The Manitoba Healthy Baby Prenatal Benefit Program

Who is Participating?

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ABSTRACT

Background: Programs offering income supplements for lower-income pregnant women have been introduced in order to reduce the incidence of poor perinatal outcomes. This study used a population-based approach to examine the characteristics of mothers who received the Healthy Baby Prenatal Benefit in Manitoba.

Methods: All women giving birth between August 2001 and April 2003 (n=22,643) were studied using de-identified linked administrative data. Multivariate logistic regression was used to determine factors that predicted receipt of the benefit, adjusting for potential confounding effects. Separate regressions were run for all mothers, and for a group of mothers eligible to receive the benefit (N=1962).

Results: Almost 29% of mothers giving birth during the study period received the prenatal benefit. Mothers were more likely to receive the benefit if they: lived outside of Winnipeg; received income assistance during pregnancy; were younger at their first birth; were unmarried; made prenatal physician visits; experienced maternal depression; were having a first birth; and lived in the lowest income areas. Despite all being eligible, only 67% of non-Winnipeg and 80% of Winnipeg women receiving income assistance received the benefit. Factors related to benefit receipt for those eligible were: living in Winnipeg; making prenatal visits; not being a young teen at current birth; and experiencing a first birth.

Conclusion: It is important to look not only at the characteristics of benefit recipients but also at those not receiving the benefit, in order to develop strategies to reach those who may most need and benefit from the program.

MeSH terms: Maternal age; prenatal care; low-income population; social welfare

La traduction du résumé se trouve à la fin de l'article.

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In July 2001, Healthy Child Manitoba introduced the two-part Healthy Baby program: the Prenatal Benefit and Healthy Baby Community Support Program.¹ The prenatal benefit, the focus of the present study, “provides pregnant women with financial support to eat well during pregnancy and help ensure their babies get a healthy start in life” (p. 10). Pregnant women and teens with a net yearly family income of less than \$32,000 are eligible for a monthly financial cash benefit commencing in the second trimester of pregnancy. Benefit amounts are provided on a sliding scale with a maximum of \$81.41 monthly.

The increased incidence of poor perinatal outcomes in lower socio-economic situations has been well documented.^{2,3} Moreover, infants with poor birth outcomes such as low birthweight or preterm birth are at risk of a number of developmental, cognitive, and health problems.³ For these reasons, various prenatal programs, such as Healthy Baby, have been developed in order to prevent negative birth outcomes. Nutrition intervention programs and programs offering income supplements have both had a positive effect on birth outcomes.⁴⁻⁶

However, many public programs have less than 100% uptake rates. In the United States, food stamps (a program providing low-income families with coupons that can be exchanged for food), Medicaid (health insurance for eligible low-income children and adults), and Aid to Families With Dependent Children (a federal program that provides funds to states to implement their own welfare programs – now called Temporary Assistance for Needy Families, or TANF) all have uptake rates ranging from about 50 to 70%.⁷

Program data for Healthy Baby are collected on benefit recipients, and although these data may be useful for describing the characteristics of program participants, without comparable data on those who do not “take-up” the program, it is impossible to evaluate how well the program is reaching the target population. This study used a population-based approach, linking program data on benefit recipients to administrative health, social assistance and population registry data in order to provide a more complete description of program uptake.

Knowing the characteristics of the mothers who receive the prenatal benefit

in Manitoba, or who are eligible but not receiving it, is essential information for policy-makers intent on ensuring that the benefit gets to all women who need it. This study examined the characteristics of all women giving birth and of those receiving the Healthy Baby Prenatal Benefit. We also examined the characteristics that predicted prenatal benefit uptake among a group of eligible vulnerable mothers.

METHODS

Research was undertaken using a population-based data repository which contains linkable de-identified administrative data files on Manitoba residents including: demographics (age, sex, region of residence), hospital discharge abstracts, physician billing claims, and social service records, all linked to the records of Healthy Baby Prenatal Benefit recipients. Details about the data repository can be found elsewhere.⁸⁻¹²

The population under study was all Manitoba women giving birth between August 2001 and April 2003 (n=22,643). Although the program started in July 2001, the percentage of all mothers receiving the benefit in this month was substantially smaller than in future months, so August 2001 was chosen as the start date for this study. The end date was selected based on data availability.

