

# A new age has come: the redefinition of women's health care

Johannes Bitzer,<sup>1</sup> Andrew W Horne<sup>2</sup>

<sup>1</sup>Vice-Chairman, Department of Obstetrics and Gynaecology, University Hospital Basel, Basel, Switzerland

<sup>2</sup>Senior Lecturer and Consultant Gynaecologist, MRC Centre for Reproductive Health, University of Edinburgh Queen's Medical Research Institute, Edinburgh, UK

## Correspondence to

Professor Johannes Bitzer, Universitätsspital Basel Frauenklinik, Vorsteher und Chefartz, Spitalstrasse 21, Basel, CH-4031, Switzerland; jbitzer@uhbs.ch

Received 24 October 2011

Accepted 13 February 2012

## Background

A recent report from the Royal College of Obstetricians and Gynaecologists (RCOG), *High Quality Women's Health Care: A Proposal for Change*, published in July 2011, is proposing a radical change to the way UK women's health services are structured.<sup>1</sup> It is an exciting document that attempts to address the current challenges in women's health care and it is relevant, not only to the UK, but also to all of us throughout the European Union.

## The delivery of women's health in the current configuration cannot be sustained in Europe

As health service providers, we are all working against a backdrop of increasing financial and workforce pressures, rising health care demand and, in some countries, government-driven health service reforms. Clearly, there is an urgent need to think laterally about how services can be provided, and by whom, to ensure that the required efficiency savings can be achieved without compromising on quality of care. In the 2009 RCOG publication, *The Future Workforce in Obstetrics and Gynaecology*, it was clear that hospitals in the UK could not continue to provide the full range of obstetrics and gynaecology services that they currently offered.<sup>2</sup> These findings are echoed in the 2011 RCOG report, which concludes that "the status quo is not an option and the delivery of women's health care in the current configuration will not be sustainable".<sup>1</sup> This applies throughout Europe.

## A 'life-course' approach to the reconfiguration of women's health services

The 2011 RCOG report proposes that the solution to this problem is to facilitate a shift from the traditional health care model to a 'life-course model' of a women's health service.<sup>1</sup> The 'life-course model' has two major components: early programming and cumulative pathways.

The 'early programming' model has grown out of the seminal work by Barker.<sup>3</sup> For example, Barker has demonstrated that the lower the weight of a baby at birth and during infancy, the higher the risk for coronary heart disease in later life. The 'cumulative pathways' model is a model of risk accumulation. It proposes that episodes of illness, adverse social circumstances, exposure to environmental toxins and unhealthy behaviour can lead to a decline in health and function over time. Thus, we are advised by the 2011 report to view women's health as the product of a dynamic and complex interplay of biological, behavioural, psychological, social and environmental factors over a woman's lifetime. It is hoped that by adopting this approach to delivering health care, health care providers will be able to provide women with consistent information from a young age, enabling them to make better decisions about their own health.

## Commissioning women's health through a managed women's health network

The RCOG vision is that health care is redesigned and reinvented to shape how women's health develops over the 'life-course'. This concept aims to encourage the transition of activity from secondary to community settings and will therefore have an impact on the configuration of the delivery of all current health services. To achieve this aim, the report advocates the development of a managed clinical network specific to women's health. A managed clinical network is defined as "linked groups of health professionals and organisations from primary, secondary, and tertiary care working in a co-ordinated manner, unconstrained by existing professional and [organisational] boundaries to ensure equitable provision of high quality effective services".<sup>4</sup> As an example, the new 2011 report refers to the successful gynaecological cancer network in the UK.<sup>1</sup> For ovarian cancer, with the development of networks and centralised

specialist care, the overall improvement in 5-year survival has been 10–15%.<sup>5 6</sup> The RCOG identifies the key drivers in its success as national clinical leadership, subspecialisation, financial support for network review, political priority to succeed and implementation of targeted national policy (waiting times), continuous focus on quality and high quality data. A theoretical new UK 'women's health network' would focus on health promotion, use current contact opportunities (such as rubella screening, human papillomavirus vaccination, cervical cytology, contraception, pregnancy, menopause) to promote a healthy lifestyle and potential interventions, incentivise the public and professionals to embrace the public health agenda, and create opportunities for the public to be educated from an early age to stay healthy from birth and throughout their lives.

