Mini-Commentary on BJOG-22-0480.R1 'Perinatal outcomes of socially disadvantaged women in Australia: A population-based retrospective cohort study'.

David Ellwood[1]

[1]Griffith University

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Mini-Commentary on BJOG-22-0480.R1: *'Perinatal outcomes of socially disadvantaged women in Australia: A population-based retrospective cohort study '*

David Ellwood

Griffith University - School of Medicine

Griffth Health Centre, Gold Coast campus, , Southport, Queensland 4222

Australia

Clinicians involved in perinatal care have always been excellent recorders of data around the time of birth and now most high-income countries maintain comprehensive registers, which give insight into pregnancy and birth and help us to understand how maternal and other characteristics contribute to outcomes. The paper by Faulks et al (BJOG 2023) is illustrative of the way in which well-maintained registers of perinatal data can be used to allow researchers to interrogate the information and draw important conclusions. This Victorian study of over a million women and their babies, using data collected over nearly two decades, shows very clearly that, even in a high-income country such as Australia with a well-resourced and highly organised health system, social disadvantage is a strong predictor of health outcomes.

So, what should we do with this information? I can think of three main areas of health policy and practice which should be influenced by these findings. Firstly, those involved in designing prediction models and risk assessment tools should consider using objective measures of social disadvantage in the algorithms, as it is likely that the current approach underestimates actual risk of adverse perinatal outcomes. Secondly, prevention strategies must go beyond the clinical and look at how models of care, such as continuity of midwifery care, can help to overcome the likely contributors to adverse outcomes such as access, cultural and social safety, and lack of emotional and social support. Thirdly, the message for governments must be that improving perinatal outcomes is as much about social interventions as delivering effective health systems. In 2023, Australians are experiencing serious cost of living pressures, increasing housing insecurity and homelessness. A better start to life for the next generation requires urgent attention to these social determinants of perinatal health or else a repeat study in 15 or 20 years will paint an even bleaker picture.

There is one strong positive from these data and one important negative. The smoking rate after 20 weeks of pregnancy was only 6%, and given that the most recent of these data are nearly 7 years old the current situation may be even better. This is a mark of success of public policy, although we can still do better and strive to improve smoking cessation strategies and reduce this rate further to below 5%. The negative is that the authors were unable to comment on the impact of Indigenous status on the relationship between social

disadvantage and adverse perinatal outcomes. Efforts to close the gap in perinatal health outcomes should make it mandatory that more effort is put into ensuring that all health registers record this information.

Finally, it is of interest that the only outcome not related to social disadvantage was caesarean section. There are many ways to interpret this, but it is likely that the high rate of caesarean section in less disadvantaged women receiving private obstetric care has skewed the data. Whether this means that there are too many operative births for those without disadvantage, or too few being performed for those who are disadvantaged, requires further data analysis.