

Improving Maternity Services in Australia

The Report of the
Maternity Services Review



**Report of the Maternity Services Review
February 2009**

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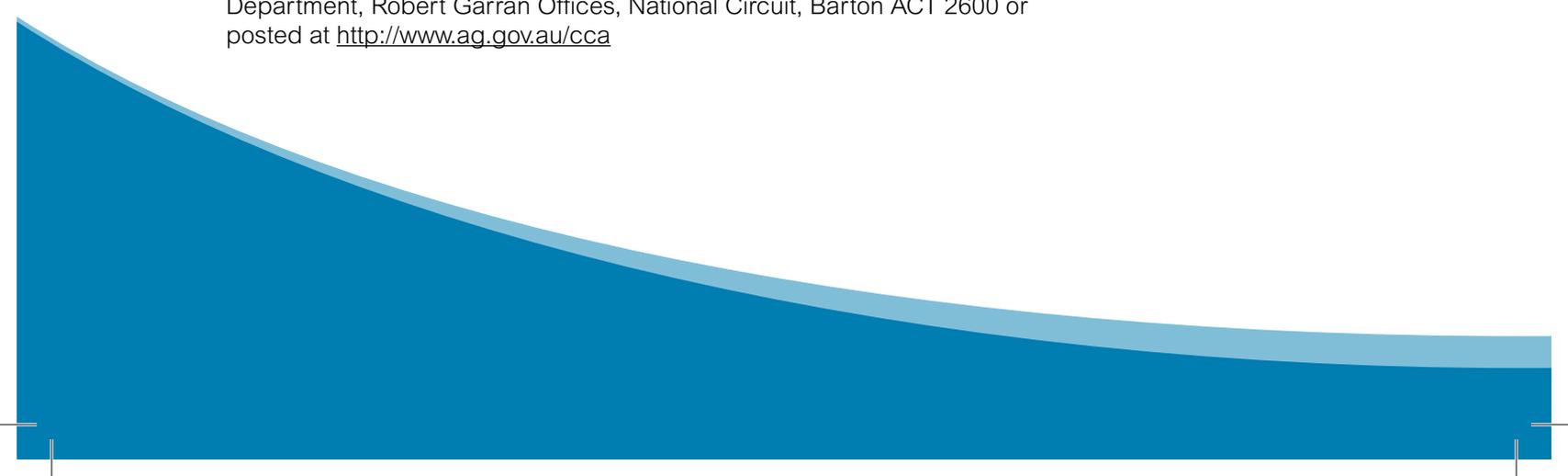
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FOREWORD

I am pleased to provide you with the Report of the Maternity Services Review.

This Review has made it even clearer to me that pregnancy, birthing and early parenthood are profoundly important life experiences.

As well as the physical, social, practical and emotional dimensions of these experiences, the time leading up to birth, the birth itself and the postnatal period are for many women and their families infused with deep spiritual and/or cultural significance.

For the many individual women who contributed to the Review, their motivation to engage was often based on dissatisfaction with the current system and the choices that were or were not available to them.

While views expressed by those who contributed to the Review were often divergent, there was widespread agreement about the issues that present the greatest policy challenges, as well as consensus that safe, high-quality and accessible care *based on informed choice* must be the goal to which we aspire.

Addressing this goal has provided the focus and backdrop for this Report and its recommendations. While defining the goal is relatively straightforward, a more challenging task lies in deciding how this goal is best achieved for women and their families, including women in rural and remote areas, Indigenous women and women with 'high risk' pregnancies.

Of the many significant issues contained in the Report, there are three that I bring to your attention:

First, it is clear that there are many strengths in our current system, most notably our strong record of safety and quality. This must not be understated: generally speaking, we have in Australia a highly committed and professional

maternity services workforce that is looking after mothers and babies extremely well. However, in light of current evidence and consumer preference, there is a case to expand the range of models of maternity care.

Secondly, it is imperative that we do more to improve the birth outcomes for Indigenous Australians. For most organisations participating in the Review, disparities in outcomes for Indigenous mothers and babies are considered a most pressing national issue.

Thirdly, there is a lack of unanimity within and between some groups of the medical and midwifery professions on the issue of how to deal with risk and consumer preferences. While it is acknowledged that safety and quality of care is an overarching goal, it would be remiss to always use it as an excuse not to change practice. In maternity services, where most pregnancies follow a normal pattern, we must ensure, first, that practice is based on evidence and, second, that we are not allowing our safety and quality concerns to prevent us acting on evidence that supports changes to practice. Risk must always be a carefully monitored balance of safety and informed choice.

The divergence of views also involves the issue of what extra services taxpayers should fund to meet the desires or preferences of individuals and practitioners. Any final policy recommendation must reflect a considered analysis of the positions of all stakeholders. Nonetheless, the submission process highlighted many maternity services where medical practitioners and midwives work well together.

The issues raised by the Review are difficult and complex. There is a clear role for leadership by the Australian Government in concert with the state and territory governments to ensure that Australian women

and their babies are provided with the best possible care. There is equally an onus on the professions to work with governments to achieve this.

I am conscious that the findings of this Review may not satisfy all contributors. Nonetheless, the case for change is unarguable.

In presenting this Report, I would like to acknowledge the hard work and dedication of the Review Team in the Department who have supported me in the conduct of the Review. I would also like to extend my thanks to those who contributed to the Review.

Rosemary Bryant.

Rosemary Bryant

Commonwealth Chief Nurse
and Midwifery Officer

February 2009

INTRODUCTION

This Report presents for the consideration of the Minister for Health and Ageing, the Hon. Nicola Roxon, MP, the findings of the Maternity Services Review (the Review) conducted by the Australian Government Department of Health and Ageing, and led by the Commonwealth Chief Nurse and Midwifery Officer, Rosemary Bryant. The Review, including this Report, is a key step towards delivering the Government's election commitment to develop a National Maternity Services Plan (the Plan).

The aims of this Review were to:

- elicit a range of perspectives on maternity services in Australia
- identify key gaps in current arrangements
- determine what change is required
- determine what is needed for change to occur, and
- inform the priorities for national action, and the development of the Plan.

It considered issues relevant to maternity services, including antenatal services, birthing options, postnatal services up to six weeks after birth, and peer and social support for women in the perinatal period.

Overview of Review Recommendations

The Review takes place at a time when the number of births in Australia is rising. The latest Australian Institute of Health and Welfare (AIHW) report on Australia's mothers and babies shows that, in 2006, the number of births in Australia was 282,169, an increase of 3.6 per cent from the previous year.¹ Australia's increasing number of births, combined with growing workforce pressures, requires us to look at more effectively using our workforce to provide safe, high-quality maternity care,

based on good evidence, to Australian mothers and their babies.

In conducting the Review, the Review Team was concerned to ensure that any changes it proposed built on the current strengths of maternity services in Australia, and that safety and quality must be the chief concern in determining appropriate models of care across Australia.

For women in rural areas, the range of choices available is constrained by safety and quality considerations and the availability of an appropriate workforce. Compared with obstetricians, other specialists and general practitioner (GP) obstetricians, midwives are more evenly distributed across rural areas of Australia. Even so, the mix of services that can be available in small communities is constrained; for example, if the number of deliveries is small, a viable and safe birthing service may not be possible. The desire for safety and quality also underpins requirements for education, registration and continuing education for the maternity workforce.

At the same time, it is important that safety and quality do not become the catch-cry to limit consideration of innovation and reform to care approaches. It is vital that approaches to change are evidence-based and take full account of consumer preferences.

The Report makes a series of recommendations in the key areas of:

1. Safety and Quality
2. Access to a Range of Models of Care
3. Inequality of Outcomes and Access
4. Information and Support for Women and their Families
5. The Maternity Workforce
6. Financing Arrangements.

In some instances, the recommendations identify specific areas where further collaborative work between the Commonwealth, states and territories, professionals and consumers is needed. In others, the recommendations identify areas where action could occur more quickly. A summary of the recommendations of the Review Team is provided at [Attachment A](#).

Overall, the recommendations of this Report, if accepted and incorporated in the Plan, would continue to provide Australian women with safe, high-quality maternity care but would support an expanded role for appropriately qualified and experienced midwives and increase the range of collaborative models of maternity care available. Such changes would take place within a model of collaborative care drawing on the expertise of the diverse health professionals involved in maternity care—and within an evidence-based safety and quality framework.

The processes undertaken by this Review have allowed us to identify current gaps, some priorities for action, and other, more complex, areas of policy reform requiring further development.

In summary, the Report recommends:

- changes to improve choice and availability of a range of models of maternity care for Australian mothers by supporting an expanded role for midwives, including consideration of changes to Commonwealth funding arrangements and support for professional indemnity insurance for midwives
- changes including an expanded role for midwives to take place within a strong framework of quality and safety

- new national cross-professional guidelines be developed to support collaborative multidisciplinary care in line with best practice, along with a system for advanced midwifery professional requirements
- improved national data collections and targeted research to support a safety and quality framework and allow the impact of changing models of care to be effectively monitored
- changes to support the expansion of collaborative models of care, improved access for rural and Indigenous mothers and reduced workforce pressures (particularly in rural and remote areas of Australia): consideration of targeted additional support to attract and retain a rural maternity workforce—including midwives, GP obstetricians, GP anaesthetists—and improved access to specialist obstetric care
- assisting Australian women in being better able to make decisions about their maternity care by accessing comprehensive reliable information: consideration of better access to a range of information on antenatal, birthing and postnatal care and options, including internet resources and the establishment of a single integrated pregnancy-related telephone support line.

