Comment on
'Impacts of Medical Technology in Australia
Productivity Commission Progress Report'

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Thank you for providing us with the opportunity to respond to the Productivity Commission Progress Report on the Impacts of Medical Technology in Australia.

An area missing from the report's analysis is the medicalisation of childbirth. The consequent recourse to unnecessary technological interventions is at a high cost, for what can also be perceived as nonmedical problems or normal /natural life events. Our concern is particularly antenatal care and birth. The 'construction' of healthy women and their unborn infants as patients (Harrison, 2003; Williams, 2005) is having profound impact on costs and avoidable injury. For more than 20 years researchers have argued that women's natural life processes, especially concerning reproduction, have been medicalised. By this is meant that women are subject to processes where normal physiological events become defined and treated as medical problems, usually in terms of illnesses or disorders (Conrad, 1992; Oakley, 1984; Turner & with Colin Samson, 1995).

In comparable countries, for example New Zealand and the United Kingdom, governments alarmed by the cost of medicalised childbirth and reassured by the evidence of safety, are encouraging a return to professionally managed home birth or birthing centres. In Australia for the first time governments are now auspicing alternative birthing services in a number of states. For some women and infants pregnancy and childbirth are compromised by ill health and abnormality and medical intervention (including the major abdominal surgery of caesarean section) is needed to ensure the health and safety of mother or infant. However, for the majority of women pregnancy and birth are uneventful, in a medical sense, are not pathological, and can be successfully managed with a minimum of medical and technological intervention.

Nevertheless, current Australian health policy and medical insurance schemes encourage hospital birth for the majority of women under the care of a specialist obstetrician, who may not be present at the birth. In addition an increasing array of medical technology is becoming available to monitor the progress of pregnancy and fetal development, provide genetic screening of the fetus and newborn infants and, in the last few decades, to enable fetal surgery to correct a variety of anatomic and non-anatomic defects (Flake &

Harrison, 1995; Harrison, 2003; Levy & Albers, 2000). These developments have the potential to further inflate national health costs.

The Progress Report notes that policy changes to encourage private medical cover, including the *Lifetime Health Cover*, have also increased membership of private funds to around 43 percent and had the effect of increasing the number of services performed particularly in private hospitals. This includes antenatal, birth and postnatal care for healthy young women and is contributing to increasing levels of interventions during birth. According to the Australian Institute of Health and Welfare (2004) there are over 250,000 hospital admissions for this population group annually in Australia. A significant minority of these women (35.1 percent) experience some form of operative birth (23.3 percent caesarean and 11.8 percent forceps, vacuum extraction and/or vaginal breach delivery). The operative birth rate is 10 percent higher than the top of the range recommended by the World Health Organisation (WHO). A recent Australian study found that intervention rates were higher for medically 'low risk' women giving birth in private hospitals with a private obstetrician. (Roberts, Tracy, & Peat, 2000). The associated higher costs for birth have also been calculated in another study showing that the relative cost of birth increased by up to 50 percent for low risk primiparous women and up to 36 percent for low risk multiparous women as labour interventions accumulated. The authors noted that "the Commonwealth government is actively promoting private medical care for childbearing women, with both rebates and tax incentives, with little regard for the impact of private obstetric care on length of hospital stay and other health service utilization" (Tracy & Tracy, 2003).

Evidence shows that in western countries, including Australia, obstetric medical intervention is increasing with a tendency for cascade with one intervention leading to the likelihood of another (Roberts, Algert, Douglas, Tracy, & Peat, 2002; Tracy & Tracy, 2003). Pregnancy and normal vaginal delivery are being redefined, falsely, in this country as a risk to be managed for all women with increased routine obstetric intervention and more sophisticated antenatal screening. The efficacy, implications and cost effectiveness of such interventions are currently being debated in various medical or socio/medical journals and reports, or have been proven to be ineffective (Johanson, Newburn, & Macfarlane, 2002; Tracy & Tracy, 2003). For example the routine and widespread use of ultrasound to monitor fetal progress has been the subject of particular scrutiny and various studies have concluded that screening ultrasonography has not improved perinatal outcomes (Ewigman et al., 1993; T. Roberts et al., 2002).