Several characteristics of mothers potentially related to uptake of the benefit were examined. Area of residence was broken down into Winnipeg (urban) or non-Winnipeg (primarily rural). Women were defined as receiving income assistance if they were present in an income assistance case for at least 6 months during pregnancy. Age of mother both at current birth and at birth of first child was recorded. Whether or not this birth was a first birth was also considered. Marital status of mother was taken from the population registry; women living common-law who have not reported their union to Manitoba Health appear as single in the registry, so the percent of married women is likely underestimated in this study. The number of prenatal physician visits made during the nine months prior to the birth were counted and the month during pregnancy of the first prenatal visit was recorded. Maternal depression was defined as a physician or

TABLE 1

Characteristics for All Mothers, Mothers on Income Assistance, and Mothers Receiving Healthy Baby Prenatal Benefit

		All Mothers (%)	Mothers on Income Assistance (%)	Healthy Baby Prenatal Benefit Recipients (%)
Area of Manitoba	Winnipeg	52.4	72.88	48.51
	Non-Winnipeg	47.6	27.12	51.49
Income Assistance Status	IA	8.66		23.01
	No IA	91.34		76.99
Age of Mother at First Birth	Missing	0.37	0.41	0.32
	0-15	2.46	8.41	4.58
	16-17	9.79	29.26	17.86
	18-19	13.75	30.73	24.68
	20-24	28.6	24.82	34.59
	25-29	26.14	4.08	12.16
	30+	18.9	2.29	5.79
Age of Mother at Current Birth	0-15	0.53	1.27	0.69
	16-17	2.76	4.84	4.03
	18-19	5.83	12.18	12.13
	20-24	22.66	41.44	36.89
	25-29	29.65	22.63	25.23
	30+	38.57	17.64	21.02
Marital Status	Missing	1.88	3.11	2.48
	Married	47.55	7.7	25.2
	Not married	50.57	89.19	72.31
Number of Prenatal Visits	None	5.21	9.07	5.79
	1-4	17.97	29.41	23.61
	5+	76.83	61.52	70.6
Month of Pregnancy of First Prenatal Visit	None	5.21	9.07	5.79
	1-3	70.1	54.64	64.36
	4-6	19.94	29.51	23.8
	7-9	4.75	6.78	4.75
Maternal Depression	Yes	3.14	6.63	4.32
	No	96.86	93.37	95.68
First Birth	Yes	40.64	19.47	39.11
	No	59.36	80.53	60.89
Area Level Income Quintile	Missing	0.12	suppressed*	0.11
	Q1	26.65	59.48	46.44
	Q2	20.65	19.52	21.31
	Q3	19.07	11.88	15.67
	Q4	17.98	5.86	11.32
	Q5	15.53	suppressed*	5.15

* cells containing five or fewer persons are suppressed

hospital diagnosis of depression in the eight months preceding the birth or the four months afterwards. Area-level income was based on household income information from the 2001 Census and assigned according to postal codes. Manitoba postal codes were categorized into five income quintiles such that 20% of the population occurred in each category.¹³ This area-level income measure provides a good approximation of individual-level household income.¹⁴ Levels of these various maternal characteristics are given in Table 1.

To determine which characteristics predicted uptake of the benefit among a group of mothers all eligible to receive the benefit, we looked at mothers receiving income assistance for six months in the nine-month period prior to the child's birth (N=1962).

Statistical analysis

The proportion of mothers receiving the benefit was calculated for each comparison

group. Multivariate logistic regression was used to determine factors that predicted receipt of the benefit during pregnancy, simultaneously adjusting for potential confounding effects of the characteristics of pregnant mothers. Separate regressions were run for all mothers, and for those mothers receiving income assistance. As there seemed to be no trend for mothers with missing values on the different characteristics, and the percentage with missing values was small, they were excluded from analyses.

