The Bush Administration's Decision to Redefine 'Child' as Conception to Age 19 as a way to increase prenatal care: advantages, disadvantages and controversy

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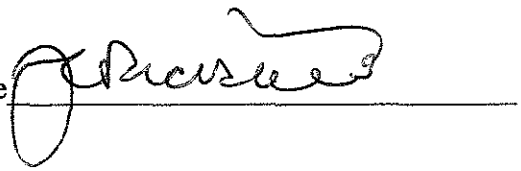
Reader Signature 

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Introduction

The United States is one of the wealthiest nations in the world and is considered to be a leader in health care technology and cutting edge research. Currently, 14% of the United States national budget goes towards health care expenses[1]. Despite spending $1.4 trillion in 2001 on health care and ranking #1 in health care expenditures, in 1995 the US infant mortality rate ranked 25th among industrialized nations, a statistic believed to be an important measure of a nation's overall health. This ranks the United States behind other industrialized nations with lower per capita health care expenditures[2,1].

Given the United States' relatively poor infant mortality rates, health care organizations and policy makers in the US have aimed to improve infant mortality rates throughout the United States. Much of the efforts have focused on examining the benefits of prenatal care on infant mortality and infant outcomes, as prenatal care is considered to be an essential part of improving infant mortality rates and maternal and fetal outcomes[3]. Healthy People 2010 published a list of goals for the health of the United States, one of them being to "improve the health and wellbeing of women, infants, children, and families[4]." They have set specific objectives aimed at accomplishing this goal, including a 2010 target infant mortality rate in the United States of 4.5 per 1,000 live births[4].

The United States' comparatively poor Infant Mortality Rate has brought about the discussion of many potential solutions and proposals, all with the goal to improve maternal and fetal outcomes by increasing prenatal care services in the United States. Three proposals aimed at improving prenatal care and infant

mortality rates that have garnered recent discussion in newspapers and policy and medical literature[10,28,42]. First, the government could increase existing Medicaid coverage to all pregnant uninsured women, regardless in income. Second, states could be granted a federal waiver allowing State Children's Health Insurance Program (SCHIP) funds to be used for prenatal care for women over the age of 18. Finally, SCHIP funds could be used for prenatal care by making fetuses eligible for health insurance, negating the need for a federal waiver.

In February 2002, Health and Human Services Secretary Tommy Thompson and the Bush Administration proposed to redefine the word "child" as " conception to age 18" as a way to make fetuses eligible for health insurance under SCHIP and thereby use existing SCHIP funds for prenatal care[5]. This paper looks at the potential advantages, disadvantages and subsequent controversy surrounding this proposal.

Prenatal Care, Infant Mortality Rates and Insurance

Since the early 1900's prenatal care has grown to become one of the most frequently used preventive health care services in the United States[6]. Despite its high utilization and the widespread belief that prenatal care is beneficial, scientific evidence proving these benefits is incomplete[3]. As policy makers and health care professionals attempt to improve infant mortality rates and birth outcomes in the United States, the role prenatal care plays should be critically examined.

A critical review article published in Obstetrics and Gynecology in 1995 looked at the association between prenatal care and birth outcomes[7]. The study

looked at all studies published before 1995, including 14 observational studies, 11 randomized controlled trials, 12 time series and 13 quasi-experimental studies. The authors found that none of the randomized controlled trials of enhanced care showed positive effects on rates of low birth weight infants or preterm delivery. Additionally, there was limited evidence from time series for cessation of effects. They concluded that the association between prenatal care and birth outcome appears to be highly sensitive to confounding and that current evidence could not satisfy the criteria necessary to establish that prenatal care definitely improves birth outcomes. They caution, however, that policy makers must consider the finding of this review in the context of prenatal care's overall benefits and potential cost-effectiveness.

