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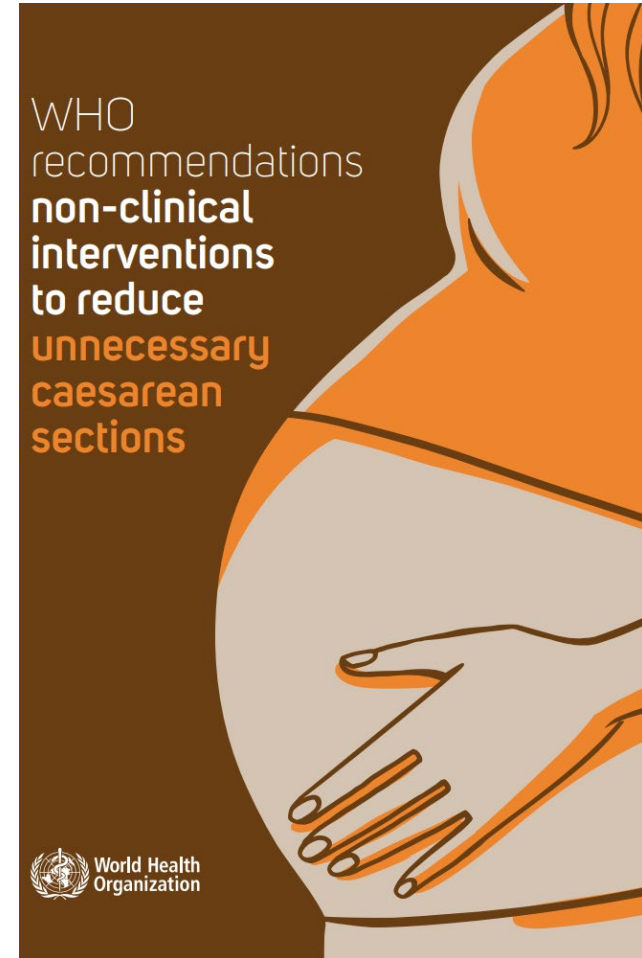
# Population trends and potential policy drivers of the medicalisation of childbirth in Australia

*Haylee Fox<sup>1</sup>, Associate Professor Emily Callander<sup>2</sup>, Dr Daniel Lindsay<sup>1</sup>, Associate Professor Stephanie Topp<sup>1</sup>.*

