heartening trend.

Between 2005 and 2011 only two substantial changes occurred in Michigan in the five indicators where a trend could be calculated. The percentage of births to unmarried women escalated

Most Michigan mothers of newborns had post-secondary education in 2011.

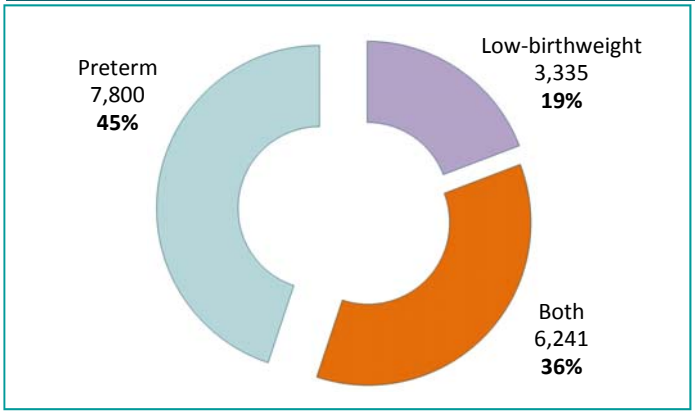


and births to teens who were already mothers declined.[5] In 2011 more of the state's babies were born to unmarried women—up by 18%—rising from 36% of all births to 42%. The incidence of birth to teens who were already parents dropped by almost two percentage points—to 17% of all the teen births.

The share of babies born too small or too soon remained roughly the same over the trend period, as did the percentage of teen births. Of the total 17,400 unhealthy births—over one-third suffered from being born with low-birthweight, as well as being premature (born before 37 weeks).

While the percentage of teen births declined only slightly over the trend period, it meant roughly 1,400 fewer teen births occurred in 2011 compared with 2005. Despite the relative stability in the percentage of teen births, the percentage of nonmarital births grew substantially.

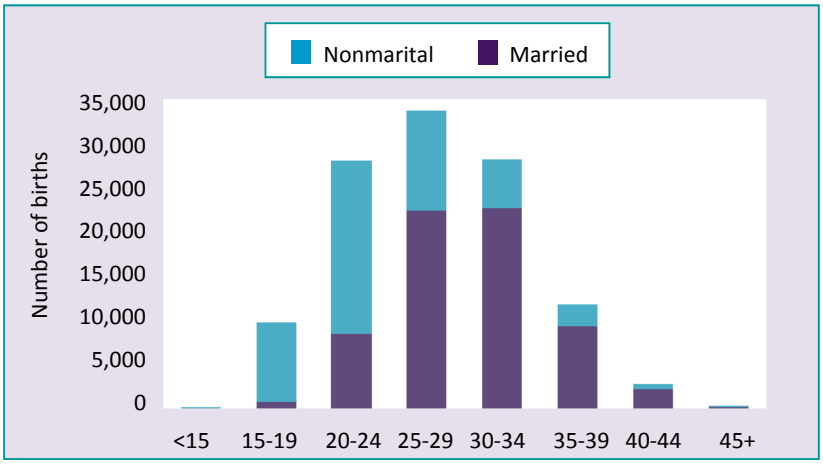
Some babies are born too soon AND too small (N=17,376).



The escalation in births to unmarried women reflects national trends and occurred despite draconian changes in policy embedded in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act that limited federal support for children of single mothers and was extended in the 2003 reauthorization.[6] The policies embedded in the Act did not result in a downturn in the rate despite having one of its four central purposes to reduce nonmarital births.

The likelihood of a baby born out of wedlock is clearly associated with the age of the mother. In Michigan roughly 93% of teenage mothers of newborns in 2011 were not married, also the case for 70% of those in their early 20s. Even among women in their late 20s, over one-third of births were to unmarried women. Marriage can provide economic security, but in an era of limited job opportunities and deterioration in wage levels, may not confer this benefit.

Most births to Michigan teens and early 20s are nonmarital.



Although almost two-thirds of nonmarital births are to couples who are living together, these couples are three times more likely to be separated by the time their child reaches age 5 than couples who married before they had children—39% vs. 13%.[7] Economic stress is then compounded by family instability, which often constrains the economic and social supports for children.

At the same time state support for families with children has been dwindling, and federal and state policymakers have placed substantial barriers for women seeking to control their fertility, state and federal funds have been cut for women who want to take responsibility for their reproductive health and the well-being of their children.