Since that critical review was published, further studies have been published attempting to clarify the relationship between prenatal care and birth outcomes. One study published in 1999 looked at the effect of prenatal care in infant mortality rates according to birth-death certificate files[8]. The study found that compared with no care, prenatal care was associated with lower infant mortality rates; however, early care was associated with higher infant mortality rates than late care. Factors that increased infant mortality rate include prematurity (OR 17.43), no prenatal care (OR 4.07), inadequate weight gain (OR 2.95), African American ethnicity (OR 2.55) and medical complications (OR 1.99). Therefore, infant mortality rate is not necessarily better when prenatal care begins earlier, although some care is better than none

Another study looking at the impact of prenatal care on birth outcomes was published in the American Journal of Obstetrics and Gynecology in 2002[9]. Data were collected from 1995 to 1997 from the national linked birth/infant death data from the National Center for Health Statistics. The researchers concluded that lack of prenatal care should be considered as a high-risk factor for postneonatal death, especially if the pregnancy is complicated by pregnancy-induced-hypertension, postdates, intrapartum fever or small for gestational age infants. The data do not however point to prenatal care being the key component of healthy babies.

A similar study, published by the same authors, looked at the impact of prenatal care on preterm births using the National Center for Health Statistics data set for 1995 to 1998[10]. Again they found prenatal care beneficial. The absence of prenatal care increased the relative risk for preterm birth 2.8-fold in both African American and white women. The authors conclude that strategies to increase prenatal care participation are necessary to decrease preterm births. Since the data for this study and those previously mentioned study were collected retrospectively from birth-death records, the results are potentially biased by confounding. Lack of prenatal care may serve as a marker for other high-risk behaviors including maternal stress, poor weight gain, long work hours, and drug or alcohol abuse.

Given the current thoughts regarding prenatal care, it would be unethical to conduct a randomized controlled trial, dividing women to receive either prenatal care or no prenatal care. Because there is no way to conduct randomized

controlled trials, all studies of prenatal care are going to have some element of selection bias, based on who chooses to get prenatal care and who doesn't. Frick and Lantz investigated selection bias in prenatal care utilization and the results were published in Medical Care Research and Review in 1996[11]. In the article, they develop a typology of prenatal care usage and then use a framework to review published studies on prenatal care and birth outcomes. They found that selectivity in the use of prenatal care does exist, predominantly on an "adverse selection process". Their model implies that studies failing to control for selection bias could underestimate the effects of prenatal care.

While these studies show trends and suggestions of the usefulness of prenatal care, none of these studies can explain why the United States ranks 27th in the world in infant mortality rates despite relatively high rates of prenatal care utilization. Matteson, et al. published a multi-level analysis of individual and community risk factors contributing to infant mortality[12]. The study looked at both personal risk factors (race, socioeconomic status, marital status, insurance) and community factors (geographic variation, health care environment, urbanization) and their impact on infant mortality rate. While the study did find that prenatal care is a part of what is important for decreasing infant mortality rates, other personal and community factors also play a large role. Personal and community risk factors are equally important in reducing infant mortality as having a good system of prenatal care.

The phenomenon known as the "Mexican Paradox" demonstrates what Metteson and colleagues were writing about. First generation Latinas living in

the United States, especially those from Mexico, have healthy babies; this is despite the fact that they get less prenatal care and are more likely to live in poverty[13]. In the state of North Carolina between 1996 and 2000, the rate of infant deaths per 1,000 live births to Mexican-born women was 6.1. Compare that to the rates of 6.6 for whites and 15 for African Americans[13]. Obviously, prenatal care is not the only factor involved in having healthy babies.

Although research studies connecting prenatal care and infant mortality are less than convincing, the stance of professional health organizations and physicians is clear. The American College of Obstetrics and Gynecology (ACOG) and American Academy of Pediatrics (AAP) recommends at least 13 prenatal visits in a normal 9-month pregnancy: one each month for the first 28 weeks of pregnancy, one every 2 weeks until 36 weeks, and then weekly visits until delivery, maintaining that lack of prenatal care contributes to poor maternal and child health outcomes[14,15].

According to ACOG, half of all maternal deaths in the US could be prevented through good prenatal care with early diagnosis and treatment of problems[16]. Lack of prenatal care increases the risk of having a low birth-weight infant. A comprehensive retrospective study done in Massachusetts looked at all births between 1994-1999 and found that the percentage of low birth-weight births among teen women (<20 years old) was 30.4% higher than it was for births to adult women (9.0% vs. 6.9%)[17]. Teen mothers with late prenatal care were more likely to deliver a low birth-weight infant than those who received adequate prenatal care (12.1% vs. 8.3%)[17].

