

Response: public and private intervention rates in obstetric practice

TO THE EDITORS: Dodd and Robinson (2004) present a commentary on our recently published work (Shorten B & Shorten A 2004) which examines the trends in obstetric interventions within New South Wales (NSW) public and private hospitals from 1997–2001. We welcome discussion on this important issue which has both clinical and economic implications. They acknowledge that our emphasis on recent changes in subsidies for private health insurance adds a concerning new dimension to what is a well established debate regarding obstetric intervention rates in Australian private and public hospitals. Rather than being primarily a concern for the ‘health funders’, it has implications for all Australian taxpayers, who bear the opportunity costs associated with subsidising potentially ineffective, or even harmful, health care interventions or models of care at the expense of other worthy health care programs.

In acknowledging that risks and benefits exist for all health care choices we must be cautious in recommending that as long as consumers are fully informed of the risks and benefits then it is acceptable to provide funding, ignoring the broader societal implications of such resource consumption. Therefore the need for “transparency and accountability” (Dodd & Robinson 2004, p. 11) within the private obstetric sector is both an economic and ethical imperative.

One of the interesting contradictions in contemporary obstetrics is the use of the argument that consumer demand is a contributing factor behind the growing rate of birth intervention. However, practitioners simultaneously recommend funding of high quality research with the purpose of gaining better evidence upon which to base clinical practice. It is important for high quality evidence to be produced and disseminated, but the existence of that evidence alone will not address the current trend in obstetric interventions. Those who support the principles of evidence based practice will be aware of the challenges faced by those attempting to ‘get evidence into practice’. The presence of evi-

dence does not equate to evidence-based practice, and consumers are not necessarily aware of this. Further, the presumption that consumers are not well informed about the vitally important consequences of their health care choices is a central pillar underpinning extensive public regulation of, in particular, the health care professions. This provides further reason to be cautious in evaluating arguments relating to consumer choice as a factor in observed interventions and outcomes.

If it is the case that “most private obstetricians are also gynaecologists, and work in several settings; and ... non-clinical factors may have a greater impact on interventions than evidence from systematic reviews” (Dodd & Robinson 2004, p. 11), then the priority lies not in simply producing more evidence but in developing and implementing strategies to ensure use of best clinical practice. Public policy regarding birthing practices should not be influenced by the business imperatives of clinicians and/or hospitals. Accountability and transparency are indeed required to ensure that the private hospital industry is providing optimal and cost-effective services and outcomes from a societal perspective. A broader implementation and evaluation of various midwifery models of care within the private sector could contribute to achieving this aim.

Dodd and Robinson (2004) argue that there is a lack of evidence for any particular rate of intervention for birth, and therefore that well-informed consumers and practitioners must make individual choices about such interventions. While this may be argued at the level of the *individual*, it cannot be extrapolated to suggest that if consumers are well informed widely different *population* rates of procedures such as caesarean section, induction of labour, epidural block and instrumental birth in NSW private hospitals are equally efficacious as those in NSW public hospitals. We are, after all, analysing women in the same state of the same country for the same period of time, and socioeconomic and measured clinical factors suggest that the group least at risk

of adverse outcomes (the privately insured) is experiencing much higher rates of birth interventions. Either privately insured women are experiencing many unnecessary interventions, partly at the expense of the Australian taxpaying population, or publicly insured women are being denied access to best practice care through inadequate levels of intervention. Health care services cannot have it both ways. Furthermore, in both public and private settings, we have documented a pronounced upward trend in most interventions. It is surely quite proper to question whether these trends are positive or negative — they are certainly cost-enhancing.

Brett Shorten

Research Fellow, Centre for Health Services Development

Allison Shorten

Senior Lecturer (Midwifery), Department of Nursing
University of Wollongong, Wollongong, NSW 2522
ashorten@uow.edu.au

Dodd J & Robinson J 2004, Commentary: public and private intervention rates in obstetric practice, *Australian Health Review*, vol. 27, pp. 9-12, viewed 8 Sep 2004, <<http://www.aushealthcare.com.au/documents/publications/30/issues/509/articles/733/Dodd.pdf>>.

Shorten B & Shorten A 2004, Impact of private health insurance incentives on obstetric outcomes in NSW hospitals, *Australian Health Review*, vol. 27, pp. 27-38.

(Received 2 Jul 2004, accepted 8 Jul 2004)