Additionally, multiple changes in the social, cultural and economic environment have contributed to the rise in non-

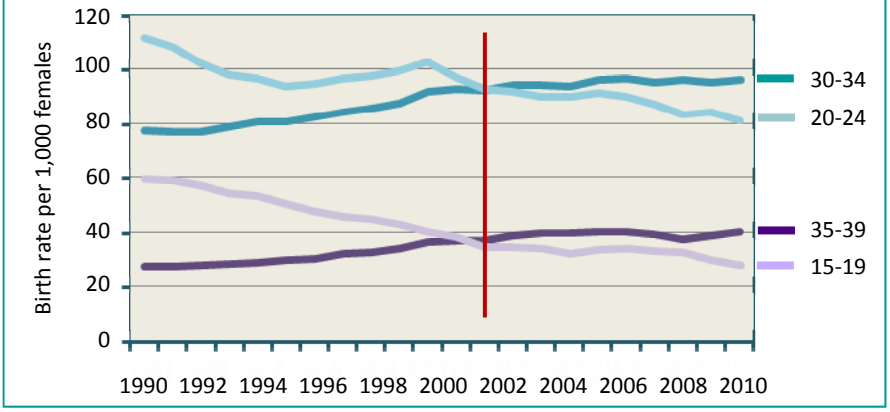
marital births, according to researchers. Escalating unemployment and eroding wages, particularly among men without a college degree, have weakened family formation. Between 2000 and 2012, the inflation-adjusted wages of young high school graduates declined 13%.[8]

The steadily rising age of first marriage in the U.S. has resulted in larger percentages of women in their prime child-bearing years remaining single: 80% of American women ages 20-24 are unmarried, as are half of women in their older 20s.[9] According to a recent analysis the median age for first birth now occurs before that of marriage among "Middle American" women – those with a high school degree or some college – a "crossover" of the sequence between those two events that began at the beginning of the last decade. Median maternal age at first birth "crossed over" to occur roughly two years before the median age of marriage for this group. By 2010 the majority (58%) of all first births to this group were to unmarried women.[10] Since this group represents roughly half of American women, this crossover has significant implications.

A substantial share of births to disadvantaged women, those without a high school education, have been nonmarital for some decades, but have continued to increase: by 2010 women at this educational level who were unmarried at the birth of their first child reached 83% from 74% in 2000. The long-term impact on the lives of these young women cannot be overstated. Their opportunities to complete or further their education and earn a family-supporting wage will be severely constrained. Average full-time child care costs for a Michigan preschooler consumed roughly 42% of the gross income from a full-time minimum wage job in 2012.

Michigan women in their late 20s still had the highest birthrate in 2011, but between 1990 and 2011 their birthrate declined slightly (8%). The steepest declines in birthrates among the age groups were among young teens ages 10-14 (77%), teens (53%) and women in their early 20s (28%). Over the same period the birthrate climbed among women in their 30s and 40s. Two critical "crossovers" occurred in 2002. After that year the birthrate for women in their late 30s started to exceed that of teenagers, and that of women in their early 30s climbed above that of those in their early 20s.

Birth rates for Michigan women in their 30s rose while those for teens and early 20s dropped



While economics exerts pressure to delay marriage and childbearing, biology has a different agenda. Women who delay childbearing past their mid-30s are at higher risk for several problems: multiple births (especially after using assisted reproductive technologies); gestational diabetes, high blood pressure or other pregnancy-related complications; miscarriages and chromosomal anomalies such as Down Syndrome.[11] All these risk factors are more easily managed by economically secure women with access to health care and social supports.

Michigan women in their late 20s still had the highest birthrate in 2011

HOW DOES MATERNAL AND INFANT WELL-BEING VARY ACROSS MICHIGAN'S GREAT START COLLABORATIVES?

Conditions for newborns vary dramatically across Michigan's 54 Great Start Collaboratives. The risks to maternal and infant well-being were least prevalent in Livingston GSC, which had the lowest rates on four of the eight measures tracked in this report. Wayne GSC, which matched Genesee for the worst ranking (tied for 53rd among the 54 GSCs), had the worst rates on two indicators—nonmarital births and low birthweight. No other GSCs ranked the lowest or highest on more than one measure. (See Appendix B.)