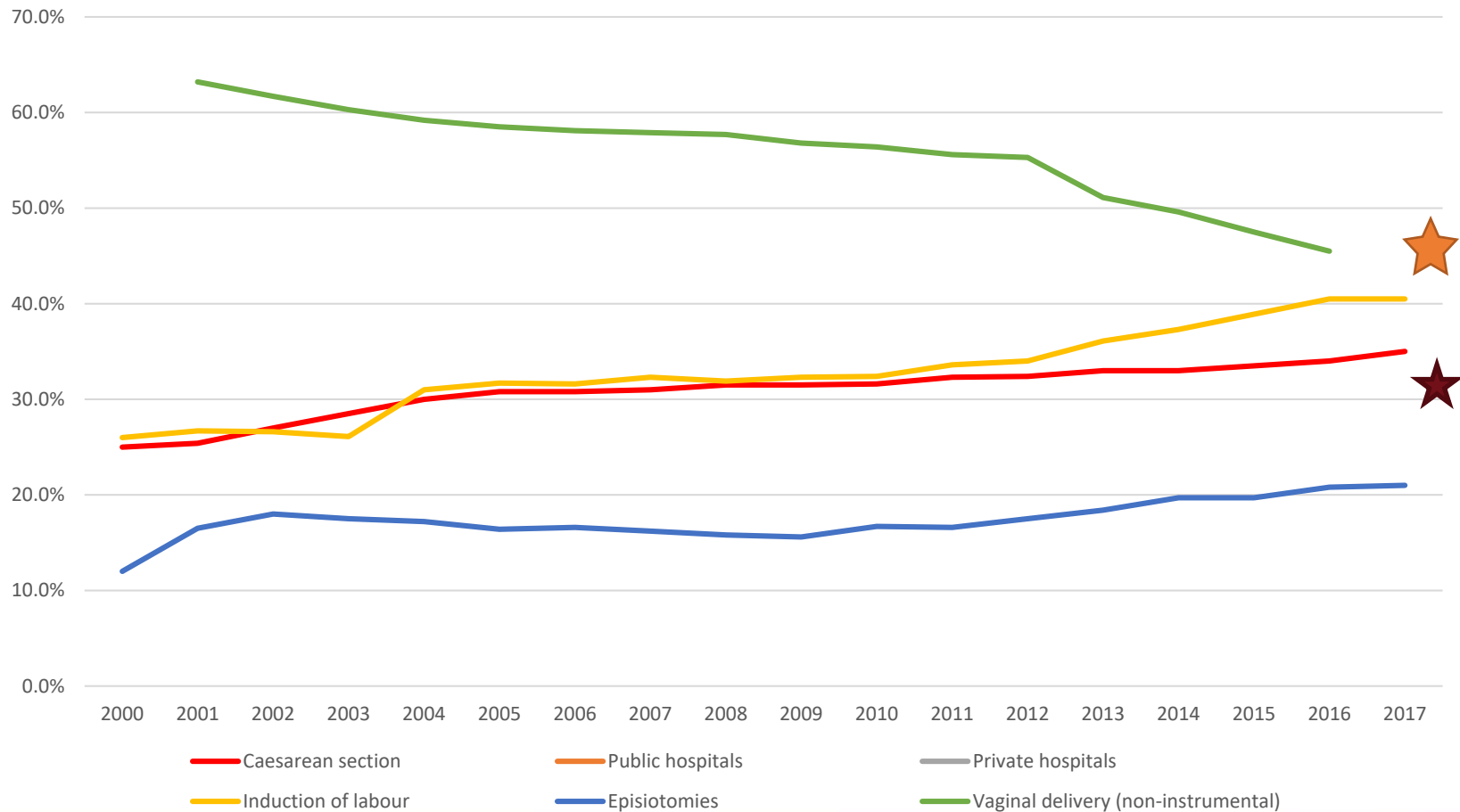
- 1. College of Public Health, Medical and Veterinary Sciences, James Cook University Townsville*
- 2. Centre for Applied Health Economics, School of Medicine, Griffith University Brisbane*

# Background – Global

- Global CS rates have almost doubled in the last 15 years
- 6.2 million excess CS performed globally each
- CS use more frequent in births in the richest quintiles
- ‘Too little too late, too much too soon’



# Background - Australia



# Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal Clinical Guideline

Normal birth

The Third Australian Atlas of Healthcare Variation

2018



## Maternity - Towards Normal Birth in NSW

**Summary** This policy provides direction to NSW maternity services regarding actions to increase the vaginal birth rate in NSW and decrease the caesarean section operation rate; to develop, implement and evaluate strategies to support women and to ensure that midwives and doctors have the knowledge and skills necessary to implement this policy.

**Document type** Policy Directive



Australian Government  
Australian Institute of Health and Welfare





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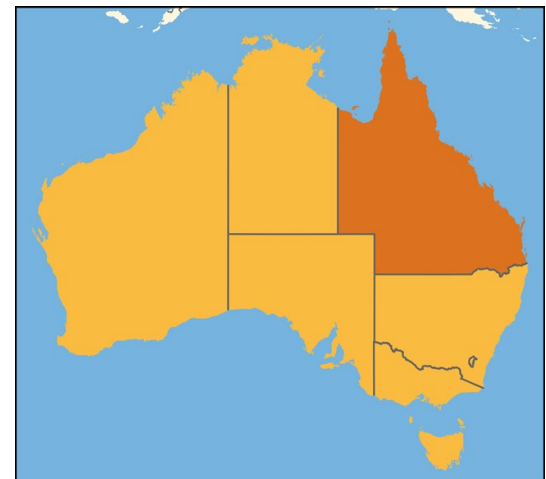
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# Methods

# Data linkage

- **Maternity1000 linked dataset:** hospital data; Emergency Department information System; MBS; PBS; Costing records
- All mothers who gave birth in Queensland between 2012 and 2015 (n=186,789), plus their resultant babies (n= 189,909) total n=376,698.



