

Growth and development in late-preterm infants: what can public policy do?

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In this issue of *Pediatric Research*, Sammallahti and colleagues showed that in late-preterm infants, faster growth in weight and head circumference from birth to 5 months corrected for age is associated with higher IQ and better executive functioning in adulthood, higher GPA at the end of school, and lower odds of receiving special education (1). This result is similar to other studies in more premature infants and highlights the importance of optimal growth in the critical first few months after preterm birth.

It is important to note that late-preterm birth is a relatively common event, representing 6.87% of all births in 2015 (ref. 2). Over 270,000 babies were born between 34 and 36 weeks' gestation in 2015, so ensuring that these children have the best chance for normal neurodevelopment and that they become productive independent adults requires effective and consistent public policy. In particular, it is crucial to provide appropriate nutrition as well as access to professional healthcare supervision in the critical infancy period.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC program) was established in 1974 to safeguard the health of low-income women, infants, and children up to the age of 5 years who are at nutritional risk (3). Although the WIC program has produced multiple benefits for pregnant women and children, it has been particularly important for infants. The WIC program serves 53% of all infants in the United States, over 1.8 million infants per year (3). The program provides breastfeeding promotion and support, and infant formula for infants of women who do not fully breastfeed. WIC program has successfully doubled the breastfeeding rates at 3 months over the last 20 years (21% in 1994/1995; 42% in 2013) (4). The program has been demonstrated to improve growth rates and cognitive development (5). By any measure, WIC program has been an effective public policy for preterm and term infants, and protecting or even expanding it should be a priority for all in the child health community.

There are clear benefits of sustained breastfeeding for infant health, and the American Academy of Pediatrics recommends exclusive breastfeeding for the first 6 months of life (6). Nevertheless, many women find continuing breastfeeding to

be challenging. Returning to work early has been identified as a major barrier to sustain breastfeeding. Ogbuanu *et al.* (7) studied over 6,000 women, and they demonstrated that women who returned to work at or after 13 weeks were 2.5 times more likely to continue breastfeeding beyond 3 months. According to the Bureau of Labor Statistics, only 13% of full-time employees in the United States have access to any paid family leave (8). In a survey conducted for the Department of Labor by Abt Associates, 23% of women return to work <2 weeks after childbirth, and nearly half return to work within 6 weeks (9). Moreover, income and education are strongly correlated with access to paid leave and duration of time off, meaning that those most in need of paid leave are the least likely to get it. There is an increasing discussion of developing a national policy supporting paid family leave (e.g., the FAMILY Act sponsored by Sen. Gillibrand and Rep. DeLauro). A strong paid family leave policy is likely to lead to improved short-term and long-term health and developmental outcomes for both preterm and term infants.

Optimal growth in infancy requires not only nutritional support but also access to high-quality medical supervision and monitoring. Over the last 10 years, impressive progress has been made providing that access by reducing the uninsured rate of children, thanks in large part to public

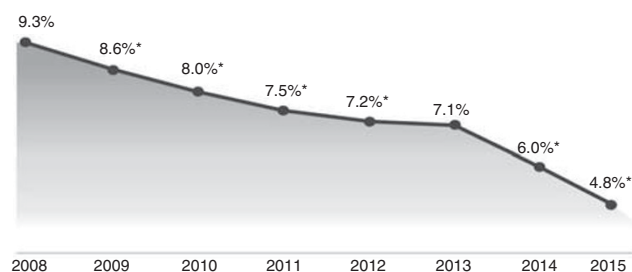


Figure 1. Rate of uninsured children, 2008–2015. Change is significant at the 90% confidence level. Only 2013 was the year that did not show a significant 1-year decline in the national rate of uninsured children. The Census began collecting data for the health insurance series in 2008; therefore, there is no significance available for 2008. From Alker Chester (10).

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policy initiatives. As shown in **Figure 1**, steady consistent yearly reductions in the uninsurance rate have been made since 2008, cutting the rate almost in half (10). However, the ~5% national rate masks substantial state variability; some states have achieved near-universal coverage (Vermont 1.0%, Massachusetts 1.1%), whereas other states have still high rates of uninsurance (Texas 9.5%; Alaska 10.6%) (10). Continuing efforts at the state level remain important.

Nearly 40% of children receive insurance coverage from public programs. Medicaid is by far the largest public program providing medical insurance to children, with 36.8 million children on Medicaid in 2015 (ref. 10). The Children's Health Insurance Program (CHIP) covers an additional 8.4 million children, and 1.1 million children receive their insurance through the healthcare marketplace (10). With the current discussion of refinancing Medicaid using block grants or other mechanisms that cap federal funds, children's insurance coverage is at risk. Additional policy challenges include the necessity for congressional reauthorization of the CHIP program in 2017 and the possibility of repeal of the Affordable Care Act. All of these pillars of progress for providing insurance to children face an uncertain future. If access to medical care and supervision is reduced or restricted, optimal nutritional and developmental outcomes for late preterm infants will be threatened.

Great progress has been made in the care of preterm infants, including effective public policy like WIC, Medicaid, and CHIP. Paid family leave is a public policy initiative that is likely to provide added improvement in preterm infant outcomes. The child healthcare community should be united in advocating for existing and new public programs that

support optimal nutritional and developmental outcomes for both preterm and term infants.

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