AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

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MATERNITY CARE IN COUNTIES MANUKAU FAILS MOTHERS & BABIES

The report of the review of maternity care in the Counties Manukau DHB area was released on 15 November. Commissioned by the Counties Manukau DHB, the Maternity Care Review Panel was chaired by Professor Ron Paterson and panel members included Anne Candy, Siniua Lilo, Professor Lesley McCowan, Dr Ray Naden and Maggie O'Brien.

In the Chairman's Foreword, Ron Paterson stated that many women with high needs do not have access to an adequate standard of maternity care, and that decisive action is needed to address the underlying population health factors that contribute to Counties Manukau's high rates of perinatal mortality.

Nothing new

The contributing factors to the rate of perinatal mortality and morbidity in Counties Manukau identified in the report are not new to many of the health professionals and consumer groups who have been involved in maternity care in the Auckland region over the past decade. Attempts have been made over the years to draw attention to the concerns of women about the state of maternity care in South Auckland and to get the DHB or the Ministry of Health to act. The general public knew almost nothing about the problems because, unlike other DHBs, the vast majority of items about maternity services in the Counties Manukau DHB meeting agenda papers took place behind closed doors.

What finally led to the commissioning of this review was the 5th Annual Report of the National Perinatal and Maternal Mortality Review Committee (PMMRC) which identified that Counties Manukau had a significantly higher perinatal mortality rate than the rest of New Zealand, particularly among Maori and Pacific women.

Access to LMC midwives and continuity of care

One of the issues identified by the review was that pregnant women in Counties Manukau do not have the same level of access to self-employed midwives that women in other DHBs do.

Only 51% of pregnant women in Counties Manukau have their primary maternity care provided by an LMC midwife. There are a number of reasons behind the low numbers of LMC midwives providing care in South Auckland. Many women in this area are living in poverty, have few resources and when they are pregnant they present with complex health, financial and social needs. Because the Section 88 funding mechanism is a one-size-fits-all payment system which has no financial incentives to provide the extra care that these women need, self-employed midwives are understandably reluctant to take on these women and provide LMC care.

The other models of care available in South Auckland are what are referred to as case-loading DHB midwives, and shared care in which maternity care is shared between a GP and the Counties Manukau DHB midwifery team. Neither of these two models of care provides the same level of continuity of care that LMC midwifery care does, and there have been

complaints about the shared care arrangement for many years. There are concerns about the knowledge, expertise and skills of the GPs providing shared maternity care in South Auckland, some of whom are not appropriately qualified to provide maternity care. It is doubtful as to whether they engaged in continuing medical education activities that focus on providing primary maternity care, and whether they are vocationally registered.

The maternity care provided by this shared care model is substandard and the maternity groups have been aware for some years that pregnant women were not being advised of their options by the shared care GPs. Women have rung complaining about the care they received, their lack of choices, being seen by different doctors and midwives during their antenatal visits, and the unacceptably few postnatal visits.

The inadequate level of maternity care being provided in South Auckland has been allowed to continue for a number of years and this has undoubtedly contributed to self-employed midwives not wanting to work there. It should not have taken a PMMRC report to finally galvanise Counties Manukau DHB into action, if indeed they have been galvanized into action.

MOH responsibility

The Ministry of Health must also share some of the responsibility for the current situation. The Ministry has permitted the Counties Manukau DHB to continue flouting the maternity service requirements that other DHBs were required to meet. Concerns about the situation in Counties Manukau have been expressed at both national and regional meetings during the past decade. When exceptions to maternity service requirements are permitted it is of course the mothers and babies who suffer the consequences.

Increase in Section 88 funding

The increase in Section 88 funding that midwives obtained this year was insufficient and will do nothing to improve the LMC midwifery shortage in South Auckland. The NZ College of Midwives made extensive submissions to the Ministry about the need to increase the Section 88 fees as there had been no fee increase since 2007. The result was a small increase in fees for first trimester care and for postnatal care. It is woefully inadequate and does little to cover the increased workload midwives have to take on. It also will not cover the extra maternity care and support needed by mothers in South Auckland who have complex health and social needs.

Mothers in Counties Manukau

The report notes that 14% of all births in New Zealand are to women residing in Counties Manukau. Approximately 8,500 babies are born each year to women living in the CMDHB area, of whom more than 50% are born to Maori or Pacific mothers, and to mothers who predominantly live in areas of high socioeconomic deprivation. Maori and Pacific mothers are more likely to have a stillborn baby or to lose a baby in the neonatal period compared to European mothers.

The report notes that Counties Manukau has more women with high health needs during pregnancy than any other part of the country. These include obese women, smokers, teenage mothers and older mothers

who have had several pregnancies. However, in one of two reports produced for the CMDHB, researcher Dr Catherine Jackson, commented that "ethnicity was not an independent risk factor for perinatal death, ie it is not being Maori or Pacific that places you at higher risk. It is the increased odds of exposure to risk factors such as smoking, obesity, premature birth, etc."

