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"***The right to criticize government is also an obligation to know what you're talking about.***"
Lent Upson, First Director of the Citizens Research Council

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What We Learn from Cash Payments to New Mothers in Flint Could Improve Maternal and Infant Health Statewide

In a Nutshell

- Maternal and infant health outcomes in the United States are worse than other developed countries, with especially high racial disparities.
- Economic insecurity is a key driver in poor maternal and infant health.
- A new program, RxKids, seeks to improve the economic stability of households with newborns and to reduce health disparities through poverty reduction.
- The data component of RxKids could be enormously valuable to policymakers seeking to improve maternal and infant health and address the racial inequities that exist.

Maternal and infant health outcomes in the United States and Michigan – particularly mortality rates – are worse than the rest of the developed world, and the racial disparities are particularly striking. While this is a public health problem that has received considerable attention, the most recent data shows things are moving in the wrong direction.

Economic insecurity and structural racism play key roles in these negative health outcomes, but the interconnectedness of these issues and their deep roots in American society make it particularly challenging to stamp out this major public health problem. While many policy instruments are aimed at better maternal and infant health, a growing movement has turned to general poverty reduction as the answer, and Michigan is about to kick off a major experiment to test the impact of this approach.

Racial and Economic Maternal and Infant Health Disparities

Racial disparities in maternal and child health outcomes in the United States have been well-documented for decades. Despite various improvements in medical care, people of color remain at an increased risk for poor maternal and infant health outcomes. Women of color have higher pregnancy-related mortality rates and have higher shares of preterm births and low birthweight births. The rates of pregnancy-related mortality for Black women are over three times higher than the rate for White women (41.1 vs. 13.7 per 100,000 live births). In addition, infants born to Black, American Indian and Alaskan Native, and Native Hawaiian and Other Pacific Islander people die at higher rates than infants born to White women. In Michigan, Black women are 2.8 times more likely to die from pregnancy-related causes than White women.

Many of the issues that lead to maternal and child health problems are tied to a lack of resources and impact people of lower socioeconomic status, particularly related to insurance coverage and access to care. Beyond the immediate maternal and infant health concerns, a host of research shows the health impact of parental income on children's health. For instance, low parental socioeconomic status is associated with poorer brain development in utero, and parental economic insecurity has been tied to children's hyperactivity and anxiety. Further, a recent meta-analysis identified higher rates of food insecurity in households with pregnant women and mothers of children under two years of age, which was largely related to reduced household income and unemployment.

These economic issues affect parents and children of all races, but in the United States, there is a significant income gap between Black families and White families, so the general economic barriers to health broaden the racial disparities in health outcomes. However, economic status does not tell the whole story, as certain racial disparities in maternal and infant health remain even when controlling for underlying social and economic factors, such as education and income.

Maternal and Infant Health Policy

The comparatively poor overall maternal and infant health in the United States and the racial disparities that exist are widely recognized as serious public health problems. Policymakers, the health care industry, academics, and activists have studied the issue and are pursuing a wide range of interventions to improve the situation.

For example, the Biden Administration recently outlined its maternal and infant health agenda, citing the need for improved health care access, particularly through Medicaid; improving clinical practices to ensure all pregnant women are listened to by providers; collecting better data; expanding and diversifying the perinatal workforce; and strengthening economic and social supports. The National Governors Association playbook for tackling maternal and infant health echoes the same approaches.

Direct Cash Payments to New Mothers

Programs that offer cash payments to targeted high-risk populations are one potential policy strategy that focuses on building economic security to improve maternal and child health. Research has demonstrated that providing direct cash assistance can be effective at reducing poverty and leads to improvements in education, health and nutrition, employment, and women's ability to escape abusive relationships and make their own decisions about having children. The United States and other countries have been experimenting more and more with cash transfer programs and a few U.S. cities have implemented various pilot programs that aim to provide money to low-income households with no strings attached, including Ann Arbor. In theory, programs that reduce poverty should have an impact on maternal and infant health given the underlying economic causes of those issues.

Advocates of cash transfer programs point to a growing body of research that show the benefits of providing cash directly to those in need. Unlike other traditional government support services, including shelters and voucher programs, cash transfer programs remove the administrative "middle-man" that can increase cost and reduce efficiency. In addition, traditional programs generally come with a level of oversight that limits how the beneficiary is able to use and spend their resources. Advocates point to the benefits of a "rights-based approach" that empowers the recipient by prioritizing the beneficiaries' actual preferences and needs over those of a government agency.

Cash transfer programs also come with certain drawbacks and deficiencies. Critics of these types of programs argue that providing cash payments may disincentivize individuals from becoming or staying employed, but studies on cash assistance have found little evidence of this consequence. In addition, many studies based on pilot programs that involve cash assistance focus on specific populations in crisis, and less research is available on the effectiveness of cash transfer programs for more general poverty reduction and subsequent health improvement.

A more substantial drawback of cash transfer programs is that they do not address the structural and institutional deficiencies that contribute to poverty, and they have not been shown to have long-term effectiveness. In addition to the direct benefit of the money itself, cash payments may lead to changes in health behavior that could provide additional social and health benefits. However, an individual's decision-making and spending behavior is largely dependent on factors outside of his/her control. While these programs aim to trust and empower people to use and spend their money as needed, there are other structural factors that may limit the effectiveness and use of these payments. In other words, we do not yet know if cash transfer payments alone can compensate for the institutional deficiencies that contribute to and perpetuate poverty.