The largest ratio between the highest and lowest rate occurred in the percentage of births to women with less than

a high school education: the percentage in St. Joseph GSC (27%) was six times that of Livingston GSC (4%). Similarly women in Clare-Gladwin GSC were five times more likely to receive late or no prenatal care than those in Alpena-Montmorency-Alcona GSC—10% vs. 2%. Smoking during pregnancy was four times more prevalent in the northern GSC of COOR-Iosco (42%) than in Ottawa (10%).

The distribution of the GSCs by ranking on overall maternal and infant well-being echoes that based on 15 measures over childhood reviewed in the state Kids Count data book.[12] The top tier counties tend to be the most affluent, while those in the bottom tier reflect relatively high levels of poverty and other disadvantages. Disparity is most pronounced in southeastern Michigan where Wayne GSC in the bottom tier is surrounded by five top tier GSCs. Third tier GSCs are concentrated in the southwestern area, in areas of northern Michigan, as well as the GSCs north of Ottawa and the eastern UP. (See Appendix C.)

Maternal and Infant Well-Being: Best and Worst Rates in the Great Start Collaboratives

	GSC	Best (Lowest)	Worst (Highest)	GSC
Mother under age 20	Livingston	4.3	13.7	Newaygo
Repeat teen birth ***(% teen births)***	Livingston	6.9	21.8	Kalamazoo
Unmarried mother	Livingston	23.3	56.0	Wayne
No diploma/GED	Livingston	4.4	26.9	St. Joseph
Late or no prenatal care	Alpena-Montmorency-Alcona	2.1	10.0	Clare-Gladwin
Smoked during pregnancy	Ottawa	9.5	42.2	COOR-Iosco
Low-birthweight	Gogebic-Ontonagan	4.4	10.6	Wayne
Preterm	Menominee	7.5	13.2	Genesee

Note: All measures are based on total births except repeat teen births, which are percent of only teen births.

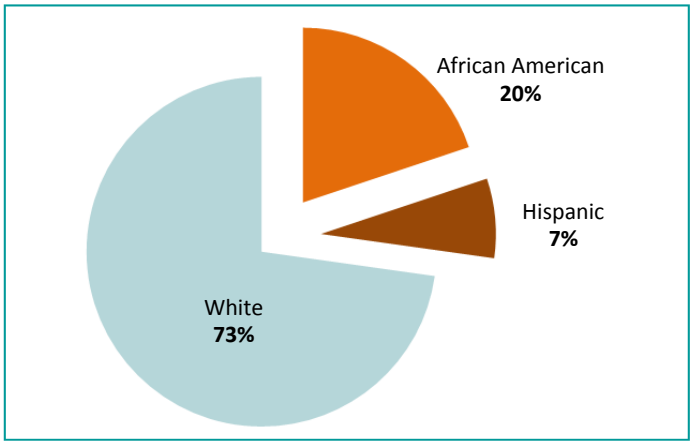
HOW DOES MATERNAL/INFANT WELL-BEING VARY BY RACE/ETHNICITY?

By 2011 over one-quarter of all Michigan newborns were to mothers in communities of color, and almost three of every four were to African American women, who are at highest risk on multiple measures of maternal and infant well-being.[13] While the number of births to mothers in these communities is declining, their percentage of all births grew by 8% between 2005 and 2011, due to the steeper drop in births among non-Hispanic white women.

African American newborns in Wayne represented roughly half of all African American newborns in the state, as well as almost half (46%) of all babies within Wayne. Genesee had the second largest concentration of African American newborns within a GSC (29%) and as a share of all African American births in the state (7%). While relatively large numbers of African American births occurred in Oakland and Macomb GSCs, they represented a much smaller share of all births (17% and 14%) within each county, thus having less impact on county averages.

In 2011 infants born to mothers in Michigan's two major minority groups were at much higher risk than their white counterparts on a number of key measures. They were more likely to be born to a teen mother. African American infants suffered from a low-birthweight rate that was double those among whites and Hispanics and a preterm birth rate more than half again as high as that among whites. Both African American and Hispanic women were much more likely to have late or no prenatal care than white women. While infants born to Hispanic mothers had the same low-birthweight rate as whites, their preterm rate was slightly higher—10.8% vs. 9.3%. These disparities highlight the need to target efforts to improve conditions of maternal and infant well-being in communities of color.