While the review was commissioned by the CMDHB and the report was focused on the issues and the needs of the women in South Auckland, there were many factors described in the report that also apply to women in West Auckland.

All women are vulnerable

The Panel interviewed staff and self-employed LMC midwives and asked about services provided to vulnerable women. They were repeatedly told that "all women are vulnerable." The report notes that Dr Jackson concluded that 81% of women who delivered at CMDHB facilities during 2007-2009 would be classified as high risk based on the PMMRC criteria, but cautioned that this serves to highlight "the limitations of a high-risk approach in a population that is predominantly high risk."

It is essential that all CMDHB women are provided with high quality maternity care, not just those singled out as being "vulnerable." Improving services to all women avoids stigmatising or marginalising particular groups of women who are assessed, labelled and subsequently assigned to receive special services. All women are entitled to a high standard of maternity care, including continuity of care, not just those identified as "most vulnerable."

The recommendations

The report contains a raft of recommendations for improving both maternity care and reproductive health services in Counties Manukau. Many of the recommendations have the word "urgent" attached to them.

The Panel makes a strong statement at the beginning of the report about "the critical importance of providing care in a culturally appropriate manner." One of the recommendations refers to the need to ensure "that educational material and information is provided in a variety of languages, that the maternity workforce better reflects the wider community, and that maternity care is provided in a manner that more appropriately meets the needs and requirements of different cultural groups."

Other recommendations include:

- encourage women who are healthy and have a normal pregnancy to opt for midwifery care and to birth at a primary birthing unit
- seek an urgent review by the Ministry of Health of the section 88 funding mechanism for LMCs nationally, in order to create incentives to provide care for women who have clinical or social risk factors
- encourage midwives to work as self-employed practitioners in the CMDHB region and increase the number of LMCs available
- review, as a matter of urgency, the current delivery and funding of family planning services in the CMDHB area, with a view to increasing access to these services, particularly for young and "at-risk" women
- consider the establishment of a local non-surgical termination of pregnancy service at Counties Manukau
- improve access to pregnancy related ultrasound scanning

- implement an integrated maternity information system

The prioritisation of the vulnerable
There are four recommendations concerning vulnerable women:

- establish a set of criteria to define and identify the most socially and medically vulnerable pregnant women
- establish a vulnerable women's multi-disciplinary group to refer vulnerable women to
- consider ways in which those identified as most vulnerable can be provided with continuity of care
- urgently consider the development of comprehensive social worker and/or community health worker support services, to assist pregnant women to address the social factors that impact on their health status.

The report also stresses the importance of getting women to attend "a full pregnancy assessment appointment" with a midwife or GP in the first 10 weeks of pregnancy. About 25% of pregnant women in Counties Manukau do not have any antenatal care and this group has the highest perinatal mortality rate.

However, until a system of high quality, culturally appropriate maternity care is established in Counties Manukau pregnant women will remain isolated from the services they need. Defining them as one of those in the "most socially and medically vulnerable" group is also unlikely to win them over.

A copy of the *External Review of Maternity Care in the Counties Manukau District* is available at: http://www.cmdhb.org.nz/News_Publications/Reports/report-external-maternitycare-review.pdf

THE BATTLE FOR THE TRUTH ABOUT TAMIFLU

In an unprecedented move the *British Medical Journal* (*BMJ*) has begun an online open data campaign in an effort to achieve independent scrutiny of data from clinical trials. The major target of its first initiative is Roche, the pharmaceutical company that manufactures the antiviral drug oseltamivir, more commonly known as Tamiflu. On its website the *BMJ* states that "working with others, we seek to highlight problems caused by lack of access to data, and we welcome any suggestions on how to take things further." (1)

Around 2008/2009 New Zealand was one of many countries around the world that began spending millions of dollars on stockpiling Tamiflu which Roche claimed was the drug of choice for the treatment and prevention of influenza A and B viruses. When the H1N1 (swine flu) pandemic began in mid 2009, demand for Tamiflu skyrocketed.

How effective is Tamiflu?
The US Department of Health and Human Services said it would save lives and reduce hospital admissions. The European Medicines Agency said it would reduce complications. The Australian and New Zealand health agencies agreed. (2) But where is the evidence to support these claims?

This is where the Cochrane Collaboration comes into the picture. The Cochrane Collaboration is a vast independent non-profit international collaboration of academics that produces hundreds of systematic reviews on medicines every year. Given the enormous sums of money

that were now being spent on Tamiflu, the UK and Australian governments asked the Cochrane Respiratory Diseases Group to update its earlier reviews on Tamiflu.