Low birth-weight infants are at higher risk for respiratory illnesses including respiratory distress syndrome, poor infant growth, and sudden infant death syndrome (SIDS). The infant mortality rate in the United States, defined as deaths per 1,000 live births, was 7.0 in 1999, with the United States ranking 27th internationally in infant mortality[18]. It is important to break infant mortality rates (IMR) down into birth weight ranges, as the mortality rates vary with tremendously with varying birth weights. Term infants and those weighing more than 2,500 grams have an IMR of 1.5 while infants weighing less than 1,500 grams at birth have an IMR of 200-220[18]. Therefore, early prenatal care could potentially improve the US infant mortality rate by preventing premature births. Moreover, low birth weight/preterm birth is one of the top three most expensive causes of a hospital stay in the United States[19].

In 1999, 13.4 percent of pregnant women (more than 420,000) were uninsured, an increase from 11 percent in 1990[20]. Data prepared for the March of Dimes by the U.S. Census Bureau refines the information further and report that nearly one in five women of childbearing age (15-44) or 11.7 million women were uninsured in 1999[20]. These women accounted for 27 percent of all uninsured Americans. The National Center for Health Statistics (NCHS) reports that 3.9% of pregnant women and 8.8% of pregnant teenagers received late or no prenatal care in the United States in 1998[18]. Overall, only 82.8% of pregnant women received prenatal care in their first trimester of pregnancy in 1998[18]. Women without insurance coverage typically obtain prenatal care later and make fewer visits during their pregnancy than women with insurance.

Changing the definition of "Child as a mechanism to increase access to prenatal care

In February 2002, Health and Human Services Secretary (HHS) Tommy Thompson announced that the Bush Administration was considering a proposal that would allow fetuses to be eligible for insurance coverage through the State Children's Health Insurance Program (SCHIP)[5]. SCHIP was enacted in 1997 with a goal to provide health insurance for low-income, non-Medicaid eligible children from birth to age 19[21]. Integral to SCHIP's enactment is the definition of the world "child". Webster's unabridged dictionary defines child as "a young person between infancy and youth" and defines infant as "a child in the first period of life, beginning at his or her birth". The word child has always implied birth to age 18. Using this definition and the language used in the 1997 SCHIP legislation, the SCHIP insurance was designed to cover children from birth to age 18, not a fetus in utero.

The SCHIP program gained bipartisan support upon its creation and was given a total 10-year funding authorized at $40 billion[22]. All states now operate SCHIP programs, however, available funds are not being completely used[21]. In an attempt to increase prenatal care funding and use available and unused SCHIP funds, the Bush Administration proposed to redefine childhood as "conception to age 19"[5]. By using this new definition, states would be able to use available SCHIP money for prenatal and delivery care.

An integral part of this proposal is that the SCHIP budgets have excess money to spend on prenatal care. With the enactment of SCHIP, individual states were given nearly $4 billion a year in funding for the first 4 years (FY 1998-2002)[22]. For FY 2002-2004, federal funding drops by approximately 25 percent, giving states roughly $3 billion per year. After this time, funding will increase again to $4 billion per year in FY 2005-2006 and to nearly $5 billion per year in FY 2007. The Urban Institute published data showing the utilization of available SCHIP funds[22]. In the first year of the program, states spent approximately $121 million, or 3 percent, of the $4.2 billion available to states that year. They estimate that only one-fifth of states – 10 states – will use all of their available SCHIP funds over the next 5 years. When looking specifically at North Carolina, the states has spent all of it's original 1998 allotment, but has only spent 42% of the funds available to the state for the time period of 1998-2000[22]. Many state SCHIP programs have not yet reached their full maturity; therefore, spending can be expected to increase dramatically. This dramatic increase in spending will seriously affect the spending patterns in the future. Despite the fact that SCHIP participation is increasing, the majority of states will have federal money left over that could be redirected towards paying for prenatal care services.

In a HHS press release in September 2002, Secretary Thompson said:

> President Bush and I are committed to doing everything we can to encourage states to use all their funds to expand health coverage to low-income children, pregnant mothers and others in their states that otherwise would remain uninsured. By giving states more flexibility to expand coverage, we are helping to expand access to coverage for millions of Americans."[21]

After a period of debate and clarification, the proposal was accepted on September 27, 2002, with the final regulation published in the Federal Register on October 2, 2002[23]. It is now up to individual states to determine whether they want to expand their SCHIP programs to include fetuses and thus cover prenatal care.