# Population trends

- Adjusted caesarean section rates in Hospital and Health Service jurisdictions in Queensland
- Association between socio economic and demographic characteristics and birth delivery type with chi-square analysis
- Odds Ratios of likelihood of receiving obstetric intervention and having an unassisted vaginal delivery
- Confounding variables: pre-existing health condition, maternal age, previous pregnancy complications, complications arising during the current pregnancy, obesity, area-based socioeconomic deprivation, distance from the birthing facility, and smoking
- Analysis was undertaken using SAS9.4 statistical software.



# Methodology – scoping review

- Scoping review of Australia's macro level health and financing mechanisms
- Interpretative synthesis of their impact on the delivery of maternity care
- Google search engine; targeted websites; academic databases







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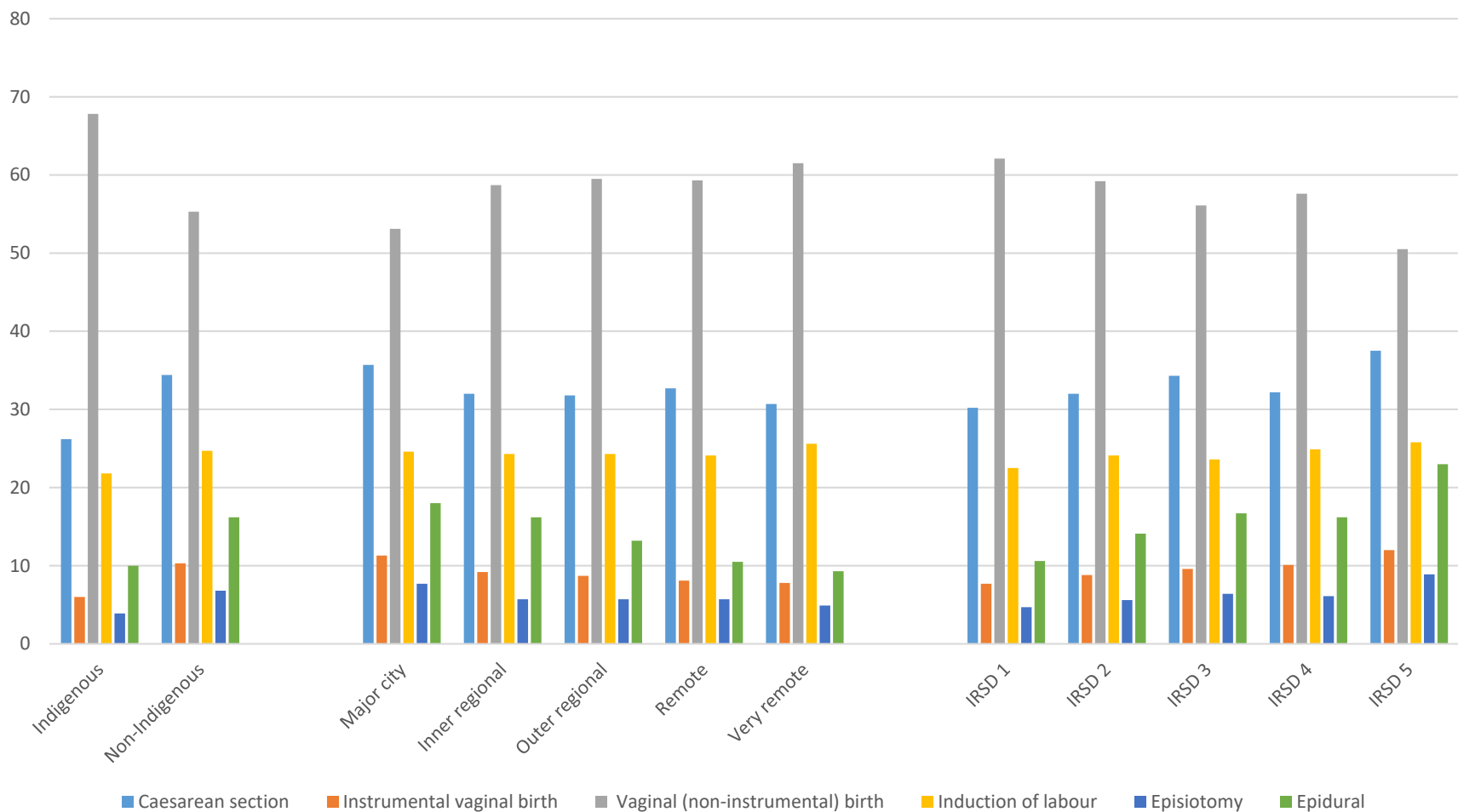
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# Results