More than one of every four births in Michigan is to a woman of color



Hispanic infants were only slightly more likely to be born to a teen who was already a parent than their African American counterparts (22% vs. 21%), but they were at much higher risk of being born to a mother who lacked a high school diploma or GED (42% vs. 25%). Hispanic infants were the least likely to be born to a mother who smoked during the pregnancy (13%), compared with almost one-quarter (23%) of white infants and 18% of African American infants. African American infants were more than twice as likely to be born to a mother who lacked a high school education as their white counterparts (25% vs. 10%) and had more than double the risk of being born to an unwed mother (81% vs. 32%).

WHAT ARE THE TRENDS IN MATERNAL AND INFANT WELL-BEING BY RACE/ETHNICITY?

Between 2005 and 2011, all the major racial/ethnic groups in Michigan experienced declines in their percentages of repeat teen births and increases in their nonmarital births with whites reflecting the most dramatic changes on both measures. Nonetheless, nonmarital births was the only risk factor that increased for whites.

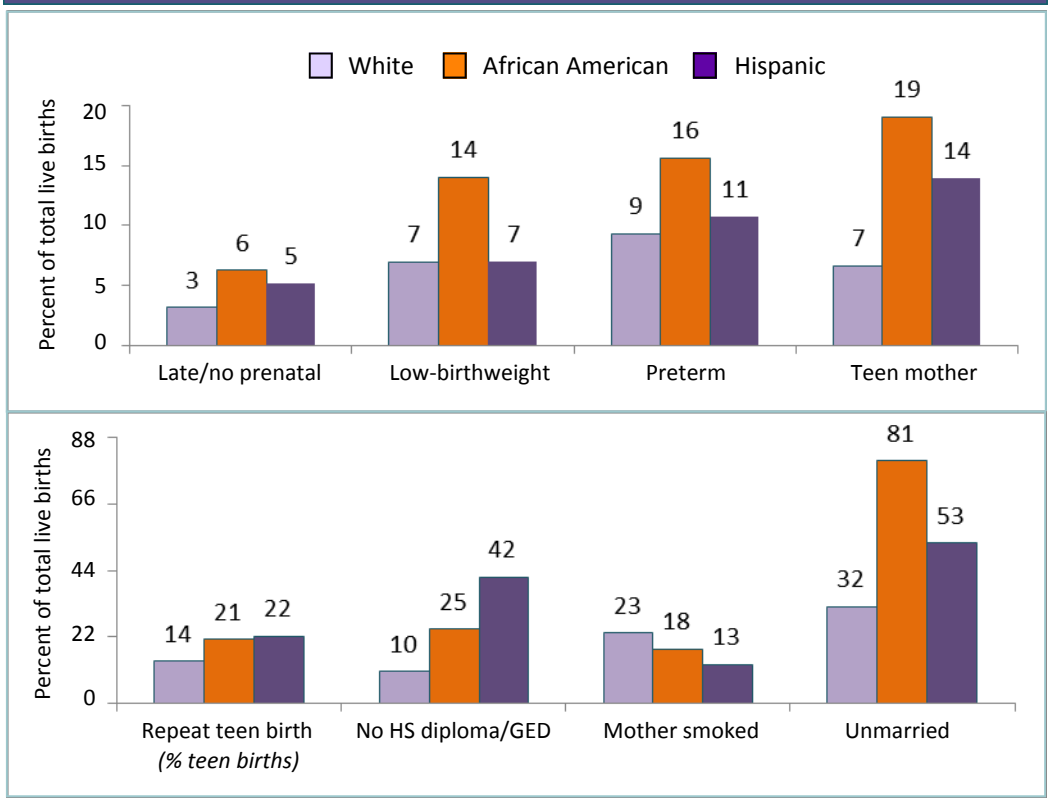
Only African American infants saw increased risk of being born to a teenager and decreased likelihood of low-birthweight. Over the trend period only Hispanics experienced worsening trends in percentages of low-birthweight and preterm births).

WHAT ARE THE TRENDS IN MATERNAL AND INFANT WELL-BEING AMONG THE GSCS?

The state increase in nonmarital births was reflected in every GSC, while the slight worsening of the percentages of unhealthy births was much less pervasive. Despite the relatively small improvement in the state average for the percentage of teen births, most GSCs saw their rates drop between 2005 and 2011. In contrast, the relatively larger drop in the state's repeat teen birth share was reflected in fewer GSCs.

