American Academy of Nursing on Policy

American Academy of Nursing on policy: Reducing preterm births in the United States: Maternal infant health, child, adolescent and family, and women's health expert panels

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Executive Summary

The rising rates of preterm birth (PTB) (less than 37 completed weeks gestation) in the United States is an urgent population/public health issue. Education of the healthcare workforce, policy makers and the public on risk factors for prematurity, and identification of strategies to counter the rising rate of PTB is critical. This policy brief illustrates the problem and sets forth policy recommendations to reduce prematurity rates.

Background

PTB continues to be one of the leading causes of infant mortality and morbidity globally and nationally. Globally in 2015, 15 million PTBs result in about 1 million deaths per year; of these deaths, 75% were preventable (Liu et al., 2016). **The U.S. ranks among the top 10 countries** worldwide for the highest number of PTBs; countries such as India, China, Nigeria, Pakistan, and Indonesia are only a few other countries ranking higher than the United States (Bronstein, Wingate, &

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Brisendine, 2018; March of Dimes, Partnership for Maternal Newborn and Child Health, Save the Children, & World Health Organization [WHO], 2012; WHO, 2017, 2018). In the United States, **infant mortality is also 71% higher than in other developed countries** (Bronstein, Wingate, & Brisendine, 2018; Sawyer & Gonzales, 2017). After a steady decline in U.S. PTB rates in 2007 to 2014 (Martin & Osterman, 2018), **PTB rates have risen again,** for three consecutive years. National 2016 birth statistics that were recently released indicate a new peak in PTB of 9.85% - thus, approximately 400,000 infants in the United States are born preterm.

The rise in PTB rates is associated with the increased number of infants born late preterm (34–36 weeks of gestation) that increased from 6.87% in 2015 to 7.09% in 2016 (Hamilton, Martin, Osterman, Driscoll, & Rossen, 2017) and wider use of assisted reproductive technologies (Hwang et al., 2018). A notable disparity exists in PTBs based on the mother's race and ethnicity, age, and geographical location (zip code):

- In 2016, PTB rates were 13.77% for non-Hispanic black women, 11.39% for women of American Indian or Alaska Native origins; and 9.45% for Hispanic women (any race). All rates are considerably higher than the rate of 9.04% among non-Hispanic white women.
- PTB rates are the highest among young women age 19 and younger and women aged 35 and older. In 2016, the PTB rate among all women aged 40 to 44 years was reported to be 13.97%. The rate of PTB in White, non-Hispanic women, aged 45 to 54 was 20.47%, while in non-Hispanic black women it reached 27.80%.
- In 2015 to 2016, the increased PTB rates were reported in 13 states of the United States–California, Georgia, Idaho, Indiana, Kentucky, Michigan, Minnesota, Mississippi, New York, Oregon, Tennessee, Texas, and Virginia; the states with higher proportions of diverse racial/ethnic groups and variability of health care facilities. No states reported a decline in PTBs (Martin et al., 2018; Martin, Hamilton, Osterman, Driscoll, & Drake, 2018).

Factors Associated with PTB

The factors associated with high PTB rates are multidimensional stemming from a complex interplay of individual-, social- and environmental-level contextual factors (IOM, 2007; Manuck, 2017; Esplin, 2014). Among these factors are: changes in obstetrical practices including increased rates of elective cesarean births, delayed childbearing, greater use of infertility treatments, illicit drug use, tobacco use, maternal mental health, maternal co-morbidities and chronic illnesses like diabetes, obesity, and hypertension. Maternal risks for PTB are strikingly magnified for impoverished, marginalized, and under-represented populations.

Access to quality healthcare plays a significant role as well. The current system of maternity care is not improving infant outcomes at a rate that is critical for American women. The United States is the only high resourced country without paid maternity leave. According to the International Labour Organization data from 180 countries, mean maternity leave duration was 15.4 weeks (SD = 7.7; range 4–52 weeks) and one additional week of maternity leave was associated with a 0.09% lower preterm rate (95% confidence interval −0.51 to −0.04) adjusting for income and being from an African country (Kwegyir-Afful, Adu, Spelten, Rasanen, & Verbeek, 2017).