Evidence also shows that not all interventions can be termed beneficial. For example epidural analgesia provides efficacious pain relief during labour but can result in prolonged labour and increased use of oxytocin augmentation, instrumental births and caesarean section (Oats, 2004; C. L. Roberts et al., 2002; Tracy & Tracy, 2003). The Australian Council For Safety and Quality in Health Care (2004) includes caesarean birth within a group of techniques such as the over prescribing of antibiotics that are yet to be proven as 'appropriate', actually relevant to the patients' needs and based on established standards. They state that caesarean section is the most common surgical procedure in Australia, that rates are rapidly increasing across Australia and are higher for mothers

treated as private patients in both public and private hospitals. Caesarean section is appropriate in some instances but it is associated with risks such as maternal mortality, neonatal respiratory distress and post operative complications (Morrison, Rennie, & Milton, 1995; Shearer, 1993). There is also evidence of increased risk of maternal morbidity for women undergoing elective caesarean section compared with vaginal delivery for low risk births (Bewley & Cockburn, 2002a, 2002b; Lilford, Van Coeverden De Groot, Moore, & Bingham, 1990).

Increased obstetric interventions during pregnancy and childbirth are being framed as legitimate consumer choices, even rights, for women, including those without medical indication. Again arguments about the right to choose and those citing both the ethics and evidence for the interventions and the risks involved in obstetric intervention are currently under discussion in various medical journals (Bewley & Cockburn, 2002a, 2002b; Tippett, 2004). We would also argue that a market or business model of service delivery to privately insured women as 'customers' is also driving increased use of technology and often unnecessary obstetric 'doctor-led' interventions for healthy women having normal pregnancies. The market place is being defined without the benefit of informed consumerism that usually protects against monopolist exploitation (Barclay, Andre, & Glover, 1989; Perkins, 2004).

The evidence is clear that there are alternative, safe, less technology driven, ways to manage pregnancy and childbirth which are also more cost effective than current practice in Australia. These include home birth, continuity of midwifery care and one-to-one midwifery care (Homer, Davis et al., 2001; Homer, Matha, Jordan, Wills, & Davis, 2001). These models have been proven to reduce caesarean section, neonatal nursery admission and costs and have been recommended in various government reports (Department of Health Western Australia, 1990; NHMRC, 1996; Senate Community Affairs Reference Committee, 1999; Victorian Department of Health, 1990). Variations of these models are being practiced in some states in Australia and are available and encouraged in Britain, New Zealand, Sweden, Canada and the Netherlands.

The current review of the impacts of medical technology enables the complexity of this aspect of the health care system to be examined, but it also needs to be considered with other issues including an ageing health workforce, decreasing numbers of obstetricians and midwives, increasing insurance costs, and ethical issues.

We would contend that at some stage policy makers will need to make decisions about where to allocate funding for maternal and infant health to ensure that all women and their infants receive appropriate, beneficial and cost effective care while those most 'at risk' receive the benefits of the advances in medical technology.

Specifically our comments relate to:

Preliminary Finding 2.1, 3.1

Key drivers of increased obstetric intervention and use of medical technology are that the majority of Australian women give birth in hospital where 'doctor-led' interventions are increasing. Increased private medical insurance, admission to private hospitals and less concern with cost encourages women to become consumers of an increased range of available medical technology, while for obstetricians it makes sound business sense to perform these procedures. Mothers/parents now expect to be offered a range of pain relieving interventions and diagnostic procedures some of which have an inconclusive evidence base, may be harmful both in the short and long term for some women and are increasingly being offered for medically low-risk births. There is a cascading and costly effect of obstetric interventions.

Preliminary Finding 4.2

Major medical technological breakthroughs in reproductive health are already rapidly increasing net health expenditure. This confirms the need for the highly paid medical expert and increases ill informed consumer demand. As a result arguably unnecessary universal applications of technology occur including the routine and overuse of ultrasonography and unnecessary operative birth compared to normal vaginal birth.

Preliminary Finding 4.3 & 4.4

Evidence suggests that, as with the use of other medical technology, increased private health insurance has increased the use of obstetric interventions for many young, healthy women and the morbidity rates for them and their infants.

Preliminary Finding 5.1; 5.2; 6.1

The benefit, cost effectiveness and evidence base for the use of some routinely and widely used technology is not demonstrated. Access to technology is not equal nor is it based on the use of technology or obstetric interventions according to need or reasoned, evidence based, at risk criteria.

Preliminary Finding 9.2

New medical technologies including fetal surgery and genetic screening and testing may be beneficial for some infants but costs and access to specialists may preclude them being available universally. A reallocation of resources from the costly funding of unnecessary and overused technology and obstetric intervention for healthy women to women and infants who are at risk of adverse outcomes may be a better use of public funds.

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