Teen Births: Only 12 of the 54 GSCs experienced a worsening trend with their percentages of teen births increasing over the trend period. The percentage of total births to teenagers dropped the most—by roughly one-third—in the GSCs of Menominee, St. Joseph and Missaukee-Wexford, while rising the most (17%) in Macomb.

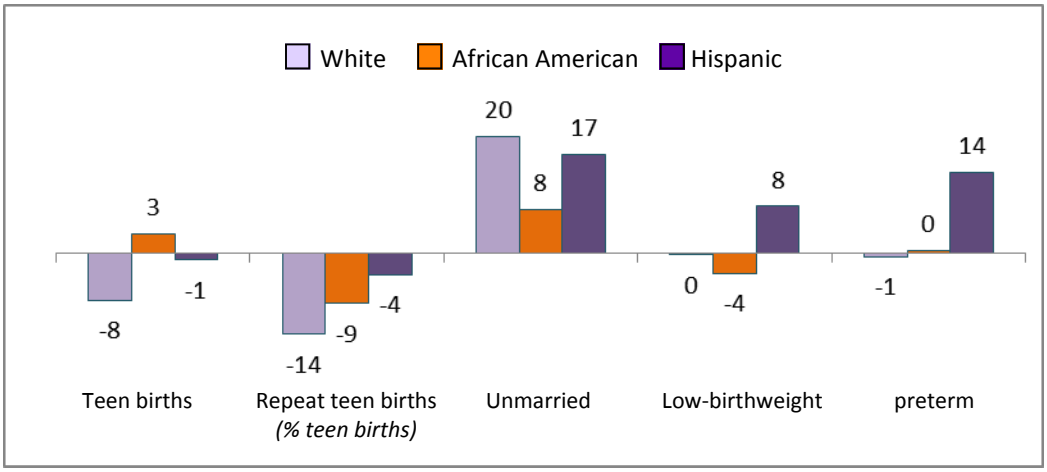
Risks to infants often vary quite substantially by indicator across racial/ethnic groups.



Repeat Teen Births: Most GSCs saw decreases in births to teens who were already parents. Among those with declining rates Ionia led the way (down by 48%) with Livingston, Sanilac and Shiawassee close behind with declines of over 40%. In 18 GSCs the risk of a teen mother having another baby rose over the trend period with the Delta-Schoolcraft GSC having the steepest increase (43%).

Nonmarital Births: Every GSC experienced an increase in births to unmarried women. St. Joseph GSC had the smallest increase (3%) while Macomb saw the largest (47%). Some of the most affluent areas, such as Oakland, Livingston and Washtenaw, sustained some of the largest escalations.

Most rates fell for whites and African Americans while risks rose for Hispanics.



Low-Birth Weight Babies: Most (34) GSCs saw their percentages of babies born with weight under 5.5 pounds rise or stagnate. Lapeer and Dickinson-Iron GSCs sustained the most dramatic increases (up by at least half) while Cass GSC saw their rate drop by one-quarter over the trend period.

Preterm Births: The risk of a preterm birth—being born before 37 weeks—rose in roughly half the GSCs with Genesee sustaining the largest increase over the trend period (43%). While Midland had the most dramatic decline (37%) in their rate, Clare-Gladwin followed closely with a decline of almost one-third.

HOW CAN WE SUMMARIZE THESE FINDINGS?

The investment in early childhood in Michigan must begin with assuring more children have the "right start" at birth. Currently Michigan compares poorly with other states on several measures and recent trends are troubling. Overall Michigan saw little improvement between 2005 and 2011 in maternal and infant well-being. The most progress occurred in the 9% decline in the percentage of births to teens who were already parents.

While the number of teen births declined by over 2,000, because of similar declines in births to women over age 20, their percentage of total births saw little change—dropping from 9.5% to 9.4%. Nonetheless roughly 9,700 young women under the age of 20 gave birth in 2011. Their opportunities to complete an education and get a good job will be severely limited. Their situation will have lifelong consequences for them and their children. For many their capacity to be successful parents, workers, citizens and taxpayers will be compromised.

The biggest change in maternal/infant well-being occurred in the dramatic increase in births to unmarried women: They now comprise 42% of all births in the state. Multiple factors may be affecting these trends, which are also occurring at the national level and escalated during the economic downturn.