Together, the recommendations propose changes that not only build on what currently works well for mothers and babies in Australia but also move to expand the range of available choices for mothers in a way that is informed by evidence, without compromising quality and safety, and having regard to workforce availability and resource implications.

Context

The starting point for the Review was that Australia is one of the safest countries in which to give birth or to be born. At the same time, despite our strong record of safety and quality, maternity care in Australia is not meeting the needs of all Australian women. A significant part of Australia's maternity care is delivered in tertiary settings, rather than primary care settings, and by specialist obstetricians. Most women give birth in hospitals in a conventional labour ward setting—in 2006, 97.3 per cent of women gave birth in hospitals. Public hospitals deliver a significant proportion of antenatal care (55 per cent), as do private obstetricians (30 per cent), while GPs deliver 15 per cent of such care.² At the same time, some Australian women are seeking, but have limited access to, other models of care such as birthing centres and antenatal and postnatal care in community settings.

In addition, Australia has a high rate of obstetric interventions including caesarean section; 31 per cent of births in 2006 were delivered via caesarean section, compared with the Organisation for Economic Co-operation and Development (OECD) average of 22 per cent.³ While caesarean section rates are explained in part by factors such as maternal age and medical conditions such as obesity, diabetes and hypertension, there is debate surrounding this issue, suggesting further evidence is needed.

Moreover, while maternal and fetal mortality and morbidity rates have improved, the gains are not shared equally across the population; outcomes for Indigenous mothers and babies, in particular, are considerably poorer than for non-Indigenous mothers and babies.

High rates of smoking, alcohol consumption and poor nutrition in pregnancy are impacting negatively on the long-term health outcomes for Australian babies. While breastfeeding initiation rates in Australia are reported at

around 92 per cent in 2006–07, the decline in exclusive breastfeeding continuation rates for infants up to six months of age (14 per cent) is of concern.⁴ Perinatal depression is estimated to affect around 15 per cent of women.⁵ While there is a range of clinical and non-clinical supports including from non-government organisations (NGOs) to support women and their families, these are not always well integrated or accessible.

As with many aspects of health care in Australia, maternity care is characterised by a mix of Commonwealth, state and private funding and service delivery. States and territories play a major role through public hospitals in particular. Currently, a significant proportion of Commonwealth funding is through the Medicare Benefits Schedule (MBS). The MBS is focused almost entirely on medical professional services, with a significant proportion channelled through the Extended Medicare Safety Net (EMSN). As a result, the range of maternity care options available outside the public system is limited. MBS financing is discussed in Chapter 6.1.

Conduct of the Review

The first step in the Review was the release of a Discussion Paper—*Improving Maternity Services in Australia: A Discussion Paper from the Australian Government*. The Discussion Paper identified a number of key themes and priority issues for maternity services in Australia and informed and guided the consultation process that followed.

The Review invited input from stakeholders through a call for written submissions responding to the Discussion Paper. In addition, the Review held a series of six round table forums to seek input from a range of key stakeholders. Further details on the consultations are provided at [Attachment B](#).

Overall, feedback from stakeholders received through submissions and the forums confirmed the importance of the key issues identified in the Discussion Paper as the most pressing issues in the current Australian context:

- Issues emphasised by consumers of maternity care included the limited availability of models of care consistent with their expectations; the impacts upon themselves, their babies and their families from the type of maternity care they experienced; difficulties in sourcing information and making informed choices on maternity care; their perceptions of risk; and, for many, their desire that pregnancy and birth be seen as a natural process.
- Midwives, nurses and their representative organisations provided detailed accounts of their experience of providing maternity services in Australia and the constraints (including funding arrangements and indemnity insurance) on their ability to practise to the full extent of their expertise. They highlighted their desire for recognition as primary providers of maternity care and provided examples of successful collaborative models of care.
- General practitioners (GPs), medical specialists and their representative organisations identified their highest priority as that of maintaining Australia's excellent record of safety in maternity care and emphasised the need for specialist expertise within the maternity care team. An issue of concern was the loss of skilled professionals and its impact on the provision of maternity care, most noticeably in rural and remote areas. These professional groups also expressed concern about moves towards homebirthing.
- NGOs outlined the scope and the scale of service provided through this sector; the complementary nature of the services they provide in relation to clinical services; their specific areas of expertise; the need for recognition on the part of clinicians of the role NGOs can play; and the need for improved referral pathways between clinicians and NGOs. In particular, the role of peer support organisations in providing mothers with pregnancy information, breastfeeding and other parenting support, including dealing with perinatal depression and grief and loss, was identified to the Review.
- Academics and researchers identified a number of issues: gaps in the current evidence base; limited opportunities to develop research in these areas; and the importance of evidence-based care built on a foundation of comprehensive national datasets. Priority research areas highlighted included identifying effective models for postnatal care, further examination of interventions, including caesareans, understanding of consumer expectations and experiences of different models of care and stillbirths.
- Allied health professionals highlighted areas where their specific expertise contributed to the provision of maternity services and identified the importance of appropriate referral pathways and guidelines. Psychologists and other mental health workers, dieticians, physiotherapists and occupational therapists (particularly for women with a disability adjusting to caring for a new baby) were among those identified as members of the maternity team.
- State and territory governments emphasised their support for Commonwealth leadership through a National Maternity Services Plan and their willingness to work with the Commonwealth on this Plan. State and territory submissions also highlighted current priorities—for example, to improve service integration and encourage more community-based care, where appropriate, as well as effective models and innovations within their jurisdictions.

Next Steps

The findings and recommendations of this Review, if accepted, will inform the development of the National Maternity Services Plan. Development of the Plan will allow more detailed consideration of a number of issues than has been possible in this Review, including those that are solely or predominantly the responsibility of state and territory governments.

A number of other reviews of maternity services in Australia have been undertaken by jurisdictions and other stakeholders in the last decade; these previous reviews, which have informed this Review, will also be relevant to the National Plan.⁶

This Review has been conducted alongside other health reform processes currently under way, in particular those of the National Health and Hospitals Reform Commission, the Preventative Health Taskforce and the development of the National Primary Health Care Strategy. Maternity-related issues are being raised and considered in these reform processes. The Plan will need to take account of the findings of these reform processes as well as the recommendations of this Review.

In the interim, the Review Report identifies a number of areas where actions could commence in the short term. Importantly, change will need to proceed with the effective engagement of a range of stakeholders, including consumers, health professionals, their representative organisations, professional indemnity insurers, private health insurers, state and territory governments, and the academic sector.

Structure of the Report

The Report considers key issues identified by the Review. It analyses the available evidence and data, describes the current context, summarises the feedback obtained through the consultation processes, and indicates related initiatives. All these factors have informed the Review Team's conclusions and recommendations. The Report also considers the issues of process and governance in moving forward from the Review to development of the Plan.

KEY ISSUES FOR THE MATERNITY SERVICES REVIEW

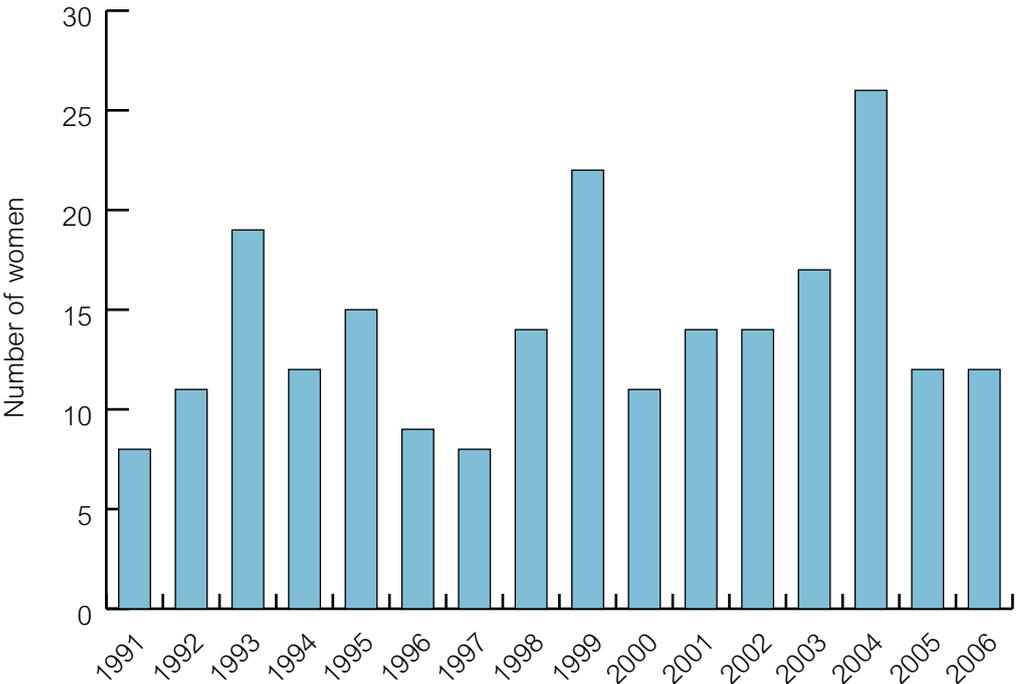
1. Safety and Quality

Current Context

Over the course of the last century, Australia made significant progress in improving the safety of pregnancy and childbirth. In 1936, there were 600 maternal deaths per 100,000 live births. By 1950, this had dropped to 109 per 100,000 live births and, by 1980, this figure had dropped to below 10 per 100,000 live births.⁷

