Spoken text

Good afternoon ladies & gentlemen

In the next 15 minutes I like to give you a short overview of three main problem points on Swiss maternal health care and ofSwiss Midwifery. In my view existseveral discrepancies and gaps which I can't discuss in deep but we might have the possibility afterwards in the following workshops.

Folie2

Those 3 main conflicting points

1. pregnancy- childbirth- postnatal time: is **a continuum** but **care** is **fragmented**
2. **over-medicalization** of pregnancy & childbirth and **high specialized care** from doctors in**normal live events** but in contrast**postnatal timeis underserved**
3. **after the medicalization – now more pressure because of the economization**:

I will discuss possible influencesof an upcoming concept"DRGs" on maternity care & midwifery from examples of Germany where DRGS are implemented.

If we look back – after **the move of** homebirth to hospitals childbirth –- there was a steady reduction in maternal and infant mortality rates. The introduction of antibiotics, safe anaesthetics and asepsis seem to make hospitals in the 20th century a safer place to give birth and resulted in more women giving birth in hospital

But as the hugeanalysis from Marjorie Tew (2007) shows – she is a British statistician undepidemiologist -a simple relation of cause and effect cannot be assumed

Other factors playedimportant roles in reducing mortality rates such as:

- smaller families
- improved living conditions
- disease control
- improved diet

and more recently:

- improved care for premature babies
- screening and subsequent termination

Marjorie Tewshowed also - that childbirth in hospitals was associated with more risks as in the private territory at homefor most women.

In this country maternal death between 1996 and 2004occurred in the majority of the cases among migrant women. This was found in a Swiss analysis from (Fässler et al. 2010)

In the last yearsmaternal mortality ratesrange between 1.3 to 10 deaths per 100 000 live births and infant mortality rates are around 4 per 1000 live birthin Switzerland. Those rates are similar to other developed countries

Folie 3

Mortality rates are one part of outcome quality measure in maternal health service. On this list you see on the right side common measured variables - on the left side important aspects of care that are less measured because it is more difficult or even not possible. But they are important in care forthe health of mothers and babies. For example "having support" is important in the prevention of postpartum depressions – to this later one more.

To come **to the first point** initially mentioned:

Pregnancy- childbirth- postnatal time: is **a continuum** but **care** is **fragmented**

A continuummeans those 3 phases are more than just on phase after the other - one phase influences the other following. For example – a mother'sexperience of birth - positive or negative - influences course of postnatal time.

Women need during all this process a continuous frame of support, the feeling of security, and care on a physical mental and emotional level

Care on this continuous process is mainly fragmented: Fragmented means: several different health carers are involved. I don't knowSwiss numbers but Australian midwives analyzed this problem - on

average 30 different health care providers - from first booking at the hospital until going home with their baby have been involved. (NSW Midwives Association 2008)
The problem of fragmentation of care is that it increases the risk of errors

- particularly poor communication, increases the costs and decreases women's satisfaction with their care (NSW Midwives Association 2008)
- mothers might get divergent counseling that makes them feel confused and unsure

Second Point: Another - questionable and expensive fact- is - antenatal routine care for the healthy **"low risk" pregnant woman is in hands of high specialized doctors.** This is like "tocrackanutwithasledgehammer". Only 7.7 % of pregnant women are seeing at once a midwife during pregnancy (SHV 2010). Additionally health insurances pay midwives for the same service around 4 times less as a doctor. As you can imagine - there is no interest of medical lobby to change this situation. This high specialized antenatal care has its focus on screening, risk assessment and substitution. Ambiguousrisk concepts– of prenatal diagnostics - make women feel unsecure - produce fears and the illusions of a guarantee for a healthy baby.
Looking the situation of birth: Quasi allbirthing women are cared by a midwife - but the most under medical administration in a hospital withshift operation. Only around 2% of women give birth at home or in a birth center. This fact might be the result of brainwashing the public and womenby obstetrics professional organizations all over the world - who get not tired to demonize home births - against good evidence – that is available.

Slide 4 Swiss Data

Here some data from 2009 (BSF):
Caesarean rates rise every year –we had over 32 % on average depending on type of hospital and canton. Highest rate were > 40% -lowest 18%. For Epidural anesthesia it is difficult to get data. There is on statistic from the ASF – ArbeitsgemeinschaftSchweizerischerFrauenklinik – but not all hospitals are part of it and data are not available without connection! Rates are between 3.69 – 53% but the French clinics aren't included and theyhave mostly rates up to 80%- like in France.