The previous review published in 2008 had found some evidence that Tamiflu did indeed reduce the rate of complications associated with the flu virus. However, an online comment posted by a Japanese paediatrician called Keiji Hayashi alerted Tom Jefferson, the head of the Cochrane Respiratory Group that he had made a mistake. According to Ben Goldacre, the author of "*Bad Pharma*," this comment triggered "a revolution in our understanding of how evidence-based medicine should work." (2)

Basically what Keiji Hayashi pointed out was that Tom Jefferson's positive findings were based on data from one paper, an industry-funded meta-analysis which summarised the findings of 10 earlier trials of which only two have ever been published in the scientific literature. The two trials that were published were funded by Roche, authored by Roche employees and Roche-paid "external" experts. The results of eight key trials of Tamiflu were never fully published, and a brief summary concluded that there was insufficient data to show it reduced complications. This means the data is not reliable enough.

Realising that Keiji Hayashi was quite right, Tom Jefferson contacted Roche and asked for the missing data. This was the beginning of what has so far been a three-year battle and which led to the *BMJ*'s open data campaign.

In an open letter to Roche about the Tamiflu trial data, *BMJ* editor, Fiona Godlee wrote "The Cochrane reviewers now know that there are at least 123 trials of oseltamivir [Tamiflu] and that most (60%) of the patient data from Roche's phase 3 completed treatment trials remain unpublished. We have concerns on a number of fronts: the likely overstating of effectiveness and the apparent under-reporting of potentially serious adverse effects." (3)

After three frustrating years of trying to get access to the data, Tom Jefferson and his colleagues have given the *BMJ* their entire email correspondence with Roche, and shared their correspondence with the World Health Organisation (WHO) and the US Centers for Disease Control and Prevention. (1)

WHO's independence questioned

Questions were raised in 2010 about the role of WHO and the secrecy surrounding the identities of the 16 emergency committee members formed to advise it on the H1N1 pandemic. Articles published in the *BMJ* in June 2010 raised concerns about whether the pharmaceutical industry had insiders on the WHO emergency committee. (4)

In February 2012 Tom Jefferson emailed WHO, asking WHO scientists how its review process had led to it including Tamiflu in its March 2011 "essential medicines" list. Had it asked the manufacturers of neura-minidase inhibitors such as Tamiflu and Relenza for the unpublished trial data? And what had they made of Cochrane's conclusion "that there is no evidence that oseltamivir can limit the spread of influenza."

WHO told Tom Jefferson that it had commissioned several evidence

reviews, including one on Tamiflu that would shortly appear in a peer reviewed medical journal. It promised to alert him when the review appeared. (5)

Tom Jefferson was even less impressed with the response he received from the Center for Disease Control. Even the US Food and Drug Administration described Tamiflu's effects as modest.

"Despite this, WHO and CDC have been extensively promoting the drug. WHO has made Tamiflu one of the essential drugs, so it sits next door to aspirin, penicillin, cortisone," he said.

Ben Goldacre says in his new book, "Drug companies around the world have produced some of the most amazing innovations of the past fifty years, saving lives on an epic scale. But that does not allow them to hide data, mislead doctors, and harm patients." (2)

In New Zealand we have Medsafe. But the only information on Tamiflu on Medsafe's website is produced by Roche which claims that Tamiflu can prevent you from catching the flu. (6) There is actually no evidence that Tamiflu is any better than an aspirin.

References

1. http://www.bmj.com/tamiflu
2. Ben Goldacre. "*Bad Pharma*." Fourth Estate. 2012.
3. http://www.bmj.com/tamiflu/roche/rr/611576#alternate
4. http://www.womenshealthcouncil.org.nz/Features/Hot+Topics/Swine+Flu+-+H1N1.html
5. David Payne. "Tamiflu: the battle for secret drug data." *British Medical Journal*. 2012;345:e7303
6. http://www.medsafe.govt.nz/consumers/cmi/t/tamiflusus6.pdf

AWHC GENERAL MEETING 6 December 2012

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- COGS grant results
- PHARMAC & medical devices
- Ethics committee meeting
- Cervical Screening Governance Group's Strategic Plan

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.

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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for December 2012:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 12 December 2012 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 5 December 2012 followed by the Full Board meeting at 2pm. Both meetings will be held in the A+ Room, Clinical Education Centre, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Counties Manukau DHB Full Board meeting will be held at 1pm on Wednesday 5 December 2012 at 19 Lambie Drive, Manukau City.

ETHICS COMMITTEE meetings – dates for the four new ethics committees are at: http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes

'Gender Matters: Determining Women's Health'

The Australian Women's Health Network is holding its 7th Australian Women's Health Conference in Sydney from 7 – 10 May 2013.

The conference will focus on showcasing cutting edge research and best practice approaches in women's health policy and practice locally, across Australia and internationally.

For further information go to http://www.womenshealth2013.org.au/