Figure 1 shows that on average since 1990 there have been between 10 and 15 deaths directly related to complications in pregnancy in Australia each year, at a time when the number of births is increasing. For its part, the AIHW reported that 29 direct maternal deaths and 36 indirect deaths occurred in the three years 2002 to 2005.⁸

Figure 1: Number of women who die in childbirth, Australia, 1991–2006

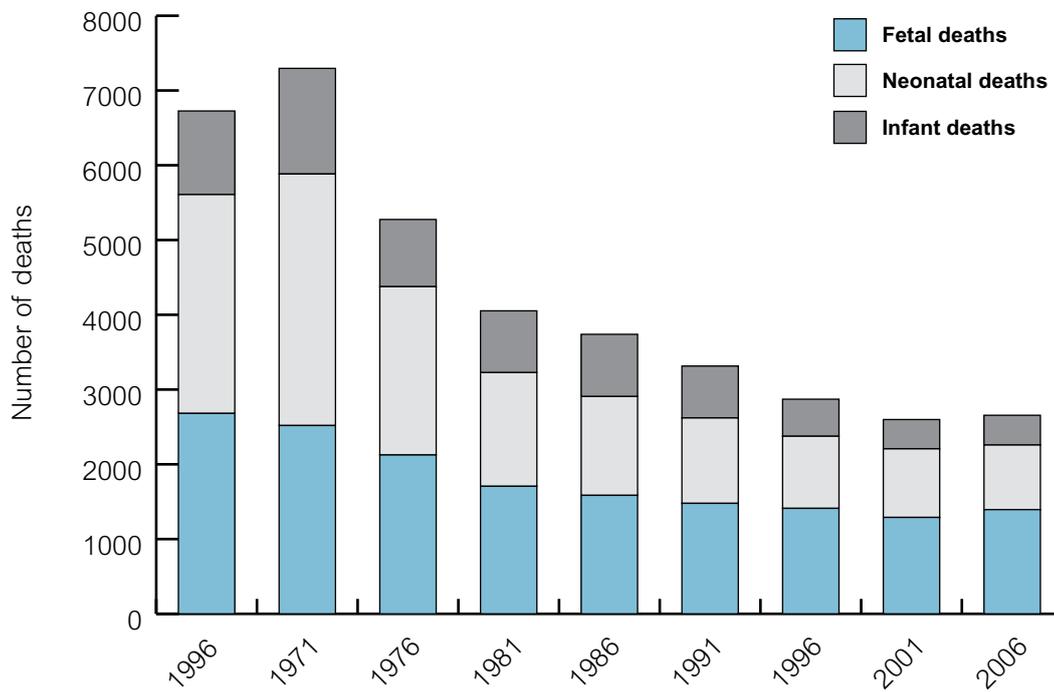


Source: Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit, *Australia's mothers and babies* (various), Cat PER 46.

Figure 2 shows the number of fetal/stillborn deaths (from 20 weeks gestation, minimum weight 400 g), neonatal deaths (to 28 days) and infant deaths (to 1 year) in Australia

between 1966 and 2006. The significant shift depicted in the figure is for the number of neonatal deaths, which has fallen from 3,364 a year to 864 over the 40-year period.

Figure 2: Number of infant deaths to one year of age, Australia, 1966–2006, 5-yearly

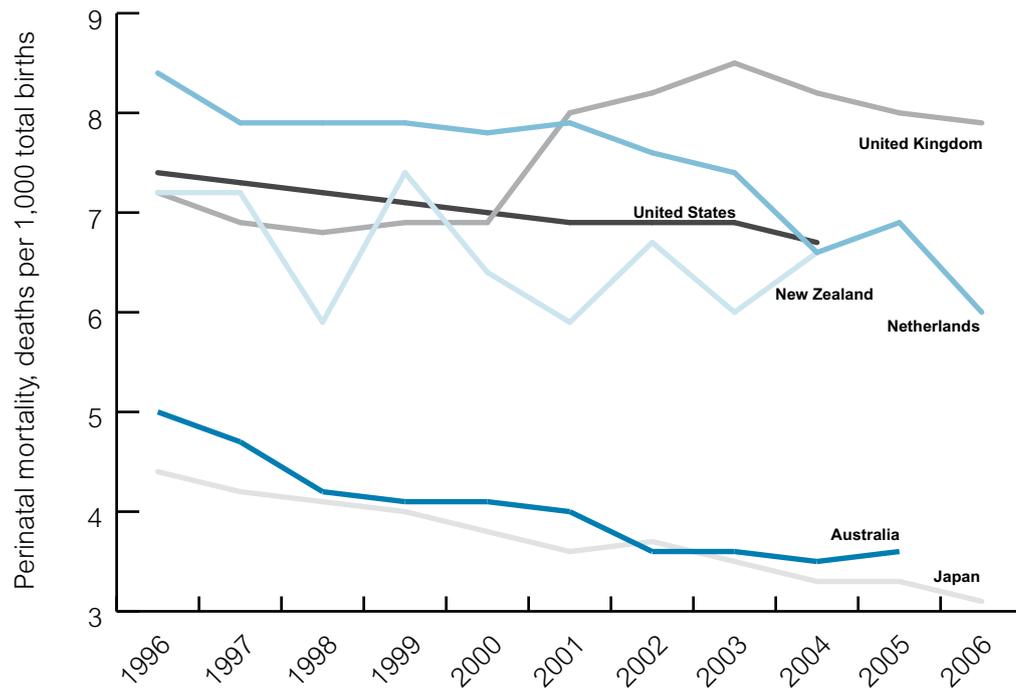


Source: Australian Bureau of Statistics, *Year Book Australia* (various), Cat 1301.0.

Australia is one of the safest countries in the world in which to give birth or to be born. Data from the OECD shows that over the past

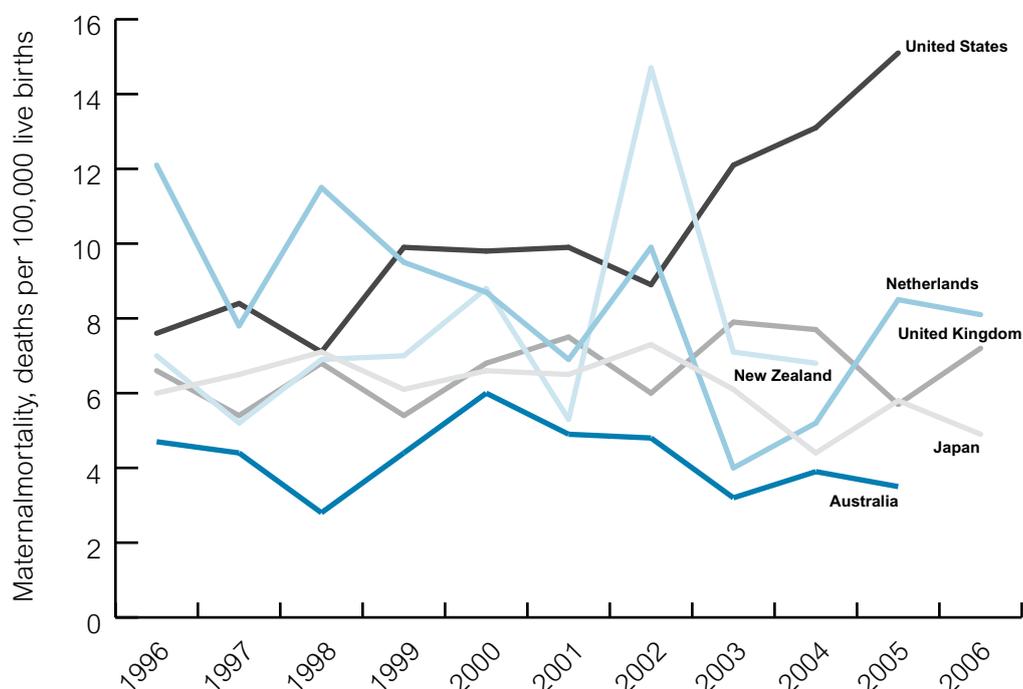
decade Australia has had consistently lower maternal⁹ and perinatal¹⁰ death rates than the majority of comparable countries.¹¹

Figure 3: Perinatal mortality, international comparison, 1996–2006



Source: Organisation for Economic Co-operation and Development, 2008, *Health Data 2008*.

