Cour des comptes

Chambres régionales
& territoriales des comptes

PERINATAL POLICY

Mediocre health results, greater mobilisation required

Thematic public report

Summary

May 2024

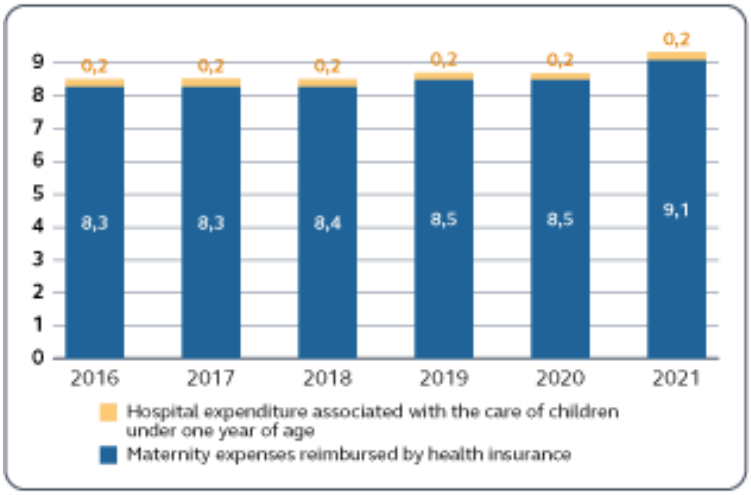
Summary

Perinatal as a concept encompasses situations relating to birth, and has wider or narrower meanings depending on the definition used. In this report, it is defined as the period from the end of the first trimester of pregnancy until the infant is one year old.

The end of pregnancy and the first few months after giving birth are a delicate period for infant development. Many factors determine the child's physical and psychological well-being and emotional and cognitive development. Their effects can be immediate, but they can also be manifest throughout an individual's life and have considerable consequences for healthcare costs. This period also presents specific challenges for women's health in particular and parenting support in general, involving issues of prevention, care and follow-up.

While the resources earmarked for perinatal policy are increasing (€9.3 billion in 2021, up 9 % on 2016) and the birth rate is falling (-5.3 % over the same period), the mediocre health results observed call into question the efficiency of the allocated resources.

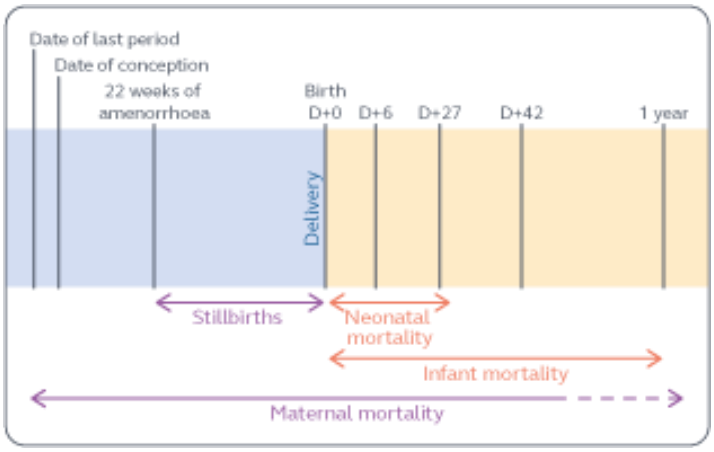
Summary of expenditure on perinatal policy (€bn)



Source: CNAM (National Sickness Insurance Fund), mapping of pathologies and Sickness Insurance expenditure (all schemes combined) and ATIH (Technical Agency for Information on Hospital Care)

The main perinatal health indicators - stillbirths, neonatal mortality and maternal mortality - highlight France's mediocre performance compared with other European countries. Perinatal health has moreover deteriorated in recent times

