RANZCOG™
Excellence in Women's Health

Te Kāhui Oranga ō Nuku

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Education and Workforce Committee
Parliament Buildings
Wellington
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# Accident Compensation (Maternal Birth Injury and Other Matters) Amendment Bill

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) supports amendments to Accident Compensation legislation to enable more women to access the care that they need after experiencing birth injuries. We recommend some changes to the current bill to ensure that it is fair and equitable.

RANZCOG would appreciate the opportunity to speak with the Committee.

## About RANZCOG

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is a not-for-profit organisation dedicated to the establishment of high standards of practice in obstetrics and gynaecology and 'excellence in women's health'. The College trains and accredits doctors throughout Australia and New Zealand in the specialties of obstetrics and gynaecology. The College also supports research into women's health and advocates for women's healthcare by forging productive relationships with individuals, the community, professional organisations, and government.

In New Zealand, RANZCOG's Te Kāhui Oranga ō Nuku supports College activities, taking into account the context of the New Zealand health system and the needs of women in Aotearoa New Zealand. A particular focus of Te Kāhui Oranga ō Nuku, and its sub-committee He Hono Wāhine, is recognising Māori as tangata whenua and supporting initiatives that will improve equity of outcomes.

## Objectives

RANZCOG welcome changes to the accident compensation system that enable the needs of women in Aotearoa New Zealand to be better met. Birth injuries left untreated, are incredibly debilitating and have long term negative consequences for women and their whanau. Delays in accessing assistance are common and create inequities for women.

According to the explanatory note the bill has two main objectives:

- to provide more equitable coverage for injuries covered by the Accident Compensation Scheme (the AC Scheme), particularly with respect to addressing gender inequity

- to provide greater clarity for claimants, and to better give effect to the policy intent of the Accident Compensation Act 2001 (the AC Act).

We support these aims. We suggest an additional objective on enacting commitment to Te Tiriti o Waitangi and equitable care for Māori, so that ACC works toward bridging disparities for Māori.

## Recommended changes

### 1. Scope of cover for physical injuries

It is RANZCOG's view that all birth injuries that result from Section 25 (1) f, *an application of a force or resistance internal to the human body at any time from the onset of labour to the completion of delivery that results in an injury,* should be covered under this legislation.

We note that in preparation for the proposed changes to the Accident Compensation Act the Ministry of Business, Innovation and Employment (MBIE) considered three options for cover:

- *2 (a) extend cover to a specified list of obstetric injuries caused to birthing parents during labour and delivery that fall under a scoping definition of 'obstetric injuries'.*
- *2(b): extend cover to all injuries that meet a definition of obstetric injury in the AC Act, for example, mechanical trauma caused by labour and delivery (i.e., do not specify the injury types which may be covered as a result).*
- *2(c): define foetus as a 'force external to the body', so all injuries caused by the foetus to the birthing parent during labour and delivery would be considered to be caused accidents under the AC Act.*

MBIE's Regulatory Impact Analysis Review Panel recommended option 2(a) which would limit cover to injuries in a specified list. This preference is reflected in the proposed changes to the act with Schedule 3A listing all injuries that will be funded should the act amendments be passed. The factors which influenced the decision to limit the injuries covered to a specified list were principally cost containment and administrative ease, on the basis that a list would better enable consistency of decision making between assessors.

It is our considered view that the decision to limit injuries to a specified list (option 2a) does not support the objectives of the bill:

- with respect to equity, not all injuries that are related to the internal forces of childbirth will be covered under these changes
- with respect to providing greater clarity for claimants, we can agree that if claim acceptance is automatic for those with an injury on the list this may speed up their claim process but leave others whose injury if 'off the list" unclear as to why or what their future options might be.

RANZCOG is concerned that the consequence of incomplete cover will be the creation of complexity and confusion over responsibility for funding of care, which will further increase health inequities in our most vulnerable populations. We believe that concerns in relation to administrative matters and consistent interpretation of claims could be addressed with appropriate training, resources, and access to expert advice. This would seem to be no more complex than the process for treatment injuries or other accidents covered in the act, for which there is no specified list.

The problem with a list of very specific injuries is that it is intentionally exclusive. If the injuries are described very generally the benefits of administrative ease are lessened. If the injuries are too specifically described, then injuries that fulfill the intention of the act but are not listed will be

denied cover. We note that in preparation for these changes, expert input was sought from some obstetrician and gynaecologists. There was not however an opportunity for wider discussion and consensus, or input from RANZCOG.

The injuries currently proposed in the bill to be covered are:

- *Labial, vaginal, vulval, clitoral, cervical, rectal, and perineal tears*
- *Levator avulsion*
- *Obstetric fistula (including vesicovaginal, colovaginal, and ureterovaginal)*
- *Obstetric haematoma of pelvis*
- *Pudendal neuropathy*
- *Ruptured uterus during labour*
- *Uterine prolapse*

RANZCOG notes that some of the birth injuries absent from schedule 3A are:

- Anal injuries without rectal involvement
- Fecal incontinence not associated with a tear or episiotomy but related to neurological damage
- Skeletal injuries, coccydynia, symphysis pubis diastasis
- Neurological injuries beyond a pudendal neuropathy, for example compression and stretch injuries to other pelvic nerves such as the femoral cutaneous, femoral, lumbo-sacral plexus, sciatic and obturator nerves
- Acute post-partum urinary incontinence and other bladder dysfunction including urinary retention
- Vaginal prolapse (we note that uterine prolapse is included)
- Loss of organ such as hysterectomy due to prolonged labour
- Urethral injuries
- Psychological or mental health issues caused by birth trauma

Given the complexity and risk of having a list of eligible injuries, we advise against it. However if the Committee, after reviewing feedback, recommends retaining a specified list then we strongly advise that there is a robust and inclusive process to further develop the list before the bill progresses.