Figure 4: Maternal mortality, international comparison, 1996–2006



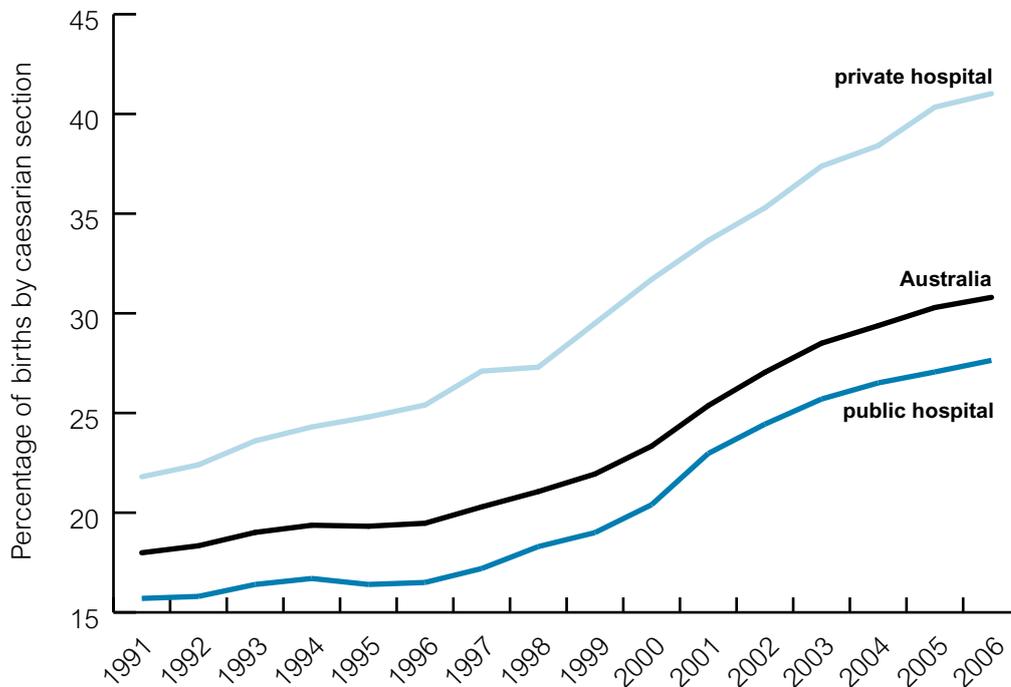
Source: Organisation for Economic Co-operation and Development, 2008, *Health Data 2008*. Note: The OECD maternal mortality for Australia is based on the Australian Bureau of Statistics' causes of death data, whereas Figure 1 presents mode of separation from hospital discharge data from the AIHW mothers and babies reports.

At the same time, Australia has a high rate of caesarean section (31 per cent of births in 2006,¹² compared with the 2004 OECD average of 22 per cent of births).¹³

There is also some evidence to show variations in caesarean section rates between public and private sectors (see Figure 5) and between states and territories (ranging from 26.9 per cent in Tasmania to 33.2 per cent in

Queensland).¹⁴ Data relating to the number of caesarean sections performed by particular service providers (public as well as private) is generally not publicly available, and so variations in the rates at which caesarean sections are performed is not available. Some submissions from individuals to the Review requested that specific hospital caesarean section rates be published.

Figure 5: Rates of caesarean section by hospital sector, Australia, 1991–2006

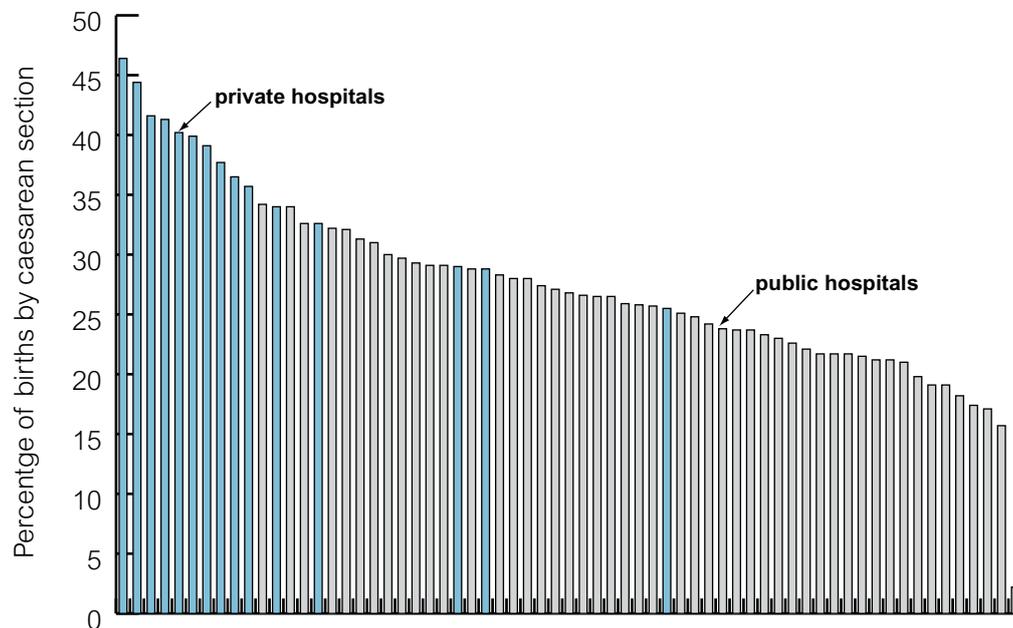


Source: Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit, 2008, *Australia's mothers and babies, 2006*, Perinatal statistics series no. 22, Cat. no. PER 46, Sydney.

Figure 5 shows a steady growth in the number of births by caesarean section in both private hospitals (increasing from 22 per cent of all births in 1991 to 41 per cent in 2006) and public hospitals (rising from 16 per cent in 1991 to 28 per cent to 2006). The increasing rate of caesarean sections has been similar for both private and public hospitals over this period.

Figure 6 shows the variation in percentage of caesarean births by hospital in New South Wales in 2005, for hospitals with more than 200 births a year. Private hospitals are shown in light blue.¹⁵

Figure 6: Rates of caesarean section, by hospital, New South Wales, 2005



Source: Centre for Epidemiology and Research, NSW Department of Health, 2007, *New South Wales Mothers and Babies 2005*, NSW Public Health Bulletin 2007; 18(S-1), pp. 95–6, available <http://www.health.nsw.gov.au/pubs/2007/pdf/mdc05.pdf>

What the Review Team Heard

- Almost without exception, the priority issue for review participants was that of ensuring Australian women and their babies have access to safe, high-quality maternity services.
- Many contributors to the Review considered that maternal and perinatal rates of mortality were not an adequate measure of the performance and outcomes of maternity services. Severe maternal and perinatal morbidity were identified as important indicators of system performance. There is clearly a group of women, the numbers of whom are unknown, who continue to have short- or long-term sequelae from their pregnancy and delivery. The limited consideration given to stillbirths and understanding of their causes was also highlighted to the Review.
- Intervention rates were identified as another key measure of system performance. While a number of Review respondents saw intervention rates as directly contributing to low maternal and perinatal mortality, this viewpoint was by no means universal. Several submissions referred to the body of scientific evidence, much of which has been published in recent years, to suggest that caesarean section increases the risk to both mother and baby in the index pregnancy, and in subsequent pregnancies.
- Numerous submissions from consumers and some health professionals referred to the ‘cascade of intervention’—the pattern

in which interventions in labour are likely, in and of themselves, to increase the need for interventions during the birth and in subsequent pregnancies. At the same time, it was highlighted that observed increases in caesarean section rates could, at least in part, be explained by a range of factors. These include increasing maternal age; increasing co-morbidities such as obesity, diabetes and hypertension; changes in care for preterm deliveries and those involving assisted reproductive technologies (ART); consumer choice and demand; medico-legal risks; and defensive practice.

- Numerous submissions and discussion at the forums advocated improved national data collection, analysis and review, particularly in the areas of maternal and perinatal mortality and morbidity. The need to consider women's experiences and perceptions of maternity services was also highlighted, along with the need to carefully consider governance arrangements for improved data collection and review.
- Also highlighted to the Review were the disparities in practice between different parts of the system and between individual institutions. Submissions and participants at the forums identified the need for a nationally agreed, consistent and standardised minimum dataset that could provide an evidence-based platform upon which a national benchmarking program for maternity services could be built.

Maternity services need to be regularly audited, hence the importance of adequate data collection and clinical indicators. This is vital particularly with the introduction of any change involving alternative workforce models to assess their effectiveness and establish whether or not there have been improvements.¹⁶

- Consumers and some health professionals emphasised the importance of going beyond a largely bio-medical approach to consider a range of other factors in assessing risk, quality and safety of maternity services.

Women need to have access to maternity services that are appropriate to their clinical, cultural and social needs ... a strict biomedical approach is unlikely to adequately reflect or accommodate the broader health picture for women.¹⁷

Recent Related Initiatives

At the Council of Australian Governments (COAG) meeting on 29 November 2008, it was agreed that the National Healthcare Agreement include performance indicators relevant to maternity care in three areas: proportion of babies with low birth weight; infant and young child mortality rates (including the gap between Indigenous and non-Indigenous); and teenage birth rate.

The Australian Commission on Safety and Quality in Healthcare, through Women's Hospitals Australasia, initiated a project in 2005 to develop a core set of evidence-based performance indicators for timely comparative analysis of practice and outcomes in maternity care. This project has recently been referred to the Maternity Services Inter-Jurisdictional Committee (MSIJC) subcommittee of the Australian Health Ministers' Advisory Council (AHMAC), which, at the time of writing, is considering the next steps for this project.

Discussion

The Review Team acknowledge that Australia's record of safety and quality in relation to maternity care as measured by mortality alone is an enviable one and that significant improvements in this regard are therefore not likely. The disparity in outcomes experienced by Australian women is discussed in more detail in Chapter 3: Inequality of Outcomes and Access.

However, there are areas where gaps in our knowledge are resulting in discord among the professions and consumers rather than providing useful feedback to inform both policy and practice.

While there is data available on Australia's maternal and perinatal mortality rates, nationally consistent data and reporting are limited. While most jurisdictions produce annual reports of perinatal statistics, the comprehensiveness and level of detail differ markedly.

