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Prenatal Care Indices: How Useful?

Drs. Alexander and Kotelchuck have done a valuable service by exposing the comparative warts of the various indices that have been developed to help judge the adequacy of prenatal care use. That said, I would like to challenge the usefulness of even the best of the indices in helping us reach our health care goals for the year 2000 or thereafter.

The most important sentence in their paper comes midway in the discussion: "Moreover, none of these indices incorporates indicators of the content of prenatal care." As an obstetric practitioner for over 30 years and a state maternal and child health policy developer for 15 years, I have found the various indices measuring the adequacy of prenatal care use to be of very limited help.

The crucial information one needs to know is the trimester of entry into prenatal care and the results of the pregnancy: fetal, neonatal, and postneonatal death, and birth weight, all available from vital statistics. Faced with bad results in the above measures from a particular county, experts need to identify barriers to access and content of care in order to develop a plan of corrective action. No such plan can be developed from state or national vital data alone, though some have tried and failed.

Barriers to early entry into prenatal care (lack of insurance, providers, child care, or transportation) are usually easily identified at the local level but not always so easily solved. Quality of prenatal care needs to be judged at the local level. Outcomes of life or death or handicap are the ultimate measures of quality care, and we are improving our ability to evaluate the particular aspects of prenatal care that get the best results.

Many of these (WIC referral, nutrition counseling, social work services, risk screening, home visiting, health education, violence intervention, childbirth classes, and help with stress reduction and smoking, alcohol, and drug cessation) have been labeled "enhanced services." They may well be the basic services. The rest of the usual prenatal visit (fundal height measurement and fetal heart tone count) may represent the enhanced, or maybe even unnecessary, services.

The Alexander/Kotelchuck article outlines the many traps of counting prenatal visits accurately enough to be meaningful. In addition to the caveats they have listed, changes in prenatal care are only going to make the use of indices based on numbers of visits worse. Healthy working women at lowest risk often campaign for fewer office visits and more telephone contact with the provider. Many high risk patients get frequent home visits or lengthy telephone consultations with a nurse-specialist that are not formally counted as prenatal visits. My point is that I do not think counting the number of prenatal visits gives any meaningful help to researchers or policy makers.

In fact, it could be dangerous. The otherwise excellent 1988 Institute of Medicine report, *Prenatal Care*, uses indices (in this case Kessner) to describe prenatal care as "adequate" or "inadequate." The fact that the indices attempt to measure the adequacy of prenatal care *use*, and not the care itself, is lost on the average reader. If insurers started using these indices as their primary measure of quality prenatal care, our current trends of improvement in pregnancy outcomes could be reversed. Already the pressure of many payors to force providers to "see more prenatal patients faster" jeopardizes quality.

Insurance does not guarantee access to care, and access to care does not guarantee quality of care. But in the quest for better outcomes in maternal and child health, I will take quality over quantity any time.

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