Potential Alternative Solutions

In analyzing and understanding the reasons why the Bush Administration chose to promote a redefinition of the word child as the way to increase prenatal care services in the United States, it is important to understand the other policy options available at the same time. While universal health insurance in the United States would be the most effective way to ensure equal access to good prenatal care for all women, it is not politically feasible in the current political atmosphere. Attempts to pass universal health care in the United States, most recently during the Clinton Administration's plan in 1993, have all failed[24]. Additionally, current White House administration policy on health care promotes market-based health insurance, not universal coverage[25]. The President aims to create a health care system that puts the needs of patients first by helping all Americans find affordable health coverage and helping ensure high quality care. He proposes to expand health accounts and offer new health credits to make private health insurance more affordable[25]. Other plans include strengthening Medicaid and health care for seniors and the disabled.

Alternative 1 – Expanding Medicaid to cover all pregnant women without private insurance regardless of income.

In 1985, the Institute of Medicine published a report that linked prenatal care and infant mortality and promoted the enrollment of all pregnant women into a system of prenatal care[26]. Shortly there after, beginning in 1985, the federal government made several changes in Medicaid policy, increasing prenatal care services to low-income mothers. A series of seven bills was passed, most as part of the Omnibus Budget Reconciliation Act (OBRA)[27]. These bills had the effect of severing the link between welfare and Medicaid. Prior to these bills, low-income women who were married or not receiving welfare were ineligible for Medicaid. Throughout the remainder of the 1980's, the Medicaid expansions continued and by the end of 1989, more than 40 states covered all pregnant women below the federal poverty level[27]. By April 1990, federal law required all states to provide Medicaid coverage to all pregnant women and newborns with a family income below 133% of the poverty level[28]. Additionally, states opting to cover women with incomes up to 185% of the poverty could receive matching federal funds[28].

Since the changes in Medicaid eligibility, numerous studies have tried to examine the effect of the expansions on birth outcomes. A review and synthesis of the evidence regarding Medicaid services was published in March 2001[27]. In this review, Howell provides a comprehensive review of published literature on this topic. The review includes fourteen studies, 5 nationally based and 9 state-

based, examining the impact of the OBRA Medicaid expansions. The main findings of the review show:

- Medicaid expansions led to new groups of pregnant women receiving prenatal coverage through Medicaid. It is not known what percent of these women were previously uninsured.
- Prenatal care utilization among low-income pregnant women increased after the Medicaid expansions, but differed in amount by demographic group and geographic location.
- Conflicting information regarding the effect of Medicaid expansion on the rate of low birth weight and premature infants. Evidence in this area is weak.
- Mixed results regarding the effect of Medicaid's expansions on infant mortality.

Given these mixed results, we can reasonably ask what we can expect to gain by further increasing Medicaid eligibility. Current Medicaid eligibility requirements remain complicated[29]. Women may be eligible, but because they are not aware of their eligibility, they are not enrolled. Additionally, the stigma surrounding Medicaid use may limit a woman's willingness to participate[30]. Expanding Medicaid eligibility to all pregnant women without private insurance would ensure that all women receive prenatal care, and the potential improved outcomes associated with having that care. This type of expansion could reduce the application process because all pregnant women without insurance would be eligible. Additionally, women would learn that this program is not "just a welfare

program". Since all socioeconomic classes would be eligible, the stigma associated with participation could be reduced.

Covering all pregnant women is certainly a step toward universal health insurance for pregnant women. It is important to point out that there are some issues that may still pose a problem for this proposal. Can women covered by private insurance switch to be covered through Medicaid? What about women who choose not to have health insurance even though they certainly can afford it? The answers to these questions would need to be resolved to make effective policy.

Alternative 2 – Expanding SCHIP to cover prenatal care without requiring states to apply for a federal waiver.

