



## **The Royal Australian and New Zealand College of Obstetricians and Gynaecologists**

### **Supplementary submission at the invitation of the Productivity Commission**

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recognises the importance of a team approach in obstetric care. This commitment is shared by other key professional colleges and groups representing specialist obstetricians, general practitioners and midwives and was articulated in a recent joint media release from RANZCOG, RDAA, RACGP, ACRRM and ACMI 'Team-based care the best model for rural birthing'<sup>1</sup>.

The College commitment to team based care is complemented by an acknowledgement of the importance of on-going evaluation of the obstetric care provided to the women of Australia. A comprehensive evaluation program requires data collection on a national scale. This is particularly important in the current debate surrounding the introduction of primary stand-alone childbirth units by State health departments. The College is concerned for the safety and quality of obstetric care in Australia, particularly for women with 'low-risk' pregnancies. The current data collection systems do not enable on-going comparison of the various models of obstetric care; nor do they indicate the safety and quality of the care outcomes provided by specialist obstetricians, general practitioners and midwives on a risk adjusted basis.

The collection of clinical indicator and obstetric outcome data is a contentious issue, with concern regarding the amount of data and duplication of data collection systems. However, Australia has a strong tradition of perinatal data collection in each jurisdiction with very active Joint Consultative Committees that annually review maternal and perinatal mortality and morbidity, and at a national level, the National Perinatal Statistics Units (NPSU). The NPSU coordinates the analysis and evaluation of the Perinatal National Minimum Data Set (PMDS), and produces valuable national reports based on the PMDS. This data set is currently under review and it is therefore timely to recommend modifications to ensure that information on the model of care, changes to the planned model of care and transfers between models of care to be included. Current data focuses on the clinical issues and the outcome of the care and misses an opportunity to collect valuable workforce data that would inform the on-going debate regarding the safety and quality of the apparently opposing models of care. Access to comprehensive risk adjusted data would enable the emotion and rhetoric to be taken out of the debate and provide clear indications of the safety and quality of the models of care. The development of a suitable data set(s) should be undertaken in consultation with the health professionals involved, namely specialist obstetricians, general practitioners and midwives.

The National PMDS provides a mechanism for the collection and analysis of information relating to the provision of obstetric care. But the PMDS does not pretend to provide guidance on how the care should be provided.

Underpinning the provision of all health services is the need for the health professional to take a comprehensive history, conduct a thorough examination and in the case of obstetric care, a risk profile for the individual woman's pregnancy. The woman's clinical status should be reviewed regularly and modifications made to her management based on the current clinical picture. State Health Departments are at varying stages of developing clinical guidelines for obstetric care. South Australia has an extensive suite of guidelines<sup>2</sup> but interestingly enough,

no guideline for the management of the low –risk pregnancy. Other states have focused on providing policy directives and clinical indicators to monitor the care provided. The College is of the view that health services and hospitals should develop policies and procedures that meet the needs of their community and reflect the capabilities of their resources, with appropriate transfer mechanism to support any service shortfalls. The evaluation of local services is supported by RANZCOG Fellows' strong tradition of actively reviewing the outcome of maternity care via regular perinatal and maternal morbidity and mortality reviews.

Individual hospitals and health services have developed multi-disciplinary protocols to monitor obstetric care and clinical outcomes which include the management of low risk pregnancies along with appropriate actions and referral processes. It would seem that at a local level good data may be being collected, but there is no consistency and aggregation of data on a national scale leading to a lack of usable data to support changes to safety and quality of health care

The Australian College Midwives Incorporated (ACMI) has developed National Midwifery Guidelines for Consultation and Referral<sup>3</sup>. The ACMI Guidelines identify risk-assessment and referral processes to support midwives in the provision of care during the pregnancy, labour, birth and the postnatal period. The guidelines include specific indications for discussion, consultation and/or transfer of care in response to conditions or abnormalities that are identified during pregnancy. These guidelines, as with many other guidelines in the health sector are only as effective as the implementation and monitoring system that is in place to encourage and evaluate their use.