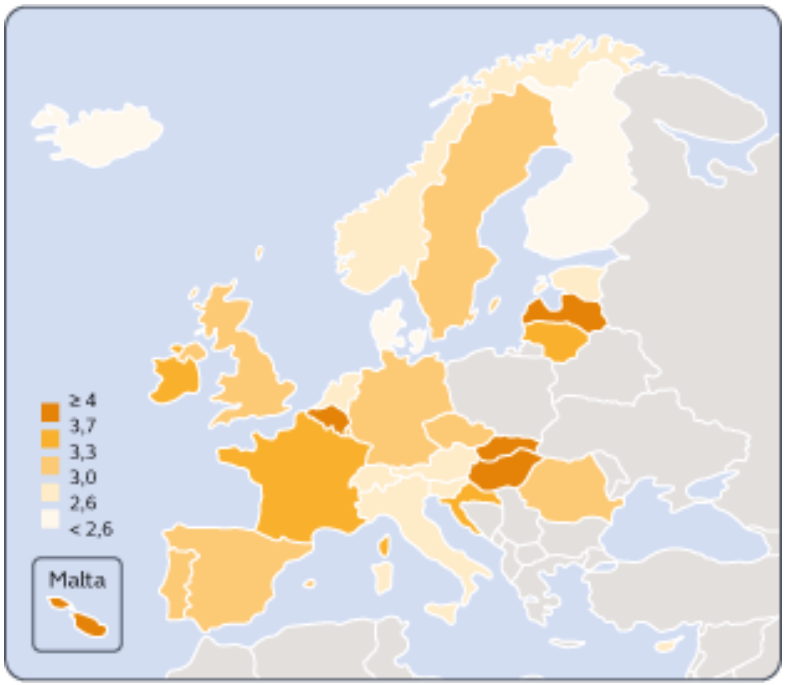
The main perinatal health indicators



Source: Court of Accounts

The rate of stillbirths in France rate, meaning the ratio of the number of stillborn babies to the total number of births, has been among the highest in Europe for the past twenty years (3.8 % for the period from 2015 to 2020). Furthermore, France is one of the only countries where it has not improved since 2000.

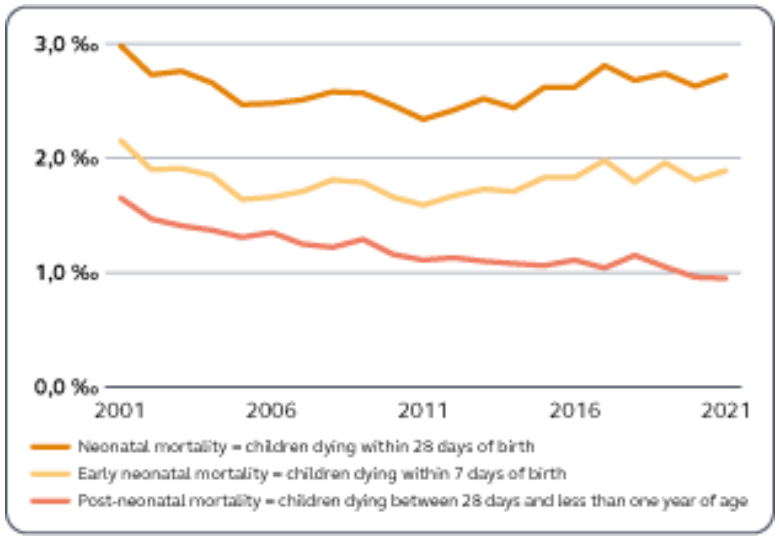
Average stillbirth rate per 1,000 live births in Europe between 2015 and 2019



Note: stillbirths excluding therapeutic terminations, following 24 weeks of amenorrhoea.
Source: Court of Accounts based on Euro-Peristat data 2015-2020

For neonatal mortality, meaning infant deaths occurring during the first month of life, France ranks 22nd out of 34 European countries, with a rate of 2.7 %. The trajectory has been unfavourable since 2012, after improving between 2001 and 2011. If the French neonatal mortality rate had been identical to that of leading European countries, almost 40 % of the deaths recorded in France between 2015 and 2017 could have been avoided, i.e. 2,079 children.