The study was approved by the Health Research Ethics Board, University of Manitoba, the Manitoba Health Information Privacy Committee, and Manitoba Family Services and Housing.

RESULTS

Compared with all mothers, mothers receiving the Healthy Baby Prenatal Benefit were more likely to be from outside of Winnipeg, on income assistance, younger

TABLE II
Characteristics of Mothers Who Received the Healthy Baby Prenatal Benefit

		Received Benefit (%)	Odds Ratio (95% Confidence Interval)*	p-value
Area of Manitoba	Winnipeg	26.69	0.59 (0.46-0.75)†	<0.0001
	Not Winnipeg	31.18	1.00 (-)	
Income Assistance Status	IA	76.55	2.59 (2.12-3.16)†	<0.0001
	No IA	24.30	1.00 (-)	
Age of Mother at First Birth	0-15	53.78	5.65 (4.26-7.49)	<0.0001
	16-17	52.59	5.37 (4.37-6.60)	<0.0001
	18-19	51.75	4.84 (4.02-5.84)	<0.0001
	20-24	34.87	3.65 (3.11-4.28)	<0.0001
	25-29	13.42	1.61 (1.38-1.88)	<0.0001
	30+	8.83	1.00 (-)	
Age of Mother at Current Birth	0-15	37.82	0.25 (0.12-0.53)	0.0003
	16-17	42.01	0.51 (0.39-0.68)	<0.0001
	18-19	60.00	1.27 (1.06-1.54)	<0.012
	20-24	46.93	1.20 (1.06-1.35)	0.004
	25-29	24.53	0.97 (0.88-1.08)	0.633
	30+	15.71	1.00 (-)	
Marital Status	Not married	41.22	1.96 (1.81-2.11)	<0.0001
	Married	15.28	1.00 (-)	
Number of Prenatal Visits	1+	28.65	1.44 (1.24-1.68)	<0.0001
	None	32.06	1.00 (-)	
Maternal Depression	Yes	39.66	1.50 (1.24-1.81)	<0.0001
	No	28.47	1.00 (-)	
First Birth	Yes	27.75	1.44 (1.31-1.58)	<0.0001
	No	29.56	1.00 (-)	
Area Level Income Quintile	Q1	50.23	3.74 (3.15-4.44)	<0.0001
	Q2	29.75	2.04 (1.70-2.45)	<0.0001
	Q3	23.69	2.09 (1.74-2.51)	<0.0001
	Q4	18.15	1.83 (1.52-2.20)	<0.0001
	Q5	9.56	1.00 (-)	

* Also included in model is the interaction between area and income assistance and between area and area-level income quintile

† See Table III on the interaction between area and income assistance

TABLE III
Interaction Between Area and Income Assistance

Area Level Income Quintile	Odds Ratio (95% Confidence Interval)	
	Winnipeg	Non-Winnipeg
Income Assistance	3.35 (2.51-4.46)	2.59 (2.12-3.16)
No Income Assistance	0.59 (0.46-0.75)	1.00 (-)

TABLE IV
Characteristics of Mothers on Income Assistance Who Received the Healthy Baby Prenatal Benefit

		Received Benefit (%)	Odds Ratio (95% Confidence Interval)	p-value
Area of Manitoba	Winnipeg	80.35	2.07 (1.64-2.61)	<0.001
	Not Winnipeg	66.35	1.00 (-)	
Age of Mother at First Birth	0-15	74.55	1.42 (0.54-3.76)	0.480
	16-17	73.87	1.16 (0.48-2.84)	0.740
	18-19	77.28	1.26 (0.52-3.01)	0.611
	20-24	77.62	1.20 (0.51-2.84)	0.672
	25-29	87.50	2.14 (0.75-6.15)	0.158
	30+	82.22	1.00 (-)	
Age of Mother at Current Birth	0-15	60.00	0.13 (0.03-0.56)	0.006
	16-17	69.47	0.36 (0.17-0.76)	0.008
	18-19	81.17	0.94 (0.57-1.56)	0.822
	20-24	76.75	0.90 (0.63-1.27)	0.534
	25-29	73.87	0.72 (0.50-1.03)	0.070
	30+	79.48	1.00 (-)	
Marital Status	Not married	76.51	0.92 (0.60-1.42)	0.718
	Married	78.81	1.00 (-)	
Number of Prenatal Visits	1+	78.20	2.46 (1.76-3.45)	<0.001
	None	60.11	1.00 (-)	
Maternal Depression	Yes	81.54	1.31 (0.81-2.12)	0.264
	No	76.20	1.00 (-)	
First Birth	Yes	81.41	1.71 (1.14-2.58)	0.010
	No	75.38	1.00 (-)	