The RANZCOG is deeply concerned about the safety and quality of the care provided by stand-alone primary childbirth units and in July 2005 the RANZCOG Council endorsed a statement that defines the College position on the minimum standards and requirements of stand-alone primary childbirth units<sup>3</sup>. The statement identifies the necessity of timely access to obstetric, paediatric, anaesthetic and midwifery services in pregnancy, labour and for at least several hours after birth to ensure the safety of women and babies.

The condition of the woman and fetus can change remarkably quickly from that of an apparent low risk pregnancy to that of an obstetric emergency. Australian women and babies deserve access to true specialist services if things do not go well in labour, during delivery or in the immediate hours following delivery.

*'The RANZCOG accepts that some women who have been carefully assessed as being at lower risk of pregnancy complications will choose to labour in relatively low-technology primary care units.*

*Wherever possible, and certainly in metropolitan areas, such units should be sited within or immediately adjacent to a 24-hour obstetric facility, which must have anaesthetic / analgesia services, operating theatres and blood products with timely access to neonatal paediatric expertise and intensive care specialist consultation.*

*Where, by virtue of remote location, such onsite services cannot be provided, patients should be informed of the limitations of services available and the implications for intrapartum and postpartum care. Antenatal transfer to a centre with more comprehensive services should be offered.*

*In all circumstances where transfer may be necessary, formal systems must be in place to ensure safe, timely and rapid transfer of women and/or their babies who require specialist treatment. These arrangements should be collaborative and hold the safety of mother and baby as paramount. In addition, these arrangements must be subject to regular prospective practice audit and be supported by robust, consistent data collection systems.*

*The RANZCOG is concerned that in some situations in Australia and New Zealand funding issues and shortages of key health professionals are driving decisions on the appropriateness of different models of care, rather than considered assessment of best practice. The RANZCOG would welcome open debate on this matter between the community, relevant professional groups and government representatives. Such debate should occur prior to changes in service delivery being made<sup>4</sup>.*

## **The international scene**

In New Zealand, United Kingdom, United States and Canada initiatives are underway to link the monitoring of both the safety and quality of obstetric care with the model of care and the care provider. It is only by developing suitable robust and comprehensive data collection that risk adjusted data will be available to inform the debate surround the provision of low risk obstetric care and safety and quality of transfer processes on those occasions when there is a rapid progression from low risk to a higher risk.

### **New Zealand**

In 2002 the Ministry of Health set down terms and conditions for the provision of maternity services in the 'Maternity Service notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000' with guidelines for consultation with obstetric and related specialist medical services<sup>5</sup>. The guidelines define three levels of referral along with a list of conditions and stages during a pregnancy with the appropriate referral level. The Ministry of Health does not collect any data on the implementation of the guidelines but do occasionally audit a random sample of obstetric cases. The Health and Disability Commissioner, when investigating adverse outcomes may in some cases, investigate compliance with the referral guidelines. In the short term, the New Zealand Ministry of Health does not plan to introduce a data collection process to enable on-going auditing of the referral process.

New Zealand unlike Australia has not had a mechanism to review perinatal and maternal mortality. However, it is pleasing to note that National Epidemiology and Quality Assurance Committee have recently established a Perinatal and Maternal Mortality Review Committee. One of the first tasks of this Committee is to establish a mechanism of collecting all the perinatal and maternal deaths for review.

In 1996, the debate surrounding appropriate maternity care for women and the development of alternative models of care resulted in the introduction of sweeping changes to New Zealand's maternity care system. The changes were designed to give 'each woman ... every opportunity to have a fulfilling outcome to her pregnancy and childbirth, through the provision of services that are safe and based on partnership, information and choice'. Section 51 of the Health and Disability Act proposed a Lead Maternity Carer (LMC) system 'chosen by the woman with responsibility for assessment of her needs, planning her care with her and the care of her baby'<sup>6</sup>.