As identified above, alongside mortality, severe maternal morbidity¹⁸ and stillbirths were other areas identified to the Review where better data collection, analysis and review were needed to inform research, practice and policy. There is currently no national reporting of maternal morbidity, no national dataset and no nationally agreed definition.¹⁹ The differences in definitions used for stillbirth across jurisdictions and between the Australian Bureau of Statistics (ABS) and the AIHW, alongside the limited understanding and magnitude of the problem (around 300 stillbirths per year at full term), were highlighted as an area where greater standardisation of data and improved reporting are needed to aid national research and understanding.²⁰

Most topical, is probably the debate among the professions and consumers about reasons for the current rates of caesarean sections and the impact of caesareans on women, babies and the health system, including the impact on available resources. State perinatal statistics for 2005–06 showed that the proportion of caesarean births that were either 'elective', 'planned' or did not involve labour varied from 46 per cent in Queensland to 58 per cent in New South Wales. While caesarean section is considered to have a high degree of safety and to contribute to our low levels of mortality, there is also a view that defensive practice is resulting in higher-than-desirable rates of intervention. Caesarean section as a surgical procedure is accompanied by the additional risks associated with any surgery—for example, infection. Furthermore, observational studies have identified the following risks associated with caesarean sections: increased maternal morbidity or mortality, adverse psychological sequelae, negative implications for future fertility, and problems in subsequent pregnancies.^{21 22}

Determining the appropriate approach to caesareans and other interventions in a way that takes account of both the medical safety of mother and baby and the wishes of mothers is a complex issue, where a more informed discussion and debate is required. Women with normal pregnancy also highlighted to the Review the range of interventions they experienced (including repeat ultrasound, electronic fetal heart rate monitoring on admission in labour and induction) that they believed were of no proven benefit.²³

A number of submissions highlighted the need for national guidelines for maternity care (see Chapter 2) and for improved information to assist women in making informed choices (see Chapter 4). Robust, comprehensive data collection, reporting and review—along with

targeted research in key priority areas—are necessary in order to monitor and inform more effectively the performance of maternity services. In addition, a number of important areas—including caesarean section, stillbirths, women’s experiences and perceptions of different models of care, and effective models of postnatal care—were identified as lacking evidence and requiring targeted research. It is vital to maintain Australia’s good safety outcomes in the possible future implementation of a range of models of maternity care.

Conclusions

The Review Team concluded that:

- Australia’s strong record of safety in maternity services is an acknowledged strength of our maternity system.
- Changes to maternity services need to be guided by evidence.
- Stable, ongoing arrangements for national maternity data collection, analysis and review must be a priority.

Recommendations

- 1. That the Australian Government, in consultation with states and territories and key stakeholders, agree and implement arrangements for consistent, comprehensive national data collection, monitoring and review, for maternal and perinatal mortality and morbidity.**
- 2. That the Australian Government, in consultation with states and territories and key stakeholders, initiate targeted research aimed at improving the quality and safety of maternity services in select key priority areas, such as evidence around interventions, particularly caesarean sections, and maternal experience and outcomes, including from postnatal care.**

2. Access to a Range of Models of Care

Current Context

Currently, the great majority of Australian women deliver their babies in hospitals in a conventional labour ward setting (Table 1 below). The AIHW reports that, in 2006, a total of 269,835 women gave birth in hospitals (97.3 per cent) while 5,460 women gave birth in birth centres (2.0 per cent). Planned homebirths and other births, such as those occurring unexpectedly before arrival in hospital or in other settings, accounted for the smallest proportion of women who gave birth (2,053 women, 0.74 per cent). There has been little change in these percentages over the

last decade: the proportion of women giving birth at a birth centre increased from 1.84 per cent in 1996 to 1.97 per cent in 2006 while the number of homebirths fell from 0.35 per cent of women in 1996 to 0.26 per cent in 2006 and hospital births fell from 97.45 per cent in 1996 to 97.26 per cent in 2006.²⁴

The AIHW also reports on the place where a woman intended to give birth.²⁵ In 2006, a total of 9,368 women intended to use a birth centre but only 5,460 women actually gave birth in a birth centre; the large difference may be due to difficulties in accessing birth centre care, or births being escalated to hospital care. Furthermore, 886 women intended to have a homebirth but only 708 actually had a homebirth.²⁶

Table 1: Women who gave birth, by place of birth, 2006

	NSW	Vic.	Qld	WA	SA	Tas.	ACT	NT	Aust
Mothers (number)	91,303	68,547	55,719	28,253	18,518	6,053	5,354	3,689	277,436
Place (%)									
Hospital	97.3	97.3	98.5	98.0	92.3	97.8	95.8	96.6	97.3
Birth centre	2.0	1.9	0.8	0.9	6.9	1.4	3.8	0.0	2.0
Home	0.1	0.3	0.1	0.7	0.5	0.2	0.2	0.9	0.3
Other	0.5	0.5	0.5	0.4	0.4	0.6	0.2	2.5	0.5

Source: Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit, 2008, *Australia's mothers and babies 2006*, Perinatal statistics series no. 22, Cat. no. PER 46, Sydney, p. 20.

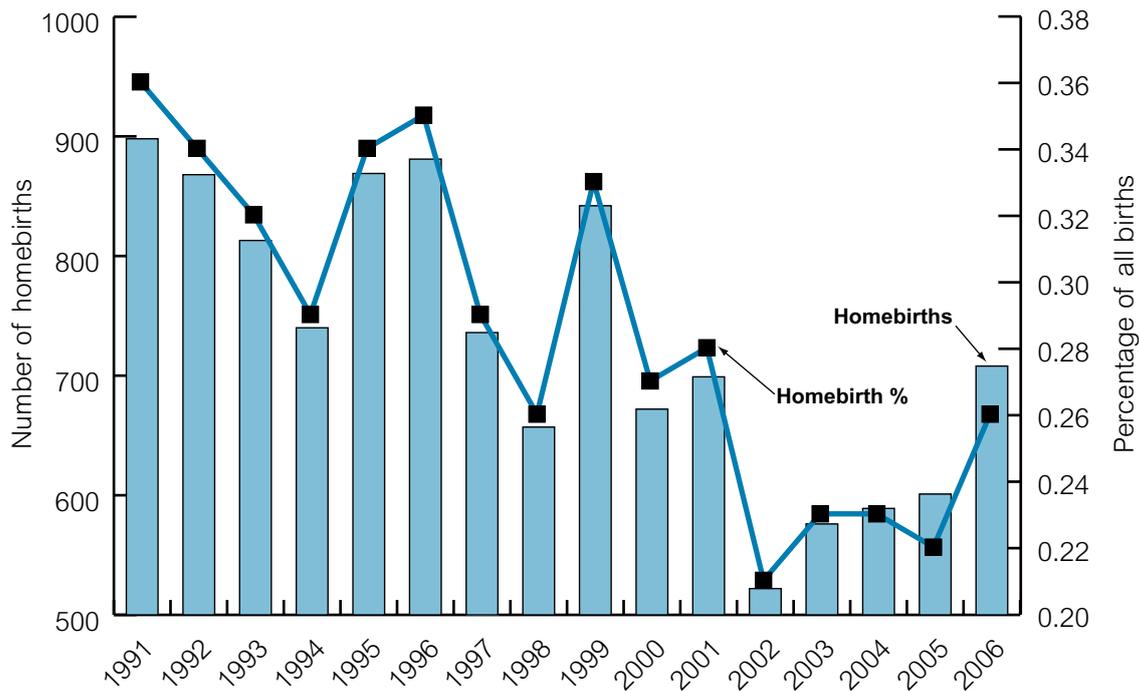
South Australia has had a much higher number of deliveries in birth centres since its Alternative Birthing Services Programme was set up in the early 1990s. Birthing units opened

at the Women's and Children's Hospital in 1992, at Lyell McEwin Health Service in 1993 and at Flinders Medical Centre in 1996.²⁷

Homebirths account for a very small number of births in Australia. In 2005, homebirth accounted for 0.22 per cent of all births in Australia,²⁸ compared with 2.7 per cent in

England and Wales,²⁹ 2.5 per cent in New Zealand,³⁰ and 0.6 per cent in the United States.³¹

Figure 7: Homebirths, Australia, 1991–2006



Source: Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit, 2008, *Australia's mothers and babies 2006*, Perinatal statistics series no. 22, Cat. no. PER 46, Sydney.

In 2004, the Australian Medical Workforce Advisory Committee (AMWAC) reported on the specialist obstetrics and gynaecology workforces in Australia. It found that, while there were a number of care options available to pregnant women in Australia, access to these models varied. Obstetricians, midwives and GPs may all be lead carers during a woman's pregnancy, or care may be shared

by a combination of providers, who may work in a range of settings, from private practice to public hospitals. Table 2 summarises the different models of maternity care available in Australia, which AMWAC drew from work prepared by the Centre for the Study of Mother's and Children's Health, School of Public Health at La Trobe University.