Trends in neonatal mortality in France between 2001 and 2021



Scope: live births in France, excluding Mayotte department, up to 2013; all of France from 2014 onwards.
Source: Insee French National Statistics Office, register of births, marriages and deaths, June 2023

Lastly, maternal deaths are a rare occurrence, with an average of 90 recorded each year. The rate of deaths during pregnancy and up to the 42nd day after birth, an international reference indicator, is 8.5 per 100,000 live births in France. This is comparable to the average for European countries. Nevertheless, 60 % of maternal deaths are considered to be potentially avoidable. In two-thirds of cases, they occurred after non-optimal care, due in particular to malfunctions in the care system and perinatal care pathways.

Against this backdrop, the evaluation in this report addressed the following four questions:

1. Are the factors that explain France's mediocre results in terms of perinatal health clearly identified, and do they provide sufficient guidance for prevention and healthcare during pregnancy, childbirth and the first-year post-partum?
2. To what extent have changes in the way care is organised helped to improve the safety and quality of care and thus reduce perinatal mortality, maternal mortality and severe maternal morbidity in the long term?
3. How have primary and secondary prevention measures for risks that could affect the health of mothers and children and the development of children effectively reduced cases of serious morbidity and mortality at birth and during the first year of life?
4. How can supporting parents, before or after childbirth, help to prevent psychological suffering, in particular post-partum depression, and problems in the relationship between parents and children, in addition to violence towards children and child abuse?

Significant perinatal risks, marked by inequalities, which require better monitoring

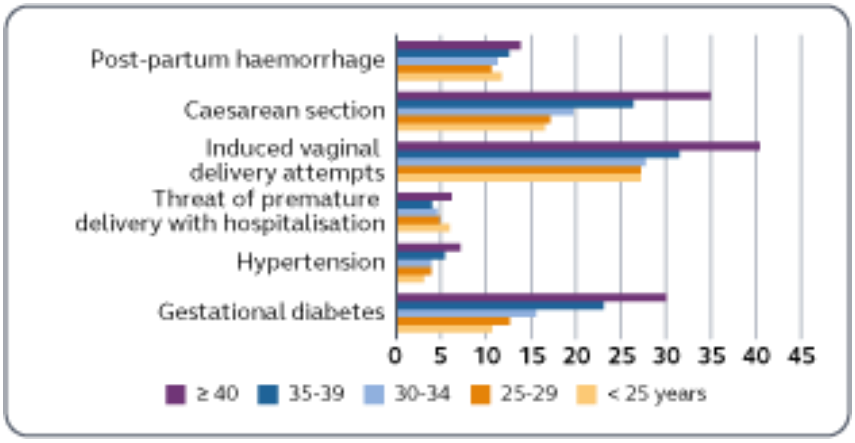
Major risks, some of which are becoming more prevalent

Obesity or excess weight in women prior to pregnancy are risk factors, as is inappropriate weight gain during pregnancy, whether this is too much or too little. Despite positive developments, addictive habits and the consumption of high-risk products such as drugs, alcohol and tobacco remain at high levels, despite their toxicity for both mother and child.

The incidence of prematurity and low birth weight (less than 2,500 grams) has been stable since 2016, after rising steadily over the previous decade. The rates of prematurity and low birth weight stand at 7 % each, putting France at the median level in Europe.

The proportion of late pregnancies, after the age of 35, is increasing and now accounts for almost a quarter of all births in France. They are associated with increased risks for both mothers and children, as well as greater obstetric complications.

Complications during pregnancy and characteristics of childbirth by age of mother at delivery (%)



Source: INSERM (French National Institute of Health and Medical Research) for the Court of Accounts

Social and territorial inequalities in perinatal health

Perinatal health is characterised by major social and territorial inequalities. The vulnerability of families and mothers, as measured by income, qualifications or access to social security cover, is associated with greater maternal and infant morbidity and complications during pregnancy. These inequalities are greater for mothers born abroad, whose social situation correlates with greater morbidity and risk, while almost a quarter of births are to foreign mothers. Lastly, the overseas territories face particular difficulties.