Under the maternity services system, an LMC may be a midwife, a specialist obstetrician or a GP obstetrician. The LMC will 'take responsibility for the care provided to the woman throughout her pregnancy and postpartum period including the management of labour and birth. This has led to the erosion of the GP's traditional role in obstetrics. The funding model of the new LMC system - the Maternity Payments Schedule – also appears to have discouraged many GPs from practising obstetrics

In the 1999 review of maternity services one of the recommendations focused on the need for an active program of performance management to be implemented and that the program be closely monitored by the Ministry of Health. The issues to be addressed included the need to;

- monitor perinatal outcomes,
- provide evidence on the safety of maternity procedures
- seek ways to improve service quality.
- performance management should be informed by mortality review procedures
- monitor existing performance more effectively.
- monitor and evaluate improvements proposed in this review
- create a rigorous framework to monitor and evaluate the benefit to mothers and their babies of direct contracts outside of Section 51.

Obstetricians in New Zealand supported this initiative from the Ministry of Health. Robust data is essential to enable to valid review of obstetric outcomes.

### **United Kingdom**

The importance of careful documentation of maternal and fetal risk factors in the antenatal notes encompasses the recommendations of successive reports from the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI): “The quality of maternity records needs to be improved to enable clear identification of risk factors and documentation of management plans for these during both ante partum and intrapartum periods.”<sup>7</sup>

In 2001, in the absence of a viable national initiative, the Perinatal Institute instigated the development of pregnancy notes<sup>8</sup> these are now complimented by Intrapartum notes ('Birth Notes'), consistent with the principles applied in the Pregnancy Notes. All NHS facilities in the West Midlands are trialing a new data collection program using a core data set based on the pregnancy and birth notes through the new Maternal and Neonatal Electronic Recording System (MANNERS<sup>9</sup>),

The data set includes core clinical information, similar to data collected in Australia, but of particular interest is the emphasis placed on the collection of information relating to,

- the antenatal care plan,
- care plan at the start of labour,
- lead professional
- professional for delivery
- professional at resuscitation

It will be interesting to monitor the outcomes of the program, it will certainly collect a lot of valuable information but the management of the data collection may prove overwhelming in its complexity.

### **United States of America**

In the United States the Department of Veterans Affairs (VA) have taken a lead in developing quality improvement programs and clinical practice guidelines for use in the VA hospitals throughout America. A very detailed clinical practice guideline; Management of the Uncomplicated Pregnancy<sup>10</sup> was developed to,

- standardise prenatal care for lower risk patients to minimize variation
- standardised care plan to improve overall patient satisfaction with prenatal care,
- explicit, evidence-based interventions for screening and management,
- standardised education of patients and providers,
- standardised counseling for antenatal diagnostic screening,
- standardised prenatal screen to identify women with high-risk pregnancies,
- accompanying tool kit to empower implementation.

The Uncomplicated Pregnancy Guideline is presented in an algorithmic format for the practitioner to follow at specific intervals during pregnancy. Interventions and contraindications are provided in an effort to reduce variation in the delivery of prenatal care. The responsibility for implement the guidelines is devolved to the organisation and monitored by the Department.

### **Canada**

The Public Health Agency of Canada guidelines for maternal and newborn services have influenced the provision of maternity services in Canada for the past 30 years. The guidelines have been through a number of revisions and now appear as the *Family-Centred Maternity and Newborn Care: National Guidelines*<sup>11</sup> provide a framework for organisations and health professionals in the provision of maternity services.

In 2000, a National Conference on the Future of Maternity Care in Canada was convened to address the severe shortage of maternity and newborn care professionals in Canada. “The

underlying concern was that without an appropriate number of skilled professionals, women and their babies would be put at risk. It was recognized that rural and remote Canada had been the first to experience these shortages, but there was now evidence which would indicate larger urban areas and even tertiary care obstetrical centers were being challenged by decreased human resources." As a result of this initiative Health Canada has funded The **Multidisciplinary Collaborative Primary Maternity Care Project (MCP<sup>2</sup>)**. This project is designed to focus on workforce shortages being faced in Canadian maternity services. The key goal of **MCP<sup>2</sup>** is to understand the barriers that exist in the provision of maternity services and then to ".....facilitate the implementation of national multidisciplinary collaborative primary maternity care strategies as a means of increasing the availability and quality of maternity services for all Canadian women." The **MCP<sup>2</sup>** brings together all the key organisations representing the full range of maternity care providers in Canada and is funded by the Primary Health Care Transition Fund of Health Canada.