Initial SCHIP legislation designated funds to provide federal health insurance to low-income, Medicaid ineligible children from birth to age 19[31]. Under these original rules, SCHIP funds could be used to cover prenatal care costs for any pregnant woman under the age of 19. Additionally, original SCHIP legislation allowed individual states to use SCHIP money to pay for prenatal care for women older than 18 by applying for a federal waiver[31]. To date, only New Jersey and Rhode Island have received federal waivers enabling them to cover older pregnant women under SCHIP[28]. By alleviating the burden of applying for a federal waiver to use SCHIP funds for prenatal care, the remaining 48 states could increase prenatal care coverage for older, low-income pregnant women who are not Medicaid eligible.

This option is nearly identical to the proposal the Bush Administration pushed forward in October 2002. The end result is the same: states use existing SCHIP funds to pay for prenatal care services. The differences are subtle, but important. With the Bush Administration's proposal, the fetus is eligible for the health insurance coverage, and the word child has been redefined. With the alternative just discussed, the woman is eligible for health insurance through SCHIP and no redefinition of child is necessary.

Potential advantages of the Bush plan

Knowing the viable policy options available to increase prenatal care, we can now examine potential advantages and disadvantages of the Bush Administration's proposal to redefine 'child' versus the other options. The first and most obvious advantage is that the proposal would allow low-income Medicaid ineligible women the ability to receive publicly funded prenatal care through the SCHIP program. As stated previously, SCHIP has a 10-year funding of $40 billion, with available funding not being completely used[22]. Tapping into the SCHIP funding gives states a new pool of available money for prenatal care funding. In the September 2002 Health and Human Services press release, Secretary Thompson states that the proposal "represents a speedy new option for states that want to do more to ensure that women get critical prenatal care"[21].

The final regulation, published in October 2002, clarified an additional key advantage for this proposal[23]. Given the new definition of "child", in certain circumstances, fetuses would be eligible for funding even if the mother wasn't.

This rule extends eligibility to fetuses without regard to the immigration status of the mothers[23]. Thus, fetuses of immigrants who have been in the United States for over five years would be eligible for coverage.

Given the possibility of increased coverage, this proposal could potentially increase prenatal care services significantly. There is no data currently available to quantify this potential increase, but some numbers have been proposed. In a statement prepared for the March of Dimes, Ken Thorpe speculated that some 41,000 uninsured pregnant women over the age of 19 could be covered[20]. The Bush Administration predicted that 13 states would choose to cover "unborn children" and that 30,000 fetuses would gain coverage as a result[32].

Potential Disadvantages of the Bush plan

Despite the advantages discussed above, there are numerous disadvantages to this plan. This first disadvantage of this plan is that it only discusses the funding of prenatal care. Lack of money or health insurance is not the only barrier to obtaining prenatal care[33]. A MMWR Weekly Report published in May 2000 reported the 1997 Pregnancy Risk Assessment Monitoring System (PRAMS) data[33]. Reasons for delayed or no prenatal care varied by age, ethnicity and method of payment of prenatal care services. The most common reason for not receiving early prenatal care was "I didn't know I was pregnant" (37% - 47%). The second most common reason cited was "I didn't have enough money or insurance to pay for my visits" (36% - 41%). Among women who use government programs and assistance to pay for their prenatal care, 33% stated

that lack of money was their reason for late prenatal care despite having federally funded care. The third most common reason for not receiving early prenatal care was inability to get an appointment (27% - 36%)[33].

Another recent study, published in *Obstetrics and Gynecology* in 2000, supports the argument that lack of insurance may not be the only barrier to timely prenatal care for low-income women[29]. This study looked at women covered by continuous prenatal insurance coverage, either private insurance or California Medicaid, and their use of prenatal care services. The results of the study suggest an important role for other barriers to care in addition to insurance study. The study found that low-income women with unwanted or unplanned pregnancies, no regular provider before pregnancy, and less than a high school education were significantly less likely to have timely prenatal care than other low-income women with similar insurance coverage. The Bush Administration's proposal deals only with the insurance status of low-income pregnant women and does not address the important pre-pregnancy factors that are equally important in providing good, accessible prenatal care.