Number of births	76'820
Caesarian sections	25'171
Caesarian delivery rate	**32.8%**
Type of the institution: Public subsidized	30.6%
Private	41.4%
Epidural anesthesiaCH ??? Data from 2005- 2008:PDA rate spontaneous delivery 24% Ø Without Lausanne & Geneva (60-80 %?)	between 3.69% + 53.32 %

The high rates of intervention reflect a techno-medical paradigm and understanding of health systems that is strongly oriented toward science, high technology, economic profit, and patriarchally governed institutions.Characteristics of this paradigm in maternal health are:

- Mind-body separation - the body as a machine
- The body of women is perceived as not - perfect that needs diagnostic & treatment
- Women lost autonomy over theirbodies.
- Women believe not being able to give birth
- Labor pain is seen as an unnecessary torture without sense (Davis- Floyd 1994)

Historical research form Barbara Duden- shows a change in body perception - She states a change "from good hope to bad expectations » (Duden 1991, 2002)

In fact maternal health care can be seen as a**history of de-empowering** women. In this logic fits - the **potential of Midwives is not used**- they lost autonomy and experienced **de-**professionalization – Midwifery in the last century is a history of subornation to medicine.

Looking postnatal time

In contrast to first two phases **postnatal care is underserved** and does not meet many women's need. Women are left alone. Midwifery research from other countries e.g. (Barcleyfrom Australia) who conducted a big phenomenological study several months after childbirth **named experiences of becoming mothers a misery**. I believeit is not that different for many women in Switzerland – an impression I got after my own small research from reports of other midwives. Many difficulties start **after the regular postnatal** care– a few weeks or month later.

Slide 5 postnatal time

On this slide some points are listed – women need in this time

- Protection, support, orientation in a new life situation "Mothering the mother" " is the keyword.
- routine care is : short, inflexible, early discharge happens more and more without care,
- this vulnerable time is undervalued – under-researched:
- andto short defined in duration (6-8 weeks) as newer research shows.
- It is reduced to somatic matters
- and there is tendency of the various professions to act in isolation from - or even in competition with each other

In consequence on postnatal mental health is not enough attention paid.

Slide 6 PND prevalence

If we look prevalence from from prospective studies of other developed countries — we can see the high prevalence's of PND. No Swiss data are available except from hospitalized cases "coded as mental and behavioural disorders during puerperium- thereare each year 70- 80 cases. In the IDC 10 System PND is not special coded.

25 - 50%	postpartalerblues	firstweekp.p
10%	**severedepression**	**first month up to 1 year p.p.**
3 - 5%	**moderate – severedepression**	**first month up to 1 year p.p**
2 : 1000	puerperalpsychosis	firstmonthp.p.

Slide 7 Data calculate for Switzerland

One has to assume that prevalence in Switzerland is not that different from other countries. If we take prevalence's from other countries and calculate them for Switzerland - we are supposed to have

ca. 8'000	**severe depression 10 %**
ca. 2'400 -4'000	moderate to severe depression 3- 5 %
Ca. 2 von 1'000	psychosis 0.2%

Slide 8 possible effects of PND

Postnatal depression has long lasting and severe effects on the health of mother and baby and the whole families –as several international prospective follow-up studies show: (Alpern& Lyons-Ruth

1993, Essex et al. 2001, Sinclair & Murray 1998, Hippwell et al. 2000, Murrey et al. 2003. Goodman, 2004)
For example there is a dysfunction of mother-baby relation -

- developmental disorder of the child (emotional, cognitive , behavior)happend
- mother: feeling of guild → increasing depression
- feeling embarrassed → no request for help
- conflicts with partner
- abuse of child
- suicide – extended suicide

Slide 9 the problem of PND & care is

- onset is typically after regular care – it is often not identified and often there is no treatmentor support- it is kept secret from women because of embarrassment and
- symptoms are mistaken from health carers as birth- or breastfeeding related exhaustion

There is high evidence **that routine screening with the Edinburgh Postnatal Depression Scale** (EPDS) - a validated instrument in many languages – detects PND earlyand allows to help affectedwomen. In Switzerland routine screening is not done. Not enough specialized mother baby units are available for women with PND (I know - two institutionsin the Swiss German part - Affoltern ZH and Basel. In cases where hospitalization is needed - mother and baby are separated or both are hospitalizes in general psychiatric clinic. This **is not an appropriated place** in the special situation of a mother and baby. There is also enough evidence that show the benefits of specialized multidisciplinary teams who work with mother and baby together.

Third Point: Now let's get to a other topic – **Slide 10 After the medicalization now the economization**
Next clouds are gathering together–in form of the coming up implementation of DRGsDiagnose related groups– on the 1 January 2012. Consequences on maternal health are not clear at presence. We can take experiences from other countries that have implemented DRGs years ago.

Slide 11 DRGs

What are DRGs?
I can't get in technical details but I assume that most of you have already heard of it. Many controversial debates are going on in media.
Just a few words about it: It is a prospective medico-economical patient classification systemfor hospitals. Patients are grouped into similar groups of diseasewith similar costs of treatment. Each case in a given category gets a fixed fee independent of the individual cost that happened when a patient is hospitalized.
Purpose of DRG System is to improve service - to get cost transparency – and benchmarking of hospitals. One goal is shorter hospital stays

Slide 12 Example Germany

Here an example from Germany–a retrospective analysisfrom 2007in a University Clinicfrom Munich. The author compared costs of two delivery modes. 100 cases have been analyzed whereof70 normal uncomplicated deliveries and 30 primary caesareans (primary means planned in advance)
Pools of costs were evaluatedon expenses on personnel - material, cost of other institutes and cost of infrastructure.
Total costs of 1673 Euro on averagewere identified for a normal labour and 2384 Euro for a primary Caesarean section.
Normallabour costs 710 Euro less on average

Slide 13 pools of costs are seen

Infrastructure and staffhave the highest part of total costs. There are no big differences betweenthe mode of delivery and the pools.