### **Summary**

The College is committed to team based obstetric care and the ongoing evaluation of the care provided to the women of Australia. This commitment is demonstrated by the inclusion of practice review as a key aspect of the College's compulsory Continuing Professional Development program for RANZCOG Fellows.

In order to undertake a comprehensive and dynamic evaluation of obstetric care in Australia data collection on a national scale is required. This is particularly important in the current debate surrounding the introduction of primary stand-alone childbirth units by State health departments. The College is concerned for the safety and quality of obstetric care in Australia, particularly for women with 'low-risk' pregnancies. The current data collection systems do not enable on going comparison of the various models of obstetric care nor of the safety and quality of the care outcomes provided by specialist obstetricians, general practitioners and midwives on a risk adjusted basis.

### **Recommendations**

**That resources are made available to enable the development, collection and analysis of a new data set(s) to be included in the national perinatal minimum data collection.**

**That the data set(s) be developed collaboratively with specialist obstetricians, general practitioners and midwives.**

**That the data set(s) relate to the obstetric model of care, health professionals involved in provision care and transfer processes.**

**September 2005**

## References

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<sup>1</sup> RANZCOG, RDAA, ACRRM, RACGP and ACMI Joint media release 'Team-based care the best model for rural birthing' <http://www.ranzcog.edu.au/media/pdfs/Team-based%20care%20the%20best%20model%20for%20rural%20birthing.pdf>

<sup>2</sup> The South Australian Perinatal Practice Guidelines (SAPPG) <http://www.health.sa.gov.au/ppg/>

<sup>3</sup> ACMI guidelines [http://www.acmi.org.au/text/corporate\\_documents/ref\\_guidelines.pdf](http://www.acmi.org.au/text/corporate_documents/ref_guidelines.pdf)

<sup>4</sup> RANZCOG Media release College statement on 'stand-alone' childbirth units <http://www.ranzcog.edu.au/media/pdfs/MR-Stand-alone%20childbirth%20units.pdf>

<sup>5</sup> Medical Council of New Zealand, Maternity Service notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000. [http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/b5feb26417807a2fcc256b9f00814666/\\$FILE/Final%20Section%2088%20Maternity%20Notice%20April%202002.pdf](http://www.moh.govt.nz/moh.nsf/c7ad5e032528c34c4c2566690076db9b/b5feb26417807a2fcc256b9f00814666/$FILE/Final%20Section%2088%20Maternity%20Notice%20April%202002.pdf)

<sup>6</sup> New Zealand Ministry of Health, Maternity Services , a reference document 2000 [http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/64f4a80cd43629704c2569d9001a01c9/\\$FILE/Maternity%20Services%20November%202000%20-%20final%20version.pdf](http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/64f4a80cd43629704c2569d9001a01c9/$FILE/Maternity%20Services%20November%202000%20-%20final%20version.pdf)

<sup>7</sup> Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) 8<sup>th</sup> Annual Report

<sup>8</sup> Perinatal Institute pregnancy notes, <http://www.preg.info/About%20the%20Notes%20v4.3.pdf>

<sup>9</sup> MANNERS Maternal and Neonatal Electronic Recording System maternity data set <http://www.perinatal.nhs.uk/manners/MCDlv5%20April%202005.pdf>

<sup>10</sup> Department of Veterans Affairs, Management of the Uncomplicated Pregnancy [http://www.oqp.med.va.gov/cpg/UCP/G/UCP\\_Sum508.pdf](http://www.oqp.med.va.gov/cpg/UCP/G/UCP_Sum508.pdf)

<sup>11</sup> Health Canada. Family-Centred Maternity and Newborn *Care: National Guidelines*, Minister of Public Works and Government Services, Ottawa, 2000 [http://www.phac-aspc.gc.ca/dca-dea/publications/fcmc01\\_e.html](http://www.phac-aspc.gc.ca/dca-dea/publications/fcmc01_e.html)