



What We Know About the Prevention of Preterm Birth

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Today 13% of U.S. births occur before 37 weeks gestational age, often leading to a personal and financial tragedy for families.

Most people know that pregnancy lasts nine months, but not everyone knows that pregnancy is most commonly measured in weeks. The normal duration (called "full term") is 280 days or 39 to 41 weeks from the first day of the last normal menstrual period. Something else that many people don't know is that preterm birth, before 37 weeks, is now the leading cause of perinatal and infant mortality in the U.S. The prematurity or preterm birth rate in the U.S. has increased by 35% in 25 years from 9.5% in 1981 to 12.8% in 2006. In 2004 in the U.S., preterm births accounted for 64% of the more than 5,000 infant deaths occurring before one year of age. The public policy implications of preterm birth include alarmingly high health care expenditures over the life course and, from a societal perspective, a significant loss of well-being and workforce productivity.

This policy brief reviews what is known about the contributors to prematurity and its impact as well as recent national recommendations to reduce prematurity.

KEY FINDINGS

- For some segments of the U.S. population and in other countries, the preterm birth rate is consistently much lower than the overall U.S. rate. These differences are poorly understood, but suggest that many preterm births should be preventable. For some high-risk women, access to preventive care is limited by lack of continuous health insurance coverage and other barriers.
- In Ohio, for example, more than 8,000 preterm births per year may be preventable.
- There are multiple opportunities for substantial public and private cost savings associated with a reduction in preterm births.
- Although public education has had a significant impact on U.S. smoking rates, the number of pregnant women smoking during pregnancy remains unacceptably high. In 2007, the percentage of women who smoked during pregnancy was 35%, 27% and 20% in Kentucky, Ohio and the U.S., respectively. Available, evidence-based smoking cessation interventions targeted to pregnant women have a higher success rate than interventions before or after pregnancy. Policies to address smoking cessation have not been widely implemented in health care delivery systems and communities.
- Elective delivery of healthy women prior to term results in increased infant complications and cost to the health care system.
- New therapies and care strategies shown to improve health are adopted into actual practice very slowly, often more than a decade after they were first shown to be effective. In pregnancy, this meant that optimal strategies to use antenatal steroids to reduce the mortality and morbidity of preterm birth were not developed for many years after the benefits of this treatment were known.
- Recent studies showing a 35% reduction in recurrent preterm birth in women treated with supplemental progesterone has not resulted in widespread adoption of this treatment for women with a prior preterm birth. Proven therapies need to be adopted by all care providers more rapidly. Organized strategies to improve care, for example through improvement collaboratives, may speed the adoption of evidence-based practice.
- Public and private systems that pay for care are not aligned with recommended, evidence-based clinical practice. The benefit packages of health insurance programs, including Medicaid, should be aligned with best evidence so that continuous access to care that improves health is available.