Slide 14: Staff expenses

These slide shows categories of staffexpensesbetween the two types of delivery- nurse – gynecologist- neonatologist – midwife –surgical nurse
Caesarean delivery saves costs of Midwives with about 20% - that costs switch mostly to the surgical nurse
One can calculate how much money could be saved - if the normal birth were in hands of midwives and at home.

Slide 15 cost return - gain
The netto gain of the hospital is seen at this slide
For a normal birth it is**173 Euro on average**
For primary caesarean section it is **1459 Euroon average**

It is obviously which mode of delivery brings economic benefit for a hospital. It is also clear – in business management logic - todays hospitals- as enterpriser –have to make profits for reinvestments. This business management logic might not be in the interest of women or midwives - because definition of quality -as seen in the beginning – is mostly reduced on measurable variables– which do not picture many important aspects in care that are linked to timeconsuming care aspects . In benchmarking logic - it is thinkable that a hospital in this system might have a good performance in economic aspects and on the level of quality and a hospitals that would set priorities more on the women's or patient's needs – would get a bad performance in benchmarking. Those economic systems are originally designed for the production of goods – now they are expanded on care between humans. The problem - care is not the same as the production of cars – where efficiency and effectiveness are sense makingaims in the production.
From experiences of other countries there are some consequences of DRGs Implementation on maternal health care known or one has to be worried about it. There might be a further pressure on time of the duration of labourand the week day.
Midwives might be replaced with further technic or with Doulas - a birth supporter paid by the women – as happened in the USA. I've heard of one example in a Swiss hospital.
The system is an incentive scheme – where profit happens by diagnosis and intervention – further «over-diagnosing women to some sickness might arrive.
Early discharge from hospitals on the second or third p.p. day might get standard - this is in fact - the worst moment to go home for mothers – baby blues - postpartum breast engorgementcomes up in these days.
Actually women who want to give birth in hospitals should be encouraged to go home on the firth day after birth – at home they will be cared continuously from the same midwife – **if she then finds one.**It would create a further shortage of midwives – what already happened in some cantons.
In summarythe implementation of DRGs is further step in a system driven by the primacy of economy and medicalization and the needs of women or the central characteristics of midwifery care might get even more lost as they already are.
But what are the central characteristics of midwifery care?
Midwives consider childbirth as a normal process and live event. There is emphasis on the natural ability of women to experience birth with minimum intervention. To name a few keywords - partnership with women - women centered - in a salutogenetic* understanding of health care(* meaning it is looked for resources of women instead for possible deficits like in the medical system)

Midwifery care research from different studies in different countries show many benefits for women
Slide 16 meta-analysis of midwifery led care
Here one important meta-analysis - a Cochrane Review. The review of midwife-led care covered midwives providing care antenatally, during labour and postnatally. This was compared with models of medical-led care and shared care. 11 trials, involving 12,276 women were taken in the analysis. Midwife-led care was associated with several benefits for mothers and babies, and had no identified adverse effects.

The main benefits were a reduction of intervention- continuity of care - . Women felt more in control during labour, having initiating breastfeeding. However, there was no difference in caesarean birth rates.
The authors conclude that most women should be offered midwife-led models of care, except to those with substantial medical or obstetric complications

In the light of all this results it is not understandable why the potential of midwives is not used more and a part of a national health strategy. There are many reasons – we might discuss later. To come to an end what challenges are up and what actions are needed

- 1) the development of a comprehensive national public health strategies with inclusion of consumers in planning of maternal health services
- 2) raising public awareness for midwifery services
- 3) Midwives should take up more there role in pregnancy as it is a key role for the course of all following phases.
- 4) strengthening the midwifery training

In my opinion a fundamental change of maternal health care is needed.Schücking (1994) state this already in 1994 in onesentence:
Instead“**high technology for all - high tech only for high risk”-** as pregnant **women with low-risk profit rather from high touch.**

To come to the very end – I like to show the Vision from the Irish - Scottish -English health authorities that should be overtaken for Switzerland and all other countries:
Slide 17Vision

- Midwives should have a visible place in a community setting where women can choose to access them as the first point of contact

Two key roles for midwives that are important:

- Midwives are the **lead professional** for women with no complications, and the other is as the **coordinator of care for all women**
-

The only country in the world I know is New Zealand who has already adapted this system in the nineties- the problem they have: a shortage of midwives – especially in rural areas.

Thanks for your attention