A deficient epidemiological monitoring system

In the absence of a unified perinatal information system, and despite the valuable contribution of existing surveys conducted regularly, the epidemiological surveillance and analysis system is unable to identify or rank the factors that explain perinatal health indicators, and consequently to provide useful guidance for public action.

The quality of perinatal health monitoring could be improved by setting up a more efficient information system, a proper birth register able to produce more complete data. Provided it is progressively expanded, the national health data system (SNDS) is probably the adequate tool for achieving the objective of centralising data production, as required by European standards. In this way, information on the birth of the child, taken from records in the register of births, marriages and deaths, could be permanently matched with the SNDS to produce more robust perinatal health indicators.

A policy that has failed to improve care safety and quality

A care supply that is ill-adapted to current perinatal issues

The organisation of care and the quality of care play a decisive role in preventing perinatal health risks and harm, particularly during and following childbirth. However, the current situation does not meet the requirements of optimal safety or efficiency in the organisation of healthcare provision.

The regulations governing the organisation and technical operating conditions of maternity units, which have remained unchanged for the last twenty-five years, do not seem to have kept pace with changes in care provision or the restructuring of healthcare provision over the last few decades.

The development of perinatal care provision is also insufficiently steered by the health authorities, against a backdrop of severe pressure on medical and paramedical human resources. Around twenty maternity units still do not meet the minimum threshold of 300 births a year, set in 1998 to ensure the quality and safety of care. The fact that maternity units with fewer than 1,000 births a year are finding it increasingly difficult to attract and retain qualified staff also calls for a case-by-case analysis of the conditions under which they carry out their work. As far as neonatal critical care is concerned, there are major disparities between regions, prompting a reassessment of provision in certain regions. Finally, women with high-risk pregnancies should always be monitored in facilities equipped to deal with possible complications and those that could affect newborn babies.

These findings call for a review of the organisation of perinatal care, with the aim of improving care safety and ensuring that resources are allocated more efficiently.

In order to consolidate the demographic balance in the perinatal professions, efforts must be made to provide training for childbirth professionals, taking into account the actual location and nature of practice of current professionals. This should include improving the attractiveness of these professions in hospitals, and improved mother and child protection services (PMI) and in towns and cities, particularly in the least well-equipped areas.

The "1,000 first days" strategy: renewed ambition, but too narrow in scope

Between 1970 and 2007, France adopted structured, mobilising perinatal plans. Public policy today is based on a more generalised design. For example, the perinatal objectives of the 2018-2022 National Health Strategy (SNS) have been adopted, sometimes redundantly, in around ten separate thematic plans.

A new ambition has been established since 2021 through the "first 1,000 days" strategy, understood as the period from the beginning of pregnancy to the child's second birthday. The plan includes structural measures such as support for the widespread use of early prenatal and postnatal sessions, reinforcing medical, psychological and social teams in maternity wards, and experimenting with personalised perinatal pathways, in addition to more incidental measures. A great deal of space is given over to experimentation, the sometimes ephemeral

nature of which can lead to the players involved running out of steam, with the risk of losing sight of the long-term objectives.

This new, more preventive approach reflects a welcome commitment to understanding the psychological risks associated with perinatal care and the developmental risks for newborn babies, and to combating social and health inequalities. However, it does not take sufficient account of the quality and safety of perinatal care, which is one of the reasons for our country's poor performance. Overseas, despite significant mobilisation, the strategy is not adapted to the particular economic vulnerabilities of these territories, nor to their specific geographical or socio-cultural characteristics.

More effective governance could result from a multi-year strategic plan specifically focused on perinatal care, covering the issues identified in the "first 1,000 days" project and those relating to care quality and safety alike, which are not taken sufficiently into account at the current time. In this context, specific levers for action in the overseas territories would need to be identified, as well as the provision of financial support commensurate with local health and social issues. To ensure the governance of this strategy and enhance its visibility, it would be appropriate to reinstate the National Commission on Birth and Child Health, review its membership and extend its scope to include maternal health.