Table 2: Models of maternity care

Model	Features
Private Maternity Care	Private patients of an obstetrician or GP obstetrician; attend private rooms for care in pregnancy and attended by the same obstetrician/ GP for labour and postnatal care.
Public Hospital Clinic Care	Antenatal care in a public hospital outpatient clinic; attend the same hospital for labour and postnatal care; pregnancy and intrapartum care provided under the supervision of medical staff, uncomplicated births usually attended by midwives.
Public Hospital Midwives' Clinic	Antenatal care is provided by a public hospital midwives' clinic, with one or more visits to a consultant or registrar; intrapartum care is provided under the supervision of medical staff, uncomplicated births usually attended by midwives.
Birth Centre Care	Team midwifery care within a separate section of a hospital where midwives provide antenatal, intrapartum and postpartum care.
Shared Maternity Care	Formal arrangements between a public hospital and local practitioner (GP, obstetrician, midwife); the majority of pregnancy care is provided by a local practitioner, with visits to the hospital at the beginning and latter part of pregnancy; public hospital intrapartum care.
Combined Maternity Care	Similar to shared maternity care but does not involve pregnancy check-ups at a public hospital clinic.
Team Midwifery Care	Small teams of public hospital midwives care for women throughout pregnancy, labour, birth and the hospital stay, with one or more visits to a consultant or registrar.
Caseload Midwifery Care	Ongoing care with the same public hospital midwife for the majority of antenatal, labour, birth and postnatal care.
GP/Midwife Public Care	GPs and hospital-employed midwives jointly provide antenatal care to women enrolled for public hospital intrapartum care.
Outreach Midwifery Care	Midwife care for women with high social or obstetric risk, focus on support and education; intrapartum and postnatal care provided by a public hospital.
Planned Homebirths	Pregnancy check-ups, intrapartum and postnatal care provided by the same midwife; transfer to hospital in the case of complications as a private patient of a GP or obstetrician; may require a number of visits with a medical practitioner.

Source: Australian Medical Workforce Advisory Committee (2004), *The Specialist Obstetrics and Gynaecology Workforce—An Update 2003–2013*, AMWAC Report 2004.2, Sydney, pp 18-20.

The Victorian Government issued a report in 1999 on models of antenatal care. It examined 18 models of care and the percentages of women who used each model. If the categories set out in Table 2 are matched up against those in the Victorian study, it can be estimated that four models of care were used by 92.7 per cent of women. Private maternity care was used by 31.8 per cent of women at the time they gave birth, followed by combined maternity care (24.3 per cent), public hospital clinic care (22.4 per cent) and shared maternity care (14.2 per cent).³²

A survey of the views of women in Victoria on their intrapartum care found the highest levels of satisfaction among women who were private patients of specialist obstetricians or GP obstetricians (83.4 per cent rated care as very good). These results may be considered unsurprising, given that private patients are more likely to have chosen the particular specialist as their health provider. Furthermore, they may indicate a preference for continuity of care from a known health provider. The next highest satisfaction rates (68.3 per cent) were reported by women who attended birth centres.³³ La Trobe University is leading a study building on the Victorian survey. It is currently analysing data on recent mothers in South Australia and Victoria and is due to report in 2009.

The Commonwealth and states and territories, through the Australian Health Ministers' Conference have, as a principle, committed to continuity of care—and, wherever possible, continuity of carer—as a key element of quality maternity care. Continuity of care enables women to develop a relationship with the same caregiver (or team of caregivers) throughout pregnancy, birth and the postnatal period.³⁴ There is some evidence to show the benefits of continuity of maternity care, which include reduced interventions in labour, enhanced experiences and satisfaction with care during pregnancy and childbirth, greater preparedness for birth and early parenting,

and reduced health care costs.³⁵ Research also supports the benefits of midwifery-led continuity of care.³⁶

Of the range of models of maternity care shown in Table 2 above, including those that provide continuity of care, not all models are available to all women. The choice and type of options vary within and between states and depend on a range of factors including the available workforce, available facilities and community needs.

What the Review Team Heard

- A key area of consensus was that maternity care should be multidisciplinary and involve a collaborative, team-based approach.

*I strongly believe that the path to providing women a better service is through the development of effective, functioning women's healthcare teams, and that this should be supported from both an educational perspective and a business model that rewards a collaborative model of care. I believe that overemphasis of who the leader of the care is (be it either GP-led, midwifery-led or obstetric-led) is unhelpful and only reinforces public perceptions of professional silos. Please can we change this to collaborative care?*³⁷

*The Rural Doctors Association of Australia believes that this care is best provided by a collaborative model that involves all members of the core maternity care team—GP obstetricians, midwives and specialist obstetricians—according to the needs and wishes of the woman.*³⁸

- Numerous submissions identified the need for national guidelines for maternity care to assist collaborative multidisciplinary care and support evidence-based practice.

- Many submissions referred to the difficulty in accessing birthing centres, some referring to possible access via a lottery or ballot system.

*Private and public midwifery care models exist in Australia, but due to a variety of barriers, operate at a very small scale ... Nearly all primary midwifery models are very popular with women and unable to meet demand.*³⁹
- Consumer submissions voiced concerns about an absence of choice in relation to maternity services, in both rural and metropolitan areas. In their submissions, some consumers expressed feelings of being subject to coercion, lack of control over the birth process, and dissatisfaction with the outcomes. In some instances, consumers advised that this has led to them giving birth at home on their own without any health professional providing assistance.⁴⁰ Many of the consumer submissions demonstrated a clear preference for care by midwives, either in birthing centres or in the home setting.
- Many submissions to the Review were from women advocating homebirth and requesting government funding in this area. For a proportion of women, the desire for a known midwife through the course of their pregnancy, and the inability to access this type of service through mainstream maternity services, was at least part of the reason for their choice of homebirth. Some submissions also expressed a concern at the lack of choice for women who were excluded from alternative models of care options as a result of being assessed as 'high risk'. For example, women wishing to have a vaginal birth after caesarean (VBAC), those who have had multiple pregnancies and those with breech presentation were identified as not meeting criteria for some alternative models of care.
- Alongside consumer submissions, a number of organisations and academics advised of the benefits to women of continuity of care (and carer) midwife-led models and the limited access to these models in Australia. Differing views were raised with the Review Team about the New Zealand experience of moving to midwife-led models of care and the reported benefits and outcomes of those changes, including their impact on collaborative arrangements between midwives and other medical professionals.
- There were numerous examples provided to the Review of existing effective collaborative models of maternity care operating in Australia. Examples included:
 - Belmont Birthing Service: women are cared for by a small group of midwives with referral to John Hunter Hospital.
 - The Kilmore Model: a team of midwives, GP obstetricians, specialist GPs and shared care GPs operate an antenatal clinic and collaborative obstetric care model.
 - Northern Women's Community Midwifery Program: a publicly funded midwife-led continuity of care model that offers women in Adelaide's northern suburbs access to a team of six community midwives.
 - Ryde Midwifery Group Practice: a caseload, midwifery-led unit associated with Ryde Hospital that offers the benefits of continuity of midwifery care to women with low-risk pregnancies.
 - Community Midwifery Program in Western Australia: provides caseload midwifery homebirthing service.

Recent Related Initiatives

Through AHMAC, work to develop antenatal guidelines has commenced.

Discussion

The dominant models of maternity care currently available in Australia involve a conventional medical model in either a public or private hospital setting. Feedback provided to the Review and other state and territory maternity reviews indicates that the demand for other models of care, such as delivery in a birthing centre, greatly exceeds their availability. Where a range of models of care operate, they generally offer midwifery-focused models within the public sector. In the private system, options for midwifery-focused models are limited.

The Review received many accounts from consumers about their positive experiences in midwifery-focused models of care, including care provided antenatally, during delivery and in the postnatal period.

Similarly, the Review heard from health professionals—GPs, GP obstetricians, obstetricians, midwives, nurses and other health professionals—who spoke of their job satisfaction and the observed benefits to women and their families when working in collaborative care models. The types of collaborative care models varied depending on location and circumstance, but similar elements were identified in these models, including interprofessional respect, team work, clear communication and referral pathways, feedback mechanisms, consumer involvement and responsiveness to local environments.

Frequently highlighted to the Review Team was the value of collaborative models of maternity care that supported continuity of care and drew on the knowledge and skills of different health professionals. Related to this was the need for interdisciplinary national guidelines for maternity care. While work

has begun to develop national antenatal guidelines, there are no nationally consistent, interdisciplinary guidelines covering the spectrum of maternity care: antenatal, birthing and postnatal services. While the Australian College of Midwives has developed *National Midwifery Guidelines for Consultation and Referral*, it was clear to the Review Team that these did not have unanimous cross-discipline support. Agreement between professions on the management of referral is a critical component to achieving effective collaborative multidisciplinary care.

The Review Team considered that greater choice for women would be provided by broader acknowledgment of the role that midwives can play as a member of a collaborative maternity team, potentially in a number of different care models. This role may not always be the same in all settings, as there are a variety of different models of care involving midwives (refer for example to Table 2 above). It was noted that, depending on the particular model, midwives may require different levels of qualification and experience.

Many of the consumers who participated in the Review consultation process had strongly held views about government funding for models of care that included birthing in a home setting. A number of submissions to the Review referred to the evidence of positive outcomes for homebirths for low-risk pregnancies. The Review concluded that, while homebirth is the preferred choice for some women, they represent a very small proportion of the total.

Even in countries such as New Zealand where homebirth is government funded, homebirth accounts for a very small number of births in comparison with other models of maternity care. New Zealand maternity data for 2004 found that, while 4.5 per cent of mothers had planned a homebirth, only 2.5 per cent actually experienced a homebirth.⁴¹

In recognising that, at the current time in Australia, homebirthing is a sensitive and

controversial issue, the Review Team has formed the view that the relationship between maternity health care professionals is not such as to support homebirth as a mainstream Commonwealth-funded option (at least in the short term). The Review also considers that moving prematurely to a mainstream private model of care incorporating homebirthing risks polarising the professions rather than allowing the expansion of collaborative approaches to improving choice and services for Australian women and their babies.