Other factors impacting PTBs include maternal smoking and use of assisted reproductive technology (ART). Adopting smoke free laws is associated with PTB rate reduction (Faber et al., 2017). A recent study examined birth outcomes in women who used ART from 2004 to 2010 in Massachusetts. Infants were included if they were born at 23 or greater weeks gestation. Findings indicated that women who used ART were more likely to produce a preterm infant when compared with non-ART users (Hwang et al., 2018).

Prematurity-associated Burden on Infants, Families and Society

While overall survival of preterm infants in the United States has increased during last decades, morbidity has not improved at the same rate. Prematurely born neonates are more likely to have increased health-related and neurodevelopmental delays including increased mental health risks for anxiety, depression and even more serious psychosis that can last a lifetime (Blencowe et al., 2013; D'Agata, Young, Cong, Grasso, & McGrath, 2016; Singh, Kenney, Ghandour, Dogan, & Lu, 2013). Quality of life for parents is also negatively impacted because of emotional stress, depression, acute and post-traumatic stress disorder (PTSD), physical fatigue, marital distress, as well as increased medical insurance needs and costs for out-of-pocket expenses (Blencowe et al, 2013; Hodek, von der Schulenburg, & Mittendorf, 2011; Lakshmanan et al, 2017). Readmissions of preterm infants to pediatric hospitals after initial discharge are costly as well and comprise a substantial proportion of all readmissions in children with medical complexities (Hudson, 2013; Kuzniewicz, Parker, Schnake-Mahl, & Escobar, 2013). The total costs to society for supporting the child's long-term quality of life as well as the on-going parental burden are immense.

Responses and Policy Options

Historically, Medicaid has been used to support the health care needs of pregnant women to prevent PTB

and has demonstrated improved birth outcomes in numerous states (Hall & Berlin, 2004). Medicaid currently provides financial support to about 45% of all births (Medicaid.gov, 2018). The results of the Maternal and Child Health Update Survey for 2014 indicate that Medicaid programs have been the primary means for coordination and implementation of care and quality improvement projects for mothers and children (Murphy & Kershner, 2015). Loss or a reduction in Medicaid spending would severely hamper health services organizations delivery of needed care to women and children. Policy initiatives such as proposed by The American Health Care Act (AHCA) which passed in the House in 2017 but ultimately failed, attempted to place per capita caps on Medicaid starting in 2020, which would have significantly reduced Medicaid funding from the federal government in any state that exceeded the "cap" (Adler, Fiedler, & Gronniger, 2017).

The Trump Administration's proposed changes in healthcare – including reduced funding for family planning, prenatal, and interconception care – increases the likelihood that the rate of PRBS will continue to rise in the United States.

The continuation of Medicaid to support maternal child health is critical to stop the PTB rates from rising even further. Loss of perinatal care insurance coverage is another aspect that will impact these rates. Lack of paid maternity leave must be addressed. Steps must be taken to ensure women's health insurance coverage and coverage for neonates and infants.

If the United States introduces the world average paid maternity leave, the policy itself will improve the U.S. PTB rate by 1.4% which would be a significant improvement for the country's infant mortality rate.

The PREEMIE Reauthorization Act of 2018, originally passed in 2006 and up for renewal in 2018, supports tracking of national data by the Center for Disease Control (CDC), advocating for support of Health Resources and Services Administration activities to prevent PTB, and the establishing of a federal umbrella for programs to reduce PTB (PREEMIE Reauthorization Bill S. 3029, 2018; PREEMIE Reauthorization Bill HR. 6085, 2018; Osberg, 2011). Specifically, this Act provides for: (1) improved tracking of U.S. national data; (2) reauthorizes activities aimed at promoting healthy pregnancies and the prevention of preterm birth; (3) extends support of the Secretary's Advisory Committee on Infant Mortality as well as renews the Committee's charge to examine severe maternal morbidity; and (4) gives the Department of Health and Human Services (DHHS) the authority to coordinate all federal activities and programs targeting, for example, preterm birth and infant mortality (March of Dimes, 2018).

State and local grassroot initiatives are working actively with legislative teams in states across the country to attack the problem of prematurity. These efforts are demonstrated by the *Learning Collaborative on Improving Quality and Access to Care in Maternal and Child Health* -a project of the National Conference of State Legislators and serving both Democrats and Republicans to improve the quality and effectiveness of state legislatures (National Conference of State Legislators, 2018) and this project is an exemplar for models of change.

The Academy's Position

The American Academy of Nursing finds the rising prematurity rates in the United States unacceptable and urges the health care providers, policy makers, and the public to focus attention and resources to address this national health issue.