Perinatal care coordination resources require optimisation

Given the diversity and complexity of the pathways taken by pregnant women, mothers and their newborn babies depending on the medical risk they are at or their vulnerability, a key issue is the coordination of healthcare professionals working in towns, hospitals and mother and child protection centres (PMI).

It would be useful to clarify the respective roles, scopes and responsibilities of the structures involved in this coordination (coordination support systems, territorial health professional communities, etc.) and the players offering personalised support to patients (personalised perinatal pathway, named midwife).

Insufficient preventive measures

Prevention must be stepped up in order to achieve a lasting reduction in risk factors during the perinatal period and to improve the health of women and children. There have been some positive developments, such as an increase in the number of rare diseases screened for in newborns.

However, shortcomings persist. Despite their appropriateness, the screening or vaccination campaigns run by health authorities have a limited impact. Furthermore, they do not effectively reach the most at-risk groups, particularly women in disadvantaged situations or those suffering from a combination of particular illnesses, either in France or overseas.

To be more effective, the public authorities need to focus on the risk factors for mothers, and do more to disseminate health recommendations to health professionals and families. We need to take greater account of mothers' individual situations, based on their backgrounds and known risk factors. Greater use of early prenatal and postnatal sessions, which are still underused, could contribute to this.

More support for parents

The recent "first 1,000 days" strategy aims to prevent the psychological and developmental risks associated with the perinatal period. However, the inadequate scope of some of the core measures of this strategy, shortcomings in the provision of perinatal and

social psychiatric care, and the plethora of parental support measures and structures, limit the prevention and treatment of psychological distress and issues in the parent-child relationship.

In this context, it would seem preferable to postpone the current dismantling of the "Prado maternity" home support service set up by the health insurance scheme.

It has proved its effectiveness and should be maintained until other ways of coordinating perinatal care pathways have demonstrated equal appropriateness.

Lastly, parenting support schemes (networks for listening to, supporting and accompanying parents - REAAP - and child-parent drop-in centres - LAEP) should be made more uniform and easier to understand, so that efforts can be concentrated on the most effective schemes and better coordination is achieved between the social players and health professionals working in this field.

The Court's seven recommendations are designed to identify ways forward in response to the issues raised by each of the four evaluation questions.

Recommendations

Question one

1. Enrich the national health data system (SNDS) with missing databases (civil registry reports and child health certificates), so as to create a single birth register *(ministry of labour, health and social care, CNAM)* *.

Question two

2. For each maternity unit with fewer than 1,000 births per year, conduct a regular review of activity at the regional level, taking into account care quality and safety, and draw conclusions on the appropriateness and conditions for continuing their activity *(ministry of labour, health and social care)* **.
3. Review the decrees setting operating standards for obstetrics and neonatology units in order to take better account of the concentration of activity in the largest units within a framework of care gradation, as well as the consequences of earlier care for premature babies *(ministry of labour, health and social care)* **.
4. Include care quality and safety issues in the "first 1,000 days" perinatal strategy *(ministry of labour, health and social care*) **.
5. Identify and implement specific actions to improve perinatal care overseas *(ministry of labour, health and social care, ministry of the interior and overseas territories, CNAM)* **.

Question three

6. Strengthen the effectiveness of perinatal prevention, particularly with regard to early prenatal sessions and their follow-up. To this end, develop training in the issues concerned and in conducting these sessions, and specify the protocol for sharing the results with the healthcare professionals involved in the subsequent care pathway *(ministry of labour, health and social care, CNAM, Public Health France)* **.

Question four

7. Strengthen the "Prado maternity" programme providing support to women returning home from obstetrics units until more effective alternatives have been deployed, particularly for the most vulnerable women *(CNAM)***.

* *Management recommendation.*
** *Public policy recommendation.*