at their first and current birth, and unmarried. They also had fewer prenatal visits, had their first prenatal visit later, were slightly more likely to have experienced maternal depression, and were more likely to be in a lower income quintile (Table I).

Table II describes the percentage of mothers who received the benefit by each of the variables, and displays the results of the multivariate logistic regression. Almost 29% of all mothers giving birth during the study period received the benefit during pregnancy (n=6527). Regression analysis of all mothers giving birth confirmed that mothers with the following characteristics were more likely to receive the benefit: living outside of Winnipeg; receiving income assistance during pregnancy; younger at first birth; 18-24 years at current birth; unmarried; making prenatal physician visits; experiencing maternal depression; having a first birth; and living in lower-income areas. An interaction between income assistance receipt and area of residence suggested that the effect of living in Winnipeg was significantly different depending on whether the mother received income assistance: those receiving income assistance were more likely to receive the benefit whereas those not receiving income assistance were less likely to receive the benefit if they lived in Winnipeg (Table III).

Table IV provides the percentage of mothers receiving income assistance who also received the benefit, and the results of the regression analysis for this group. Despite all being eligible, only 66% of non-Winnipeg and 80% of Winnipeg women receiving income assistance also received the prenatal benefit. In contrast to the results for all mothers, mothers' age at first birth and marital status were not related to whether those eligible for the benefit received it. Mothers receiving income assistance who were young teens (less than 18 years) at current birth were *less* likely to receive the benefit, similar to results found for all mothers. Factors related to benefit receipt for those eligible to receive it were: living in Winnipeg, making prenatal visits, and experiencing a first birth.

DISCUSSION

Over one quarter of all mothers giving birth in Manitoba in our study period received the Health Baby Prenatal Benefit.

In comparison with three public programs in the US (food stamps, Medicaid, and Aid to Families with Dependent Children), the Healthy Baby benefit appears to be reaching a high percentage of at least one eligible group. Almost 67% of non-Winnipeg and 80% of Winnipeg women receiving income assistance also received the prenatal benefit, compared with the uptake rates of 50 to 70% in the US programs.⁷

Mothers who received the Healthy Baby Prenatal Benefit were more likely to be younger compared to the general population of mothers. Whereas 9% of all women giving birth in this study were teens at the time of the birth, 17% of the women receiving the prenatal benefit were teenagers at the current birth. Likewise, women receiving the prenatal benefit were far more likely to be unmarried than women not receiving the benefit, and to be living in the lowest-income neighbourhoods. It would appear, then, that the prenatal benefit was more likely to reach women at risk of poor perinatal outcomes. However, our analysis of a group of mothers all eligible for the benefit suggests there may be groups of particularly vulnerable women whom the benefit is not reaching. Women eligible for the prenatal benefit but not receiving it were more likely to be young teens (less than 18 years), live outside of Winnipeg, have given birth previously, and have had no prenatal visits. Factors that may also affect uptake which we were unable to assess due to data limitations include level of social support, ethnicity and alcohol/drug dependence.

According to previous research on program uptake, there are several potential reasons why women eligible for the benefit program may not participate.⁷ Clearly, those who do not hear about the program will not apply for it,¹⁵ and one of the ways that women hear about the Healthy Baby Prenatal Benefit is through their doctor. Younger women seek prenatal care later in pregnancy and attend fewer visits when they do seek care.¹⁶⁻¹⁸ Similarly, residence in a rural area is associated with late initiation of prenatal care,¹⁹ as is higher number of previously born children.²⁰ It is therefore possible that women who are younger, live in rural areas, and who already have children are less likely to be informed of the program.