The Review Team noted that a number of state and territory governments have developed programs and policies to allow for publicly funded homebirths, under specific conditions. For example, New South Wales Health prescribes comprehensive requirements for homebirths, including safety, monitoring, evaluation, credentialing of the midwife and compliance with incident reporting requirements.⁴²

While acknowledging it is a preference for some women, the Review Team does not propose Commonwealth funding of homebirths as a mainstream option for maternity care at this time. It is also likely that professional indemnity cover support for a Commonwealth-funded model that includes a homebirth setting would be limited, at least in the short term. It is likely that insurers will be less inclined to provide indemnity cover for private homebirths and, if they did provide cover, the premium costs would be very high. Indemnity issues for midwife care more broadly are considered in Chapter 6.2.

Of concern to the Review Team is the number of submissions and other evidence that suggests a small number of Australian women are choosing homebirths without the support of an appropriately trained health professional. Accordingly, as with any other maternity care model, the Review Team considers that appropriate standards, monitoring and evaluation should be integral components of any service involving homebirth.

Conclusions

The Review Team concluded that:

- Continuity of care relies on the ability of practitioners to work together and on the capacity of services to link together as the woman moves through pregnancy to childbirth.
- Greater choice in maternity care could be provided by collaborative care models, which draw on the expertise of the range of health professionals involved in maternity care.
- It is clear that increased choice for women could be provided if there were greater recognition of the role that midwives can play in collaborative care models. Options should be explored for increasing the availability of birthing centre programs.
- Interdisciplinary national guidelines for maternity care that are agreed by the relevant professional disciplines would support the maternity care team in the provision of safe, quality, collaborative care for women and their babies.

Recommendations

- 3. As a priority, that the National Health and Medical Research Council (NHMRC) develop national multidisciplinary guidelines for maternity care to promote consistent standards of practice, quality and safety in collaborative team models. These guidelines are to be agreed by the professions involved, in consultation with consumers and state and territory governments.**
- 4. That, in developing the National Maternity Services Plan, consideration be given to the demand for, and availability of, a range of models of care including birthing centres.**

3. Inequality of Outcomes and Access

While our system delivers to most Australian women, access to quality maternity services and positive outcomes from pregnancy, this is not uniform, as some parts of Australia and some population groups experience poorer access and outcomes. As with health care services more broadly, the difficulties faced by many Australians in accessing necessary services in rural areas has been highlighted to the Review Team. Similarly, the poorer access and outcomes for Indigenous mothers and babies were identified by many as the most pressing national issue.

In considering the inequalities within our current maternity system, the Review has focused on the issues of access to maternity services for Indigenous mothers and their babies and for mothers and babies living in rural and remote Australia. At the same time, the Review Team acknowledges that inequalities in both access to services and outcomes can be the result for some individuals and population subgroups of other factors such as socioeconomic status, risk factors, and existing service delivery arrangements. The range of targeted initiatives and services, both within and outside the health sector, that currently exist or that could be considered by governments to address these inequalities is recognised by the Review but has not been part of its detailed considerations.

3.1 Rural

Current Context

Rural and remote families experience higher rates of maternal death;⁴³ rural women have significantly higher rates of neonatal deaths and remote women have higher rates of fetal deaths.⁴⁴ While these outcomes are in part reflective of the poorer outcomes for that

proportion of these populations identifying as Indigenous, this is not the entire picture.

People living in rural and remote areas face a number of health inequities, many of which result from, or are exacerbated by, problems in accessing health care services. Health inequities are demonstrated by higher incidences of chronic disease and disease risk factors, high rates of smoking, consumption of alcohol in quantities risking harm in the short term, obesity, and death rates that increase with remoteness. For example, females living in rural and remote areas were 1.3 times more likely to report diabetes than those living in major cities.⁴⁵

For rural and remote communities, accessing appropriate maternity services raises particular issues. What exacerbates this is the need for ongoing care throughout the pregnancy and, for higher risk pregnancies, the requirement for a significant period of hospitalisation prior to and sometimes after the birth. Even in a low-risk pregnancy where a woman has access to a GP, she may still have to travel a considerable distance in anticipation of the birth or for some aspects of her antenatal or postnatal care. Current supports and services, including travel and communication, are inadequate to cater for the needs of all women and their families in rural and remote areas.

As is the case for all health care, however, maternity services require access to an appropriately skilled workforce and associated infrastructure, not all of which can be provided in every community. The alternative to travel by women, for some aspects of care, is for fly-in fly-out services from maternity care professionals. The Medical Specialist Outreach Assistance Program (MSOAP) improves the access of people living in rural and remote Australia to medical specialist services by complementing outreach specialist services provided by state governments and the Northern Territory government. For its part, the Specialist Obstetrician Locum Scheme (SOLS)

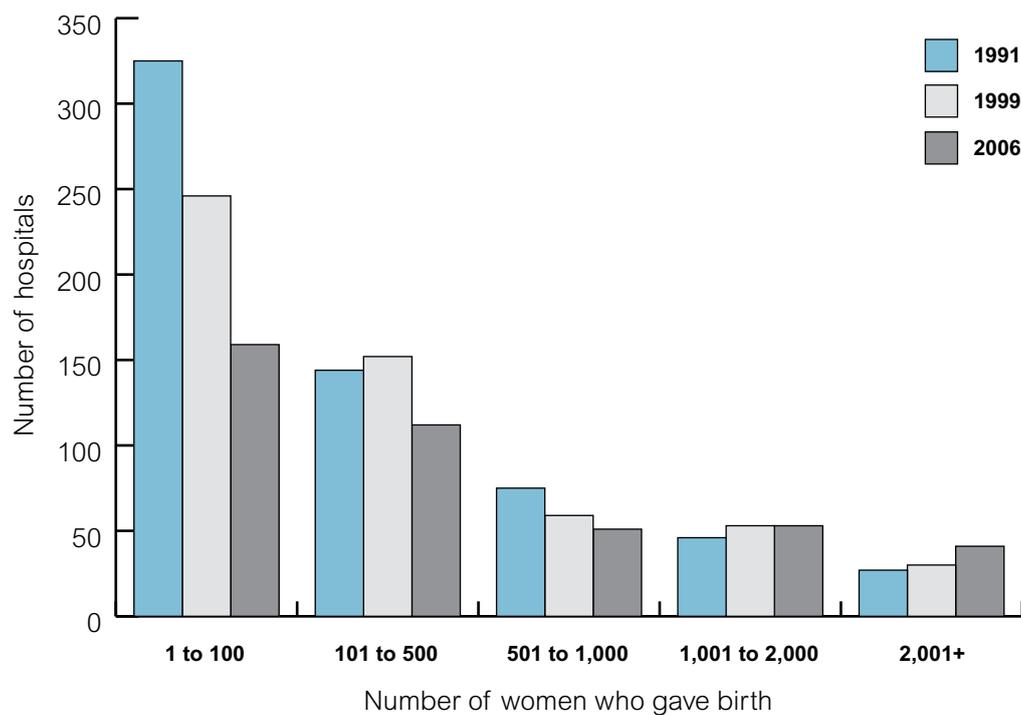
supports access of rural women to quality local obstetric care by providing locum support to the rural specialist obstetrician workforce, obstetricians and GP obstetricians.

Over recent years, there has been a decline in the availability of facilities providing maternity services in rural and remote Australia. The Rural Doctors Association of Australia (RDAA) reported in 2006 that over 130 small rural maternity units had closed across Australia in the 10 years since 1995.⁴⁶ State government closure of these facilities has been the result of workforce shortages, safety and

quality considerations and, inevitably, cost considerations.

The AIHW reports that the number of hospitals and birth centres fell by one-third between 1991 and 2006, from 617 to 416. Figure 8 shows that this reduction in hospitals and birth centres was greatest in hospitals that saw between 1-100 women who gave birth per year; the number of these centres almost halved from 325 to 159.⁴⁷ Workforce considerations for rural and remote Australia are discussed in Chapter 5.

Figure 8: Hospitals and birth centres, by number of women who gave birth, Australia, 1991, 1999 and 2006



Source: Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit, *Australia's mothers and babies 2006*, Perinatal statistics series no. 22, Cat. no. PER 46, Sydney.

What the Review Team Heard

- Many submissions to the Review highlighted the growing impacts on communities and families of a lack of maternity services in rural communities. These included family disruption and costs associated with travel and accommodation, the physical and other impacts of long travel, and the risks including roadside birthing.

*Women in rural and remote areas are no different from their city sisters in having the same wishes, but rarely are these wishes realised. If their preferred option is not available locally, they have to travel away from home, sometimes long distances to metropolitan centres, where they are dislocated from their support structures. They often have significant financial outlays for travel and accommodation. However, like most people who live in rural, regional and remote areas, they are pragmatic, and accept that they need to make some compromises for living in small communities. Nevertheless they have a right to access more options than currently exist for them.*⁴⁸

- The Review heard of the critical role played by procedural GPs (obstetricians and anaesthetists) in providing maternity services in rural communities, the impact of their declining numbers on rural communities and the opportunities for developing collaborative models of care where procedural GPs were involved.

*It is increasingly common for GPOs (general practitioner obstetricians) to work collaboratively with midwives, deliver only more complex cases and, where neonatal resuscitation skills are good, not necessarily attend the delivery.*⁴⁹

- Also highlighted to the Review was the importance of focusing on a range of models of care that allowed services, as far as possible, to be close to home and sufficiently flexible to adapt to local circumstances.