A second disadvantage to this plan is that it does not address the administrative problems or social stigma associated with government provided assistance. The fact that many people eligible for social programs do not participate in them suggests that income eligibility is not the only barrier to care. Administrative problems and social stigma are known to play a role in why eligible women do not receive publicly funded services. Pregnant women who are not automatically eligible for Medicaid due to participation in welfare must go

through a separate application process. They are required to show birth certificates, rent receipts, utility bills and pay stubs. Limits on the time an applicant has to provide these documents and attend interviews. Blank and Ruggles found that women with short expected welfare stays (i.e. – nine months of pregnancy) are the least likely to enroll, presumably because the expected benefits of enrollment do not outweigh the costs of applying[30]. Additionally, they report that only two-thirds of those eligible for AFDC and Food Stamps participate[30]. Adding another level of benefit, through the SCHIP program, is not going to be beneficial unless pregnant women are aware of their eligibility, application processes are simplified, and social stigmas are dismantled.

Although the Bush Administration did improve the initial proposal (February 2002) by including coverage for legal immigrants who have been in the United States for more than 5 years in the final proposal (October 2002), this plan still does not address the issue of illegal immigrants and recently (less than 5 years) relocated legal immigrants[23]. Ida Dawson, a Physician Assistant at the Wake County Prenatal Care Clinic was able to provide informational statistics regarding the patient population of their clinic[34]. In the past 5 years, the percentage of Hispanic patients has increased from 30% to over 65%. The majority of these patients are non-English speaking immigrants who are either recently relocated to this country or illegal immigrants. These patients typically do not pay for their prenatal care because the Health Department works on a sliding scale payment scheme and the patients slide to zero. Under the Bush Administration plan, these patients would still not be eligible for prenatal care

coverage and the health department clinic would still not be reimbursed for services provided to these women.

Finally, and potentially most importantly, this proposal has the potential to place the health needs of the mother secondary to the health needs of the fetus. Technically, the fetus is the beneficiary of this plan's health insurance coverage; as such, the fetus is the primary patient. The final regulation clarified that a pregnant woman would not be eligible for health care services that are not directly related to the health of the fetus[23]. This would include broken bones and mental health services. Additionally, the health care services offered as a result of this proposal will not cover preconception or postpartum health coverage, services that have been shown to be vital to the improvement of maternal and infant health[23,35]. A study published in American Family Physician in June 2002 discusses the important role preconception health care takes in improving pregnancy outcomes[36]. Issues ranging from folic acid and general nutrition to genetic risks and chronic illnesses should be discussed with women before they become pregnant in order to maximize good maternal and fetal outcomes. Korenbrot, et al. Published a systematic review of preconception care in Maternal and Child Health Journal in 2002[37]. The review led the authors to conclude that in order to improve pregnancy outcomes, maternal and child health professionals need to promote the concept of readiness for pregnancy. This includes making sure women are healthy and appropriately nourished before they become pregnant.

Controversy Surrounding the Redefinition of the Word "Child"

Since the day of the initial proposal in February 2002, women's rights and Pro-Choice activists are adamantly opposed to this proposal, arguing that the Bush Administration's proposal is rooted in antiabortion politics. Federal waivers are already available to allow states to apply to use SCHIP funds for prenatal care. New Jersey and Delaware have already taken advantage of these waivers and are covering prenatal care expenses using SCHIP funds at the time of the proposal[28]. Given the fact that options were already available for states to use SCHIP funds for prenatal care, women's rights and pro-choice activists are concerned that this proposal is simply laying the groundwork for reversing Roe vs. Wade. Ralph Hale wrote a letter to Secretary Thompson on behalf of the American College of Obstetricians and Gynecologists (ACOG) in which he restated ACOGs commitment to ensuring access to prenatal care early in pregnancy, but called this proposal "the wrong approach to accomplishing this goal"[37].

Pro-Choice groups are arguing that this proposal is simply a way to "give rights to the unborn and consequently undermine abortion rights"[38]. Elizabeth Cavendish, legal director of the National Abortion and Reproductive Rights Action League (NARAL) states that "what the administration is trying to do with this [proposal] is not so much promote comprehensive health care for uninsured people, but to make a political statement about embryonic personhood."[38] She also claims that this effort is "a back door way of promoting their anti-choice agenda". NARAL maintains that if the Bush Administration were truly concerned

about providing increase prenatal care, they could avoid this controversy by issuing waivers to states to cover pregnant women[39].