Likewise, if applying for a benefit is seen as inconvenient, then uptake may be

affected.⁷ For the Healthy Baby benefit, the mother must fill out a three-page form, submitting either her income tax records from the previous year or her income assistance case number, as well as a note from her doctor verifying the pregnancy and due date. This process may present enough of an inconvenience to deter some women from applying for the benefit. Making enrolment in the prenatal benefit program automatic for women on income assistance may be one way of increasing uptake in this population.⁷

Benefit size can also affect participation, with larger benefits associated with higher uptake.^{7,21,22} The relatively small size of the Healthy Baby benefit may lead to lower uptake, particularly in families close to the cut-off, as the benefit level decreases to \$10 per month for these families. Families likely apply for the benefit when the benefits of applying outweigh the costs – including non-financial costs such as inconvenience and income verification procedures.^{7,23} The application process for Healthy Baby is relatively low-cost, with no in-person interview required and a relatively simple income verification procedure. However, if the process of filling out the application is not seen to be worth the size of the benefit, the combination of inconvenience and benefit size would lead to lower uptake of the program.

In sum, when assessing program participation, it is important to look not only at the characteristics of benefit recipients, but also at who is not receiving the benefit. In this study, eligible mothers who were young teens, living in rural areas, having a subsequent birth, or not making prenatal visits were less likely to participate. Infants of women making no prenatal visits exhibit more negative birth outcomes,²⁴ and children of younger mothers experience more developmental, cognitive, and health problems later in life.²⁵⁻²⁷ These poorer outcomes indicate that the groups least likely to receive the benefit when eligible may be in highest need of the program. With information on these most vulnerable groups, policy-makers can better develop strategies to reach those who may most need and benefit from the program.

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RÉSUMÉ

Contexte : De nouveaux programmes offrent des suppléments de revenu aux femmes enceintes à faible revenu afin de réduire la fréquence des problèmes périnataux. Dans le cadre d'une étude représentative, nous avons examiné les caractéristiques des mères bénéficiaires des allocations prénatales du programme Bébés en santé du Manitoba.

Méthode : Nous avons étudié toutes les femmes ayant accouché entre août 2001 et avril 2003 (N=22 643) à l'aide de données administratives liées, mais non identifiées. Par régression logistique multivariée, nous avons déterminé les facteurs prédisant le fait de toucher des allocations, en tenant compte des variables confusionnelles possibles. Des analyses de régression distinctes ont été exécutées pour toutes les mères et pour un groupe de mères admissibles aux allocations (N=1 962).

Résultats : Près de 29 % des mères ayant accouché pendant la période de l'étude ont touché des allocations prénatales. Elles étaient plus susceptibles d'avoir touché ces allocations si elles : vivaient à l'extérieur de Winnipeg; avaient reçu une aide au revenu pendant leur grossesse; étaient relativement jeunes lors de leur premier accouchement; n'étaient pas mariées; avaient fait des visites prénatales chez le médecin; souffraient de dépression du post-partum; accouchaient pour la première fois; et vivaient dans une région à faible revenu. Bien qu'elles soient toutes admissibles aux allocations, seulement 80 % des femmes vivant à Winnipeg et 67 % des femmes vivant ailleurs au Manitoba qui bénéficiaient d'une aide au revenu touchaient aussi les allocations prénatales. Les facteurs liés à la perception d'allocations chez les femmes admissibles étaient les suivants : vivre à Winnipeg; avoir fait des visites prénatales; ne pas avoir été adolescentes lors de l'accouchement actuel; et en être à leur premier accouchement.

Conclusion : Il est important d'examiner non seulement les caractéristiques des bénéficiaires, mais aussi celles des mères qui ne touchaient pas d'allocations pour pouvoir élaborer des stratégies susceptibles d'atteindre les mères qui pourraient avoir le plus besoin du programme et en tirer le meilleur parti.

Place Matters

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