Why can't more American women access medications for preterm birth?

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There are two medications that prevent preterm birth, the most common cause of perinatal death in the U.S. One costs 16 cents a week, one US$285. Poor black women aren't getting either. Why?

In 2015, for the first time in eight years, the rate of preterm birth in the U.S. rose, despite increased understanding of preventative measures. By one estimate, preterm births cost us an estimated $26 billion per year.

Additionally, U.S. maternal death rates are the among the worst for economically similar countries, currently double that of Canada and Spain, and almost three times than for women in Japan. In Texas, they doubled in just over two years.

When the rates are examined more closely, they reveal an alarming narrative about differences in health outcomes that are systematic, avoidable and unjust.The increased burden of preterm birth on low-income, urban and black women in America is 48 percent higher that of white women in every state.

As an obstetric provider for women with high-risk pregnancies at Boston Medical Center, the largest safety-net hospital in New England, I witness the tragic outcomes of these health inequities every day. As an investigator tasked with reducing them, I lead teams who have identified several important barriers to access.

Preventing spontaneous preterm birth

One potentially preventable cause of preterm birth is recurrent spontaneous preterm birth. That's when babies deliver early despite attempts to prevent it, to mothers who have a history of early deliveries from the same cause.

Both the Society of Maternal Fetal Medicine and the American College of Ob/Gyn recommend a specific progesterone preparation called 17P. This medication can reduce recurrent preterm birth in women with a history of spontaneous preterm birth.

Currently, it's available only at high cost, between $225 and $385 per week. The cost has profoundly impacted obstetric providers' ability to obtain 17P for all eligible women – and contributes to the increased incidence of spontaneous preterm birth in black women.

Most health insurers who enroll low-income and urban women – those seeking low-cost insurance through connectors – require prior authorization or numerous additional communications. These hurdles can be daunting, especially for anyone with competing financial needs and language or literacy challenges.

In Louisiana, a state with one of the highest rates of preterm birth in the U.S., only 5 percent of women who should be getting this medication are able to obtain it.

When we started a study at Boston Medical Center, we found that only 37 percent of our eligible patients received 17P. Our patients were not routinely informed that they had delivered preterm and were at risk of recurrence.

In fact, we found that none of our patients delivering preterm had

documented counseling about their diagnosis or recommendations for future pregnancy during their hospitalization for that first preterm baby. Without this information, they were unaware of the risk to their next pregnancy or that they could reduce risk by asking in prenatal care for 17P.

A cheaper treatment

17P is expensive, so perhaps it seems reasonable for insurers to restrict it – even from those who qualify for its benefit.

But what about other preventable causes of preterm birth? Maternal complications of high blood pressure, also known as preeclampsia, can also induce preterm birth.

Preeclampsia, a disease of constriction of small blood vessels, costs an estimated $2.1 billion per year in the U.S. This is at a time when the poorest women in America are at rising risk of maternal death, of which preeclampsia is a leading contributor.

The population at highest risk for preterm birth due to hypertensive disorders or placental insufficiency? Black women, especially those with a personal or family history of high blood pressure; first-time mothers; and obese women with low socioeconomic status.

A medication that costs 16 cents a week is also unavailable to many of the women most likely to benefit. This magical treatment is low-dose or "baby" aspirin.

In 2014, the U.S. Preventive Services Task Force, a congressionally authorized independent group of national experts, officially recommended low-dose aspirin for pregnant women at high risk of preeclampsia.

Aspirin in highest-risk women may reduce preterm birth by 62 percent. It can also cut the overall incidence of hypertensive pregnancy complications in half.

Low-dose aspirin has been used safely for both mothers and babies for more than 80,000 pregnancies over 30 years. But our study showed that only 11 percent of high risk pregnant woman at Boston Medical Center received low-dose aspirin, when our goal is for 90 percent of qualified women to get this benefit. Why aren't women, especially high-risk women, getting this medication?

At Boston Medical Center, we are working to address our three specific identified barriers to access. Providers are reluctant to prescribe low-dose aspirin, pharmacists are reluctant to fill it, and, when prescribed, women are afraid to take it.

Though it hasn't been fully studied, reluctance on the part of providers and pharmacists likely stems from a lack of knowledge or acceptance about risk factors. Meanwhile, women, eager to have a safe pregnancy, are bombarded by mixed messaging when searching online for information about aspirin in pregnancy.

Changing the narrative

The medical community can do better to reduce this racial disparity, but doing so requires focused interventions directed toward those women most likely to benefit.

At our hospital, we were able to increase our patients' access rate to 17P to almost 90 percent. We focused on four specific barriers: lack of patient knowledge, lack of provider awareness, suboptimal communication in the electronic health record and insurance challenges in obtaining the medication. This subsequently reduced our preterm birth

rate by 62 percent.

At a time when reproductive health care sites are being closed and preventative care restrictions on poor women are implemented daily, we need to prioritize every woman's access to interventions that reach high-risk women in order to prevent infant mortality and preterm birth.

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