The Planned Parenthood Federation of America is also adamantly opposed to this regulation, stating that the proposal "elevates the status of the fetus above that of the woman. It does not provide prenatal care to the woman in whose body the fetus resides."[32] Dianne Luby, president of the Planned Parenthood League of Massachusetts says that the program sets a bad precedent by separating the concept of prenatal care by ensuring the fetus under one program but not the mother.[40]

Despite having received more than 8,000 written comments on the rule, mostly dealing the with abortion politics surrounding this proposal, Secretary Thompson maintains, "this, to me, is not an abortion issue. It's strictly a health issue."[41] In a separate interview for the Washington Post, Secretary Thompson said, "There is no abortion issue here as far as I'm concerned."[42]

What can State's and professional groups do?

The stakeholders in this process are numerous, all with their own opinions, agendas and politics. It is important to discuss the stakeholder in this process because while the Bush Administration's proposal has been ratified at the national level, the debate continues at the state level. Individual states must now choose between three options. They can:

1. Do nothing. Individual states can choose to leave their funding for prenatal care exactly as it is and decide not to use SCHIP monies for prenatal care services.
2. States can take advantage of the Bush Administration's proposal and the redefinition of child and cover fetuses under SCHIP, thus using SCHIP funds to pay for prenatal care.
3. States may still choose to apply for a federal waiver and use SCHIP to cover pregnant women, thus using SCHIP funds to pay for prenatal care.

Additionally, there is legislation pending in the United States Senate that would simply add pregnant women to SCHIP, eliminating the need for the waivers and making the new definition of the word child unnecessary. Senators Bingaman, Lugar and others introduced S. 1016, "The Start Healthy, Stay Healthy Act of 2001" which has gained bipartisan support in the senate. Additionally, Senators Bond and Breaux and Representatives Lowey and Hyde introduced S. 724/HR 2610, "The Mothers and Newborns SCHIP Amendments of 2001". These bills would alleviate the need for federal waivers, allowing income-eligible pregnant women coverage for prenatal care services[37].

Professional physician groups. This includes, but is not limited to, the American Medical Association (AMA), American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP). Their interest lies in improving the health outcomes of women and children by providing the best possible care to the

largest population. Their interests are satisfied by policy that will insure improved health outcomes and increased access to health care for women and children. Both professional standards of both ACOG and AAP specify that "a pregnant woman and her fetus should be treated together"[43]. ACOG is opposed to the Bush plan, instead supporting legislation aimed at ensuring uninsured pregnant women access to prenatal care[37]. Specifically, they support S. 1016, "The Start Health, Stay Health Act of 2001" and S 724/HR2610, "The Mothers and Newborns SCHIP Amendments of 2001" discussed previously[37].

Women's rights groups and abortion lobbyists. These groups strive to increase health services and improve health outcomes for women. While they are interested in increasing prenatal care coverage, these groups are concerned with Tommy Thompson's HHS proposal to provide insurance coverage to unborn children. They worry that defining the fetus as a person in federal legislation may lay the grounds for broader change and the eventual overturning of Roe vs. Wade, the Supreme Court ruling legalizing abortion. Like the professional physician groups, they are interested in improved health outcomes for women and children, but their interests won't be served until they are guaranteed a solution that will not threaten their position on abortion and women's rights. There are several politically active groups that have made strong statements regarding this issue.

The National Organization for Women (NOW) is the largest organization of feminist activists in the United States, consisting of 550 chapters in all 50 US states and 500,000 contributing members. It was founded in 1966 with the goal to

take action to bring about equality for all women. NOW has several official priorities, one of them being to champion for abortion rights. Since the 1960's, NOW has been advocating for full reproductive rights for *all* women[44]. NOW activists participate in policy making extensively. They do extensive lobbying work, organize marches and rallies and bring lawsuits.

National Abortion and Reproductive Rights Action League (NARAL), has been a strong political advocate of reproductive freedom and choice for over thirty years. Their mission is to "protect and preserve the right to choose while promoting policies and programs that improve women's health and make abortion less necessary"[45]. They are active in the political system through their backing of pro-choice candidates at all levels of government. They also work to educate the American public about abortion rights. NARAL has recently started a new radio advertisement campaign advocating a woman's right to choose. With regards to the Bush Administration's proposal, NARAL supports the stated goal of providing prenatal care[46]. However, they clarify that "were [the administration] truly concerned about providing increased prenatal care, [they] could accomplish this goal by issuing waivers to states to cover pregnant women"[46]. NARAL strongly supports the idea that states apply for a federal waiver to use SCHIP funds for prenatal care by covering low-income women.