The RxKids Program

Michigan is joining the experiment by funding a portion of a new program that plans to provide cash payments to new and expectant mothers in Flint. The stated goal of the RxKids program is "to improve the economic stability of households with very young children," but the initiative is clearly aimed at reducing health disparities through poverty reduction. The program, RxKids, will provide unconditional cash payments of up to $7,500 to all pregnant mothers in Flint, regardless of their income. Mothers will receive $1,500 during the middle of their pregnancy and then $500 per month for the first 12 months of their child's life.

The program is unique in that it targets a population that is generally economically disadvantaged, racially diverse, and also dealing with the aftermath of acute crises. Families in Flint are at higher risk for poor maternal and infant health outcomes, as the city is 57 percent black and nearly 54 percent of young Flint children live below the federal poverty line. While Flint was selected because of the higher risk factors, the program itself is universal and it does not specifically limit the assistance to low-income residents. New mothers in Flint are a population that would likely see significant benefits from a cash transfer program in many ways, but the observed outcomes in the program might not be generalizable to other populations.

The Need for Data

A valuable component of RxKids is that the program, which is led by doctors from the Michigan State University Pediatric Public Health Initiative, will involve data collection to measure whether and how the money impacts health and social outcomes. While RxKids is just a single program in one jurisdiction, high quality data collection could provide insight into two key policy questions that could shape maternal and infant health policy in Michigan and around the country going forward.

The first question is whether direct cash payments are effective at reducing the negative maternal and infant health outcomes. There is underlying research and theory that supports the idea that $7,500 would reduce poverty and that a reduction in poverty would reduce maternal and infant health issues, but having a concrete, targeted pilot program will provide an opportunity to zero in on the magnitude of the impact. If the program is effective at improving maternal and infant health in Flint, expanding the program elsewhere in some fashion is likely to make sense.

The second question is assessing what barriers to maternal and infant health are not easily solvable with direct financial assistance. There are many economic and non-economic reasons for poor maternal and infant health and the associated racial disparities. Getting a chance to collect data on how Flint mothers used the money to help their families will allow researchers to directly assess where other policy interventions are necessary.

An effective research design that evaluates this program should therefore focus on two key metrics: 1) tangible health and social outcomes, and 2) behavior change. First, we need quantitative data that shows whether the cash payments improved health outcomes on specific metrics related to maternal and child health. In addition, we need a range of qualitative data that will assess the behavioral changes, or lack of, that accompanied any potential differences in outcomes. Even if the cash payments are directly associated with improved outcomes, researchers need to identify the mechanism and behavior changes, if any, that contributed to those outcomes.

Understanding how individuals prioritize their financial resources to best suit the needs of their families is valuable information for long-term programs. The extra money may be used directly on health care services, or it may be used to meet other needs that indirectly improve a mother and her child's health and quality of life. For example, additional resources to meet the costs of child-care, rent, or groceries can all help to improve health outcomes. Understanding how the money is used and the detailed mechanisms that contribute to any potential health benefit will help policymakers develop other targeted public health programs.

While extra cash has the potential to benefit families in a lot of ways, some barriers to accessing care may remain unchanged by additional financial resources. For example, poor public transportation, limited time and energy, and previous negative experiences with doctors may continue to prevent individuals from seeking care for themselves or their children. In addition, community and environmental factors beyond an individual's con-

trol, such as crime and pollution, contribute to poor health outcomes and cannot be addressed with individual cash payments alone. The data obtained from the RxKids program could potentially sift through these different causal factors and provide policymakers with a roadmap for policy change.

The legislature included a $16.5 million appropriation in the Fiscal Year 2024 budget to help fund the program and should have a significant interest in getting high quality data. The boilerplate language accompanying the appropriation does not require the kind of data collection discussed above and there is no legislative reporting requirement, so it will be important for policymakers in Lansing to stay engaged with the project and make sure that the researchers are collecting data that will be informative for the policy discussions to come.

Conclusion

The United States' relatively poor maternal and infant health is a serious public health problem. There is wide ranging interest in resolving the problem itself, and the associated racial disparities, but the complexity of the problem and its interconnectedness to economic inequality and structural racism make it very challenging to address.

Growing interest in tackling maternal and infant health problems through poverty reduction has led to the creation of the RxKids program and Michigan's financial commitment to the program. While the direct cash payments themselves are likely to improve the lives of Flint families, the program's legacy may very well be the data that comes from RxKids. Zeroing in on how much maternal and infant health could be improved with direct cash payments and how families in Flint used the money could provide a roadmap for policymakers looking to help Michigan and the United States bring its maternal and infant health outcomes in line with the rest of the developed world.

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Karley Abramson joined the Research Council in 2022 as a Research Associate focusing on health policy. Previously, Karley was a nonpartisan Research Analyst at the Michigan Legislative Service Bureau where she specialized in the policy areas of public health, human services, education, civil rights, and family law. Karley has worked as a research fellow for various state and national organizations, including the National Institutes of Health and the ACLU of Michigan. She is a three-time Wolverine with a bachelor's degree in sociology, a master's of public health, and a juris doctor from the University of Michigan.

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