Recommendations

We are in a period of great volatility and risk to current funding initiatives-research and insurance, and advocacy efforts. Targeted campaigns should be a high priority to protect those that are most vulnerable: pregnant women and children. The Academy should partner with organizations across disciplines noted below to implement a broad reaching awareness campaign that will target consumers, law makers, clinicians, and governmental funding agencies such as the Centers for Medicare & Medicaid Services (CMS). Therefore, we recommend the following:

- Healthcare providers, insurers, and all citizens urge the U.S. Congress to reject all efforts to alter any funding structure for Medicaid that would impose per capita caps and work to reverse the impact of the AHCA.
- Healthcare providers, policy makers, and citizens encourage their legislators to support strategies that are represented in the PREEMIE Reauthorization Act of 2018.
- The U.S. Congress makes childrearing women and their newborns a priority funding area and raise necessary dollars to do so through an increased cigarette tax, and the promotion of a smoke free community.
- Health providers and the public health workforce strongly support strategies for improved data curation across local, state and national organizations such as Divisions of Maternal Child Health of the State and Local Health Departments and national data repositories such as Peristats with the March of Dimes.
- Nurses educate the healthcare workforce around the issues of PTB and health disparities by partnering with the Bureau of Maternal Child Health, Public Health Departments and Schools, World Health Organization (WHO), and The United States Agency for International Development (USAID).
- Health insurance companies establish mechanisms to contribute funding to maternal child health services through third party reimbursement and/or contributions to maternal child budgets for

population-based prevention. State and local governments can partner with insurance companies such as Blue Cross Blue Shield to establish funding pools in creative collaboratives.

- Nurses promote healthy lifestyles through the support of smoke-free communities such as the model from the tobacco growing state of Kentucky based on work with the University of Kentucky, College of Nursing.
- Nursing organizations advocate to state and federal legislators to support legislation which mitigates health disparities by addressing issues such as safe and affordable housing, improved transportation, food insecurity, and affordable child care.
- Nursing coalitions and other health professions organizations including the American Academy of Nursing (Academy), Academy of Neonatal Nurses (ANN), the American College of Nurse-Midwives, the American Nurses Association (ANA), the American Association of Colleges of Nursing (AACN), the American Academy of Pediatrics (AAP), American Public Health Association (APHA), Association of Maternal & Child Health Programs, Association of Women's Health, Obstetrics, and Neonatal Nurses (AWHONN), the March of Dimes (MOD), The National Perinatal Association, The American Congress of Obstetricians and Gynecologists (ACOG), American Association of Nurse Practitioners (AANP), and National Association of Neonatal Nurses (NANN) partner to draft a statement calling for comprehensive maternal child healthcare which includes maternity leave.

Dissemination Plan

I. Policy Statement published in the Academy policy pages of *Nursing Outlook*
II. Press Releases (Timeframe to be determined)
    a. Press release drafted by AAN staff
    b. Submitted to news services for release
III. Nursing Organizations (Send Letter & Policy Brief)
    a. American Association of Colleges of Nursing
    b. National League for Nurses
    c. International Council of Nurses
    d. Association of Certified Nurse Midwives
    e. Association of Women's Health, Obstetric, and Neonatal Nurses
    f. American Association of Nurse Practitioners
    g. Nurse Practitioners in Women's Health
    h. National Association of Neonatal Nurses
    i. Academy of Neonatal Nurses
    j. Council of International Neonatal Nurses, Inc.
IV. Federal Government Agencies
    a. Congressional Caucuses (contacts for all Caucus leaders)
        i. Congressional Health Caucus
        ii. Congressional Public Health Caucus
    b. Key Senators on HELP Committee (Health, Education, Labor, and Pensions
    c. Congress via the House's Energy and Commerce Committee.
V. National Health Professional Organizations (non-Nursing)
    a. American Academy of Pediatrics
    b. American Public Health Association
    c. International Paediatric Association
    d. March of Dimes
    e. The American Congress of Obstetricians and Gynecologists
    f. The National Perinatal Association
VI. Consumer Groups
    a. Preemie World
    b. Preemie Parent Alliance
    c. European Foundation for the Care of Newborn Infants
VII. Other Media (posts by Academy staff and Expert Panel Members)
    a. Facebook
    b. Twitter

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