Soaring unemployment and dwindling wage levels most severely affected men and women without a college degree, limiting their capacity for family formation. Unemployment, particularly among men, is a major reason cited for delaying or rejecting marriage, according to findings from the Fragile Families Survey. Delayed marriage results in more women remaining single through their 20s, and increased restrictions on access to family planning options also contribute to the increase in births among single women.

> ...dramatic increase in births to unmarried women: they now comprise **42%** of all births in Michigan.

The substantial differences in maternal and infant well-being across the GSCs and race/ethnicity suggest that efforts to improve the lives of young children need to be targeted by geography as well as race/ethnicity. The growth in minority children as a percentage of all children and their disproportionate disadvantage will have significant implications in the state's efforts to improve educational achievement and promote health to create a more competitive workforce.)

WHAT ARE THE IMPLICATIONS FOR PUBLIC POLICY?

Public policies that improve access to health care so that more women are healthy before they become pregnant and that allow women access to family planning services are

critical. Programs to provide opportunities for low-income workers to improve their skills so they have the financial resources to care for their children would provide more young children the "right start." The Affordable Care Act extends federal funds to accomplish some of these objectives, and state policymakers should support its implementation and look to establish other family-friendly initiatives to improve the circumstances for more children at the beginning of their lives.

The federal Affordable Care Act, which extends access to medical care and preventive services to all Americans, will particularly benefit low-income individuals. Medicaid expansion to all Michigan residents in households with incomes under 138% of the federal poverty level offers a critical opportunity to increase access to health services for the most economically disadvantaged women who have the highest probability for several risk factors for pregnancy and birth.

The federal ACA also extended funding to the states to improve home visiting programs and expand services in several high-risk communities. This effort is supporting the use of several proven, called evidence-based, home visiting models that can help achieve better birth outcomes for mothers and babies in Michigan, which has successfully applied for several grants. Improved coordination across home visiting programs and centralized access projects are some of the initiatives being piloted at the community level to target appropriate services to fit family needs. Michigan law, effective March 2013, requires all state funding for home visiting through any department be directed only to promising or evidence-based programs. An annual report to the Legislature is required to provide data on a set of common outcomes across all home visiting programs.

With rising numbers of nonmarital births, more women are on their own in supporting children.

With rising numbers of nonmarital births, more women are on their own in supporting children. As noted, the feasibility of marriage is often grounded in economic realities, so low wages and high unemployment discourage family formation despite childbirth. Michigan has one of the worst ratios in gender pay in the country, so pay equity would improve the lives of women and their children. Increasing job training opportunities for high school graduates would help more young parents and parents-to-be secure jobs with family-supporting wage levels.

ENDNOTES

1. There are 54 GSCs—37 single counties and 17 with two or more counties. Three county-based ISDs—Manistee, Oceana and Iosco—have been integrated into nearby multiple county ISDs. The ISDs match the county lines in the more highly populated southern counties but encompass as many as six counties in the northern rural areas.
2. KIDS COUNT Data Center. These measures are 2010 data. [http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?loct=2&by=v&order=a&ind=5&dtm=254&tf=133]
3. For the purposes of this discussion the year references of 2005 and 2011 refer to averages based on three years—2003-05 and 2009-11.
4. Education level of the mother cannot be tracked in the same codes prior to 2008 in Michigan due to changes in the birth certificate.
5. Due to changes in the Michigan birth certificate implemented in the summer of 2007, only five indicators can be assessed for trends between 2005 and 2010.
6. The Act was reauthorized in the Deficit Reduction Act of 2005.
7. Kay Hymowitz, et al. *KNOT YET: The Benefits and Costs of Delayed Marriage in America.* The National Marriage Project at the University of Virginia, The National Campaign to Prevent Teen and Unplanned Pregnancy, and The Relate Institute. 2013.
8. Heidi Shierholz et al. *Class of 2013: Young Graduates Still Face Dim Job Prospects*. Economic Policy Institute. April 2013.
9. Kay Hymowitz, et al. *KNOT YET: The Benefits and Costs of Delayed Marriage in America.*
10. Ibid
11. Mayo Clinic Staff. *Pregnancy after 35: Healthy moms, healthy babies*. Health Information.
12. *Kids Count in Michigan Data Book 2012.*
13. Other identifiable racial/ethnic groups in Michigan do not have sufficient annual rates for comparison.