Figure 1: Caesarean section adjusted percentages by Hospital and Health Service jurisdiction

*Sociodemographic characteristics of mothers receiving obstetric intervention during labour and birth in Queensland between 01/07/2012 and 30/06/2015*



	Cesarean section		Instrumental vaginal birth		Vaginal (non-instrumental) birth		Induction of labour		Episiotomy		Epidural	
	OR	95%CI	OR	95%CI	OR	95%CI	OR	95%CI	OR	95%CI	OR	95%CI
Indigenous	<b>0.94</b>	0.90 – 0.99	<b>0.70</b>	0.65 - 0.77	<b>1.14</b>	1.09 - 1.19	<b>0.86</b>	0.82 - 0.90		0.65 - 0.80	<b>0.74</b>	0.69 - 0.79
Inner Regional	<b>0.96</b>	0.93 – 0.99	<b>0.92</b>	0.88 – 0.97	<b>1.06</b>	1.03 – 1.09	1.10	1.10 - 1.13	<b>0.89</b>	0.84- 0.95	<b>0.98</b>	0.94 – 1.02
Outer Regional	1.03	1.00 - 1.06	<b>0.87</b>	0.83 - 0.91	1.01	0.9-1.0.4	1.10	1.07 - 1.14	0.94	0.89 - 1.00	<b>0.79</b>	0.76 - 0.82
Remote	1.10	1.05 - 1.15	<b>0.77</b>	0.72 - 0.83	1.00	0.96 - 1.04	1.05	1.00- 1.10	<b>0.88</b>	0.80 – 0.95	<b>0.57</b>	0.54 - 0.61
Very remote	1.00	0.95 - 1.10	<b>0.85</b>	0.77 - 0.94	1.05	0.99 - 1.11	1.20	1.17- 1.32	<b>0.85</b>	0.76 – 0.96	<b>0.60</b>	0.55 - 0.66
IRSD 1	<b>0.93</b>	0.89 – 0.97	<b>0.80</b>	0.75 – 0.86	<b>1.15</b>	1.10-1.20	<b>0.79</b>	0.75- 0.83	<b>0.63</b>	0.58- 0.69	<b>0.72</b>	0.68 - 0.77
IRSD 2	<b>0.95</b>	0.92 – 0.98	<b>0.85</b>	0.81 - 0.89	<b>1.11</b>	1.08 -1.14	<b>0.91</b>	0.88- 0.94	<b>0.70</b>	0.66 - 0.74	<b>0.90</b>	0.86 - 0.94
IRSD 3	0.99	0.96 - 1.03	<b>0.90</b>	0.85 - 0.94	<b>1.04</b>	1.01- 1.08	<b>0.84</b>	0.81- 0.87	<b>0.80</b>	0.75- 0.85	0.96	0.92 – 1.00
IRSD 4	<b>0.88</b>	0.85 - 0.90	<b>0.93</b>	0.89 – 0.97	<b>1.15</b>	1.12 - 1.19	<b>0.95</b>	0.81 – 0.87	<b>0.72</b>	0.75 - 0.85	1.01	0.97 – 1.10



# Scoping review

1. Privatisation of maternity care
2. Medicalisation of maternity care
3. Funding models incentivising volume of care
4. Limiting of access midwifery continuity of care models



# Policy implications – what needs to change?

- Funding based on quality indicators that preference **woman-centred outcomes** as opposed to funding models that reward **volume**
- What are the links between macro-level financing and hospital- and health provider-level approaches to maternity care?
- Prioritise publically funded midwifery continuity of carer models