### Changes to current service design

The 2011 RCOG report anticipates that the introduction of the women's health network will result in the delivery of more care in a community setting.<sup>1</sup> It predicts that an increasing number of hospital consultants will be expected to develop specialist services in the community, in partnership with general practitioners. Examples in gynaecology include heavy menstrual bleeding, pelvic pain, urogynaecology, contraception and medical termination of pregnancy services. As an example in obstetrics, the report recommends more midwife-led deliveries. This statement has subsequently been supported by the recent publication of the Birthplace Study<sup>7</sup> that demonstrated that low-risk women planning birth in a midwifery unit experience fewer interventions than those planning birth in an obstetric unit with no impact on perinatal outcomes. The RCOG accepts that their concept of service design is visionary and that there will be many challenges. They therefore recommend the UK appointment of a National Women's Health Clinical Director to champion implementation and provide leadership.

### Comments on the 2011 report

The 'life-course model' proposed by the RCOG to reform women's health services offers an extraordinary opportunity to redefine essential services for women's health care, to redesign organisation and delivery of women's health care, and to invest in primary prevention and health promotion throughout Europe. It is not a new model and has been most recently discussed in the context of President Obama's 2010 Patient Protection and Affordable Care Act.<sup>8</sup> However, it provides a realistic alternative to Europe's current model of delivering women's health care that is definitely not set up to optimise women's health development across the lifespan. The development of a managed women's health network to support this 'life-course model' would appear to offer several important advantages to patients and clinicians. Managed clinical networks have the ability to respond quickly to a rapidly changing

environment, and have emerged as a way of sustaining vulnerable services and maintaining access where the requirements of training or subspecialisation would otherwise mean complete closure of local services. They also offer a way of making the best use of scarce specialist expertise, standardising care, and improving access to care. In addition, networks can stimulate creativity and innovation by providing increased opportunities for interaction of people from different disciplines and organisations. However, Journal readers might be justifiably sceptical of the RCOG's interest in a managed clinical network. Historically, the RCOG has been fond of structural solutions to its problems, even though experience suggests that reorganisation can be a distraction, often fails to solve the problems it was supposed to address, and can create new ones. Furthermore, the proposed RCOG changes with respect to hospital consultant roles and setting of care bring with them with the problems of competing priorities, potential fragmentation of care, and possible confusion about responsibilities. Thus, obstetricians, gynaecologists, sexual and reproductive health specialists and general practitioners throughout Europe need to be both informed and involved in the new RCOG proposals. European doctors need to speak up and direct the reforms in women's health.

**Competing interests** None.

**Provenance and peer review** Commissioned, externally peer reviewed.

### References

- 1 Royal College of Obstetricians and Gynaecologists. *High Quality Women's Health Care: A Proposal for Change*. 2011. <http://www.rcog.org.uk/files/rcog-corp/HighQualityWomensHealthcareProposalforChange.pdf> [accessed 11 February 2012].
- 2 Royal College of Obstetricians and Gynaecologists. *The Future Workforce in Obstetrics and Gynaecology*. 2009. <http://www.rcog.org.uk/files/rcog-corp/uploaded-files/RCOGFutureWorkforceFull.pdf> [accessed 11 February 2012].
- 3 Barker DJ. The fetal and infant origins of adult disease. *BMJ* 1990;301:1111.
- 4 Scottish Executive. Department of Health. *Introduction of Managed Clinical Networks Within the NHS in Scotland*. 2009. [http://www.sehd.scot.nhs.uk/mels/1999\\_10.htm](http://www.sehd.scot.nhs.uk/mels/1999_10.htm) [accessed 11 February 2012].
- 5 Soegaard Andersen E, Knudsen A, Svarrer T, *et al*. The results of treatment of epithelial ovarian cancer after centralisation of primary surgery. Results from North Jutland, Denmark. *Gynecol Oncol* 2005;99:552–556.
- 6 Oksefjell H, Sandstad B, Tropé C. Improved survival for stage IIIC ovarian cancer patients treated at the Norwegian Radium Hospital between 1984 and 2001. *Eur J Gynaecol Oncol* 2007;28:256–262.
- 7 Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011;343:d7400.
- 8 Lu MC. Healthcare reform and women's health: a life-course perspective. *Curr Opin Obstet Gynecol* 2010;22:487–491.