

NYT. US failing in IMR starting at 1 month age. June 6. 2016

## [The Upshot article](#)

### **The U.S. Is Failing in Infant Mortality, Starting at One Month Old**



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Many more babies die in the United States than you might think. In 2014, more than [23,000 infants died](#) in their first year of life, or about six for every 1,000 born. According to the Centers for Disease Control and Prevention, [25 other industrialized nations do better than the United States at keeping babies alive.](#)

This fact is hard for some to comprehend. Some try to argue that the disparity isn't real. They assert that the United States [counts very premature births as infants](#) because we have better technology and work harder to save young lives. Therefore, our increased rate of infant death isn't due to deficiencies, but differences in classification. These differences are [not as common](#), nor as great, as many people think. Even when you [exclude very premature births from analyses](#), the United States ranks pretty poorly.

Even among those people who accept the statistic, most assume that high [infant mortality](#) is because of [poor prenatal care](#). But new evidence is coming to light that contradicts that conclusion. [The problem appears to be focused on what happens after birth, not before.](#) This new evidence could change our thinking about how to fix the problem.

Photo



Credit Hanna Barczyk

Infant mortality is [not distributed equally](#) in the United States. In 2013, the infant mortality rate among [non-Hispanic whites](#) was 5 per 1,000 births, as was the infant mortality rate among Hispanics. The rate among [non-Hispanic blacks](#), however, was more than 11 per 1,000 births.

A number of [other factors](#) seem to play a role. Mothers younger than 20 years or older than 40 have children with a higher infant mortality. First babies have a higher chance of death than later siblings. Unmarried mothers also have a higher rate of death in their children, more than 70 percent higher than that of married mothers.

The No. 1 cause of infant mortality among newborns is premature birth, which has traditionally been linked with inferior prenatal care. That may not be the case in the United States. A [2006 study published in Epidemiology](#) looked at how preterm delivery occurred among women in active-duty military installations.

Such women receive the **same prenatal care regardless of race, or even socio-economic status.** Because they were guaranteed care, their overall risk of premature delivery was low, just over 8 percent. **But even among these women, black women were more than two times as likely as white women to deliver prematurely, regardless of military rank.**

A [Cochrane Systematic Review](#) of the additional support women received during at-risk pregnancies included 17 studies and more than 12,000 women. Additional care was not associated with any improvements in any perinatal outcomes. **C-sections were less common, as was hospital admission after birth, but infant mortality was not affected.**

[Another such review](#) examined how the **number of prenatal visits** affected infant mortality. Seven studies involved more than 60,000 women in countries of varying income. There was no difference in high-income countries in the number of deaths of those who had more or fewer visits (although the number of deaths over all was low). In low- and middle-income countries, perinatal mortality was higher in groups with reduced visits, but the overall difference was small. The authors concluded that in places where the number of visits was already low, reducing the number of visits further was a bad idea. This doesn't necessarily apply to standard care in the United States, though.

A [recently published paper](#) in the American Economic Journal: Economic Policy adds to this discussion. Alice Chen, Emily Oster and Heidi Williams combined data from the United States with data from Finland, Austria, Belgium and Britain. **As other studies have done before, they adjusted for differences in coding of very premature births. And as other studies found before, the United States has a significant infant mortality disadvantage.**

This study was different, however. It used microdata, or individual records of birth and death, as opposed to the aggregate data usually employed for cross-country comparisons. First, the researchers differentiated between neonatal mortality (death before one month of age) and postneonatal mortality (death between 1 and 12 months of age). The results showed that when it comes to neonatal mortality, the United States and other countries were pretty similar. If anything, [the authors](#) report, the United States might have a mortality advantage during this period.

**Differences in postneonatal mortality, or from one month to one year, however, were much more stark. In fact they begin to accelerate at one month of age.**

One explanation could be that this is just a delay in deaths. Perhaps the United States is simply better at keeping these babies alive a little while longer than other countries are. Differences are seen all the way to one year, though, making this unlikely. This difference also doesn't appear to be because of race. A sub-analysis that excluded blacks from the sample still found a similar

postneonatal mortality disadvantage in the United States. Racial differences may be more applicable to neonatal mortality.

Deaths in the postneonatal period are due, in large part, to [sudden infant death syndrome \(SIDS\)](#), sudden death and accidents. Moreover, they seem to occur disproportionately in poor women.

It's not clear that "health care" is what might reduce deaths in this group. That doesn't mean there's nothing we can do. It might even be cost-effective to try. The authors of this paper estimated how much we might consider spending. They calculated that decreasing postneonatal mortality to that of comparable European countries might lower the death rate by 1 in 1,000. Assuming a standard value of \$7 million per life, it might make sense to spend \$7,000 per infant. That might seem like a lot of money, but it's not out of the realm of what we spend on many other medical interventions.

What exactly we might do with that money is up for debate. One suggestion made by the authors, with which I agree, is that we consider programs of home nursing visits to reduce the incidence of SIDS and accidents. But some things do seem evident. The first is that our constant calls for improved and more prenatal care may not significantly improve our disadvantage in infant mortality. The second is that spending a significant amount of money on poor women to improve the health of their 1-month to 1-year-olds might not only save lives; it might be cost-effective, too.

An earlier version of this article referred incorrectly to infant deaths from 1 month to 1 year of age. That is postneonatal mortality, not perinatal mortality.

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**Comments, Feedback on NYT article:** Barbara M. Ostfeld PhD

Below, I've pasted a link to an article in the NY Times that came out on June 6<sup>th</sup>. It addresses the unfavorable comparison between US infants and those of 25 other industrialized nations with respect to infant mortality. The article recognizes that there is a variance across nations in decisions as to how preterm infants are managed that may contribute to this ranking. However, it goes on to examine a study of post-neonatal deaths which it suggests would be less affected by variation in practice decisions. The US did not compare favorably in this age range. **SIDS was the leading cause of post-neonatal infant death, and these occurred disproportionately in poor women, which we all well know.** The study authors suggest **two interventions:** home nursing visits and spending significantly more money per infant to increase survival. Our NJ-based home visiting programs represent a valuable resource.

## NJ Data:

On another matter, based on the averaged period 2011-2013, the most recent era for which state to state comparisons are possible, New Jersey shared with Colorado, a more homogeneous state, the distinction of having the lowest SUID rates (0.5 per 1,000 live births). In limiting the age of death to the post-neonatal period (1 month to one year), the same pattern occurs, with New Jersey having the lowest rate compared to all other states including Colorado (USDHHS, CDC, NCHS, DVS). While these findings are notable, the great challenge is in sustaining or improving upon them, particularly given underlying issues beyond safe infant sleep. These challenges include poverty and associated social determinants of health. We are particularly concerned about regions where economic challenges rise. Sustaining existing programs and launching new ones is critical."

Link for comments in paragraph one:

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NYTimes.com <<http://mobile.nytimes.com/2016/06/07/upshot/the-us-is-failing-in-infant-mortality-starting-at-one-month-old.html?smid=tw-share&referer=>> from (((Aaron Carroll)))'s

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