## 2. Commencement of cover

The changes to the act enable women who give birth after 1 October 2022 to get ACC funded support. Women whose injuries predate 1 October 2022 are excluded from cover. We believe that all women with birth related injuries should have access to the care necessary to restore them to good health. At the present time many women are not getting access to this care within the publicly funded healthcare system. Further, access is varied and inequitable across different DHBs.

We recognise that there is no funding provision for injuries that predate the legislation. However, we would like on public record our concern for the many women with historic functional impairments related to birth injuries who are currently not meeting thresholds for care within the health system. These proposed changes to the act will significantly improve access to care for many women with birth related injuries, which we applaud, but will increase the inequity between those who have access to ACC funded care and those whose care will remain within the health system.

### 3. Timeline for lodging claims

RANZCOG notes that the timeline for claiming cover for birth injuries must extend beyond 12 months of injury. While some birth related injuries will be apparent at the time of birth others, such as prolapse, can take some time, sometimes some years, to become evident.

### 4. Reimbursement and funding gap cover

RANZCOG is concerned that ACC funding may not cover the full cost of treatment for some care. At the present time many interventions, such as physiotherapy, for ACC funded injury are associated with a co-payment of between $25 and $30 or higher per visit. For women from more deprived circumstance this will equate to a barrier to care and exacerbation of inequities.

## Wider issues

### 5. Injuries to baby

We note that injuries to the baby during birth are not included in this amendment. If the force of labour is recognised as a potential damaging force capable of injury to the birthing woman, then it seems inequitable to not consider funding injuries to the baby that occur as a result of the same force.

### 6. Equity and Te Tiriti o Waitangi

We are concerned that Māori women will be less likely to benefit from the funding changes the bill proposes. Māori are less likely than others to receive help from ACC for injuries and are less likely to be referred by a medical practitioner to ACC. It will be important that there is consultation with Māori on implementing these changes and that proactive steps taken to assist Māori women to access care.

### 7. Investment in prevention

This proposed amendment to the Accident Compensation Act goes part of the way to addressing many of the childbirth related impacts on pelvic floor dysfunction. However, the investment in addressing injuries postnatally needs to be combined with investment in prevention including education, screening, and antenatal physiotherapy.

Pelvic floor physiotherapy is an important and valuable investment in women's health, and when provided antenatally is likely to reduce adverse outcomes postpartum. This approach is supported by good evidence. Pelvic floor physiotherapy, in particular has been shown to be a cost effective intervention in pregnancy, reducing the severity of the impact of childbirth on pelvic floor function. RANZCOG calls for ACC investment in intrapartum injuries to be accompanied by an investment in prevention, possibly via collaboration between ACC and the health sector.

There has recently been strong advocacy to the Health Select Committee from the multidisciplinary advisory group, APHERM (Advocating Pelvic Health Empowerment and Rehabilitation for Mothers) calling for a multidisciplinary plan and investment in prevention "*To improve pelvic floor health for New Zealand women pre and post birth*". RANZCOG supports this call.

## 8. Workforce and training issues

If this amendment to the Accident Compensation Act is successful the increased funding will result in an increase in demand for care from the healthcare workforce, particularly physiotherapists and gynaecologists. We know from the national network of obstetrics and gynaecology Clinical Directors, that there are currently insufficient numbers of qualified pelvic health physiotherapists to meet the demands for pelvic floor physiotherapy in DHBs and the private sector. A workforce assessment and plan is needed if the intended benefits from the amendment are to be realised.

It seems likely that any ACC funded gynaecological surgery required as a result of a birth injury will move to the private sector, unless there are funding arrangements between ACC and the public health system. Access to theatre for gynaecological surgery is already constrained in most DHBs. Gynaecological specialists will be incentivised to reduce their hours of work in the public sector to meet increasing private demand. Loss of specialists or specialist time to private practice raises concern about the workforce for provision of obstetric and gynaecological care in our public hospital system. In addition, there will be lost opportunities for specialist training if an increased proportion of gynaecological surgery occurs within the private sector. RANZCOG is already concerned about the opportunities for surgical training of doctors on the RANZCOG training programme, as service capacity limits care and more gynaecological conditions are managed by non-surgical means.

RANZCOG continues to advocate for health workforce planning and recommends that more detailed workforce and demand forecasting, and workforce planning, is undertaken. It will be important that the impacts of ACC cover for birth injuries, on both workforce needs and training, is considered.

## 9. Need for an integrated approach

It is important to look at the problem these changes are seeking to address (access to appropriate treatment for the adverse consequences of the birth process on a woman's health) in the broader context of the obligations and limitations of the current health system.

We believe all women should have access to the healthcare necessary to ensure they are well cared for before, during and after pregnancy to ensure the best outcome for mother and baby. While we welcome the added benefit the proposed changes will provide for some women, we are concerned that other women with the same problems, but with aetiology that does not fit with the definitions under the act, will miss out.

We are in the midst of major and significant changes to our health system structure. We have, in our recent submissions to the Pae Ora (Healthy Futures) Bill, called for a more strategic, planned and equitable approach to women's healthcare delivery. The current arrangement of health services aimed at improving women's health is fragmented at all levels, meaning that approaches are not well joined up or equitable.

Whatever the final changes in ACC funding for birth related accidental injury, the health system needs to ensure that there is equitable access to care for women with similar problems but different aetiology. This requires an overarching strategic and whole system approach to women's health, to reduce siloed approaches and create alignment and equity.

RANZCOG would appreciate the opportunity to speak with the Committee about our comments. Please contact Catherine Cooper, RANZCOG Head of Aotearoa New Zealand and Global Health on ccooper@ranzcog.org.nz for arrangements.

Ngā mihi

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