

# Unintended Pregnancies Carry Big Price Tag

**T**axpayers spend more than \$11 billion each year as a result of unintended pregnancies, according to new data from two separate studies.

The estimates are based on public insurance costs for pregnancies and infant care in the first year. Researchers from the Guttmacher Institute used state-level data from 2006 to come up with a national estimate of \$11.1 billion in public spending on unintended pregnancies. In a separate study, researchers at the Brookings Institution came up with their figures by using 2001 national data on publicly financed unintended pregnancies, resulting in average spending of \$11.3 billion annually. Both studies were published in the June issue of *Perspectives on Sexual and Reproductive Health*.

Researchers from the Guttmacher In-

stitute found that public programs such as Medicaid and the Children's Health Insurance Program bear the brunt of the nation's costs for unintended pregnancies (*Perspect. Sex. Reprod. Health* 2011;43:94-102 [doi:10.1363/4309411]). While 38% of U.S. births result from unintended pregnancies, births from unintended pregnancies make up about half of publicly funded births. But reducing unintended pregnancies also will require

major new public investments, the Guttmacher researchers wrote, including increasing access to family planning services and comprehensive sex education. The Affordable Care Act may help, too, they said, by expanding insurance coverage and giving new authority to states to expand Medicaid eligibility for family planning services.

While preventing unintended pregnancies would require an up-front in-

vestment, the researchers at the Brookings Institution said it would be more than offset by potential savings. They estimated that if unintended pregnancies could be prevented altogether, with some being delayed until the women were ready to be pregnant, it could save taxpayers about \$5.6 billion annually (*Perspect. Sex. Reprod. Health* 2011; 43:88-93 [doi: 10.1363/4308811]).

—Mary Ellen Schneider

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"Each should last no longer than 30 seconds, and you could go back to a maneuver if it didn't work the first time," Dr. Inglis said. Suprapubic pressure also could be used.

To assess the impact of the Code D protocol, the investigators retrospectively reviewed medical records for mothers and their singleton, live born, nonbreach infants delivered vaginally between August 2003 and December 2009. Analyses were based on 6,269 deliveries in the pretraining period before September 2006, and 5,593 deliveries in the post-training period.

Study results showed that the rate of shoulder dystocia did not differ significantly between periods: This complication occurred in 83 or 1.32% of deliveries in the former period, and in 75 or 1.34% of deliveries in the latter period. However, the percentage of cases of shoulder dystocia that resulted in brachial plexus injury was 40% in the pretraining period, compared with just 14% in the posttraining period.

Among the cases of shoulder dystocia, those in the pretraining period had a higher maternal body mass index (33.4 vs. 30.3 kg/m<sup>2</sup>) and infant birth weight (3,825 g vs. 3,643 g), both of which are potential confounders, Dr. Inglis noted.

But in a logistic regression analysis, use of the shoulder dystocia protocol was still associated with a reduced risk of obstetric brachial plexus injury.

The interval between delivery of the infant's head and body in cases of shoulder dystocia was longer in the posttraining period than in the pretraining period (2.0 minutes vs. 1.5 minutes).

"We wanted everyone to go slowly, so we were actually happy to see that the head-body interval went up," commented Dr. Inglis. "That certainly didn't seem to worsen the risk of Erb's palsy."

Study results also showed that staff were more likely to use the Rubin maneuver and posterior arm delivery in the posttraining vs. pretraining period, and were less likely to use the McRoberts maneuver. ■

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