National Right to Life Committee. The National Right to Life Committee (NRLC) opposes abortion. The NRLC applauds HHS's proposal to consider fetuses eligible for CHIP money. In a statement published in Georgia Right to

Life Newsletter, the legislative director for the National Right to Life Committee, Douglas Johnson said, "We applaud this Bush Administration proposal to recognize the existence of an unborn child in order to allow the baby, and the mother as well, to receive adequate prenatal care -- a concept to which only the most extreme pro-abortion ideologues will object"[47]. What is apparent from Johnson's comment is the link that the NRLC places between the Bush Administration's proposal and the right to life. The benefits of prenatal care, healthy infant and child outcomes, are not mentioned in the statement.

American Civil Liberties Union (ACLU). The ACLU is a national non-partisan organization dedicated to protecting the constitution of the United States and the rights afforded to citizens by the constitution. While the ACLU strongly supports federal funding of prenatal care for low-income women, they are adamantly opposed to the Bush Administration's redefinition of the word child[48]. They argue that the regulation is inappropriate because it "unnecessarily and dangerously undermines the foundation of the right to choose abortion; it would come at the expense of needy children; it is unauthorized by the SCHIP statute; and, because in a legal sense it separates the fetus from the woman"[48]. The ACLU supports state use of federal waivers enabling SCHIP to pay for prenatal care and urged support for bipartisan efforts in Congress to expand prenatal care to pregnant women[48,49].

Health Insurance Association of America (HIAA). According to the HIAA website, "HIAA is the voice of America's health insurers, who protect consumers from the financial risks of illness and injury by providing flexible and affordable products and services that embody freedom of choice. HIAA is a member-driven trade association that shapes and influences state and federal public policy through advocacy, research, and the timely accumulation, analysis, and dissemination of critical information to its members"[50]. The insurance companies have proven their ability to affect policy making in Washington, DC. Their lobbying efforts were instrumental in helping to defeat the Clinton Health Plan in 1994. To date, HIAA has not made a policy statement regarding the Bush Administration's proposal.

Women. Women, in general, would seem to be an obvious stakeholder group. However, this is a large group with little cohesiveness. Opinions of women on this issue will be very varied, in part determined by their stance on abortion. Unfortunately, to date, no opinion polls have been done looking at the overall opinion of women in the United State on this proposal.

Conclusions

When it comes to the Bush Administration's proposal to redefine the word 'child' in order to increase prenatal care services in the United States, opinions are varied and strong. The proposal and final ratification have been surrounded by controversy and debate since its first announcement in February 2002.

Speculations regarding the "real motives" behind the proposal have been visible in the headlines of newspapers for the past year. But what really matters is whether or not the changes to the SCHIP program can make a difference in the health of women and children in this country.

Groups arguing in favor of the proposal claim that the proposal is only about prenatal care; that the redefinition of the word 'child' for the purposes of SCHIP has nothing to do with abortion. Given the United States' long-standing debate on abortion rights, they are naive. Giving a fetus the right to health insurance, while maintaining a woman's right to choose is an obvious contradiction.

Groups opposing the proposal have concentrated their arguments, for the most part, around two key issues: abortion and women's rights. They claim that the Bush Administration is laying the groundwork for a reversal of Roe vs. Wade and putting the health needs of women secondary to those of a fetus. Their argument is political, aimed at ensuring the continuing right to abortion in the United States. Their support of the use of federal waivers shows that they are not opposed to using SCHIP funds for prenatal care, they are just opposed to redefining the word child, thereby potentially risking a woman's right to choose, to accomplish the goal.

Supporters of the proposal and people opposed to the proposal have focused their attention on the women's rights and abortion issues surrounding the redefinition of the word "child". While focusing on abortion, both supporters and opponents of the proposal have missed the larger issue; the fact remains that the

evidence supporting the use of prenatal care for improving maternal and child health outcomes is weak. No scientific evidence is available to show that increasing funding for prenatal care will actually 1) get more women to use prenatal care or 2) improve birth outcomes. While sparking a debate over abortion, the Bush Administration's proposal will likely accomplish little to ensure improved maternal and fetal outcomes in the United States.

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