*It is important that maternity care is accessible close to home. An interesting outcome of the Rural Maternity Evaluation was that women were comfortable accessing labour services away from home providing that pregnancy and postnatal services were accessible close to home.*⁵⁰

- An issue raised for rural women was the fragmented nature of their maternity care.

*It is well known that adverse events increase when the patient moves between systems or hospitals. Transition between primary care sector and acute care sector whether in the postnatal, antenatal or birthing period requires excellent communication systems, referral processes and clinical guidelines. Clarity around when accountability ends and starts is also important.*⁵¹

*The development of improved networks between rural and major centres will assist education and training, as well as the clinical management of individual cases, particularly high-risk women. Access to improved teleconference facilities will also assist rural centres in particular.*⁵²

The Review process brought to light jurisdictional differences in the supports available for health professionals. In particular, access and linkages from rural and remote primary care providers to tertiary, specialist advice and retrieval services was highlighted. Activities being undertaken in some jurisdictions to redesign their health services to provide services locally when this can be done

safely, effectively and efficiently and to better integrate services when they are provided across multiple settings were also relevant.

*The sustainability of safe, high-quality services, particularly in rural and remote communities, will depend on the creation of formal networks of health professionals (midwives, GPs, obstetricians) who work as an integrated team to ensure a seamless and holistic approach to service provision along the continuum of care. Strong clinical governance, guidelines and clear transfer and referral protocols are required to support women and their babies.*⁵³

Recent Related Initiatives

As part of the COAG Indigenous Health National Partnership, the Commonwealth committed to the expansion of the Medical Specialist Outreach Assistance Program (MSOAP) to increase access to specialist services in rural and remote areas.

In the 2008–09 Budget, the Commonwealth provided \$7.9 million over four years to support and expand the Specialist Obstetrician Locum Service (SOLS).

Discussion

The provision of maternity services to rural communities will require trade-offs between access to services locally and considerations of safety and quality. What is more challenging is determining which services can and should be provided at the local level and what is not practical or appropriate to provide, taking into account considerations of quality and safety, availability of a suitably trained workforce and infrastructure, costs and consumer preference. These are complex issues, with a variety of different views existing in the community.

Planning of rural maternity facilities, under current arrangements, is primarily the responsibility of state and territory governments. The RDAA, in its submission, has called for standards to be established for access to rural maternity services.⁵⁴ As discussed in Chapter 6.1, the new National Health Care Agreement sets a target that all Australian babies are born healthy and remain healthy and will provide scope for increasing the range of maternity health care models available to Australian women.

As noted, submissions from a number of jurisdictions point to activity to redesign health services to provide services locally when this can be done safely, effectively and efficiently and to better integrate services when they are provided across multiple settings.

For maternity care, the development of collaborative care models, responsive to community needs, together with regionally integrated service systems, could significantly improve access to maternity care for rural women, their babies and families. As part of delivering care, the scope of outreach services is important. The Review Team considers that the inclusion of midwives and other appropriate health workers in existing outreach schemes, such as MSOAP, would assist in improving access for rural and remote women to maternity care.

A number of submissions identified existing services that pointed to the potential for midwives working within collaborative models of care to expand the provision of local ante and postnatal care within small communities. Such services, when combined with transfer of the mother to larger centres for delivery, supported by referral and communication networks and systems, may provide rural women with more options and reduce travel requirements.

In considering a range of models for rural communities, the need to allow flexibility to respond to community need and priorities and workforce availability was identified as critical, as opposed to the imposing of a 'one size fits all' model of maternity care for all communities.

Linked to the availability of maternity services for rural consumers is the availability of specialist advice for health professionals providing services on the ground in rural areas. For example, a number of states and territories operate integrated specialist phone advice systems comprising bed management, obstetric advice and support, and patient transfer/retrieval. Given the workforce shortages of health professionals in rural areas, these types of services are essential.

Conclusions

The Review Team concluded that:

- Mechanisms to improve maternity care networks so that systematic processes exist to link local, regional, and tertiary services with support and backup are vital.
- Collaborative care models developed for rural communities must reflect local circumstances, including the availability of appropriately skilled workforce.
- The role of outreach services is an important component of the service mix.

Recommendation

- 5. That, given the role of the states and territories in the provision of maternity services in rural areas, the availability of rural maternity services is a priority area for the Plan, requiring the engagement of states and territories.**

3.2 Indigenous

The maternal and perinatal outcomes of Indigenous mothers and their babies are markedly poorer than those of non-Indigenous women and their babies. In 2006, Indigenous babies had a higher rate of fetal death (11.7 per 1,000 births compared with 7.2 per 1,000 non-Indigenous births);⁵⁵ a higher rate of neonatal death (7.1 per 1,000 births compared with 2.8 per 1,000 non-Indigenous births);⁵⁶ a higher rate of preterm birth (13.7 per cent compared with 5.1 per cent);⁵⁷ and a higher proportion of low birth weight (12.4 per cent under 2,500 g, compared with 6.4 per cent).⁵⁸ In 2003–05, maternal mortality rates for Indigenous women were more than two and a half times as high as for other women. There were 21.5 deaths per 100,000 women giving birth, versus 7.9 per 100,000 for non-Indigenous women.⁵⁹

These poorer health outcomes are due to a range of factors. For example, according to statistics available for 2006, Indigenous women were more likely to smoke during pregnancy (52.2 per cent compared with 15.6 per cent)⁶⁰ and were more likely to give birth while teenagers (20.9 per cent compared with 3.7 per cent).⁶¹

Importantly, Indigenous women are also less likely to access antenatal care in the first trimester of pregnancy when many risk factors could be addressed.⁶² In the four jurisdictions that recorded information on antenatal care in 2005, 96 per cent of Aboriginal and Torres Strait Islander women accessed antenatal care at some point during their pregnancy. However, compared with other women, access generally occurred later in pregnancy, and less frequently. For example, in New South Wales, 53 per cent of Aboriginal and Torres Strait Islander mothers had their first antenatal session in the first trimester of the pregnancy, compared with 63 per cent for other mothers. In the Northern Territory, 35 per cent of Indigenous mothers had their first antenatal

session in the first trimester of the pregnancy, compared with 54 per cent for other mothers. Fewer Aboriginal and Torres Strait Islander mothers access five or more antenatal sessions compared with other mothers in Queensland (72 per cent versus 93 per cent), South Australia (64 per cent versus 88 per cent) and the Northern Territory (77 per cent versus 96 per cent). Indigenous mothers who attended antenatal care were less likely to have low birth weight babies (13 per cent) than those who did not attend (39 per cent); low birth weight babies are also associated with their mothers' later commencement of antenatal care and attendance at fewer than five antenatal care sessions.⁶³

The services received by Indigenous women at the onset of labour and during birth are significantly different from those for non-Indigenous women. Between 2001 and 2004, 70 per cent of Indigenous mothers had a spontaneous onset of labour (compared with 57 per cent for non-Indigenous mothers). Of Indigenous mothers, 19 per cent had an induced onset of labour (compared with 26 per cent for non-Indigenous mothers); 5 per cent had instrumental vaginal deliveries (compared with 11 per cent for non-Indigenous mothers); and 22 per cent had caesarean sections (compared with 28 per cent for non-Indigenous mothers). Among Indigenous mothers, spontaneous vaginal deliveries were less common in major cities and areas of greater socioeconomic advantage.⁶⁴

Indigenous people face a number of barriers to accessing health services including cost, cultural appropriateness and distance from health services. Barriers to accessing health care when needed, including maternity services, vary between remote and non-remote areas, with cost being a more significant issue in urban Indigenous communities and transport/distance and the lack of availability of services being more important in remote areas.⁶⁵

What the Review Team Heard

- A number of submissions that directly addressed Indigenous issues referred to the partnership established by COAG to work with Indigenous communities to 'close the gap' on Indigenous disadvantage and 'close the gap' in life expectancy. Stakeholders stressed the importance of ensuring that the commitments made by COAG in the Close the Gap Statement of Intent⁶⁶ inform the findings of this Review and provide its broader context.⁶⁷
- A key issue discussed during the Indigenous Perspectives Forum was the need for culturally safe and community-centred models of care in partnership with Indigenous communities in rural, remote and urban settings.

*The birthing experience of Aboriginal and Torres Strait Islander women is fundamentally culturally different from that of non-Indigenous women. Birthing is and continues to be—in some communities—a cultural rite of passage where knowledge, practices and beliefs are transferred from older to younger women, identity and links are established to land and connections with country are shared and celebrated.*⁶⁸

- Submissions and the Indigenous Perspectives Forum raised the importance of understanding the preference of Indigenous women to 'birth on country' and respecting the belief that informs this preference. Submissions also referred the Review Team to the Canadian Inuit 'birthing on country' model.⁶⁹

*Land is the birthplace of women, it gives them strength and identity for survival.*⁷⁰

- The attention of the Review Team was drawn to the particular concerns of Indigenous women in remote communities associated with travelling to a larger centre for maternity care, including isolation and dislocation from their communities, inappropriate accommodation for women and their families while in town, lost wages if a partner had to stop working to look after the family, and risk to other children left in the community while mothers were away.
- Examples of culturally appropriate models of maternity services for Indigenous women identified in the Review are set out below.
 - Congress Alukura in Alice Springs provides a range of services under a midwife-led women's health clinic. The Alukura model involves an agreement with the Alice Springs hospital that has enabled midwives employed by Alukura to attend low-risk women in labour and birth.

*There are 3 key elements of Alukura's underlying philosophy. Firstly, it acknowledges that Aboriginal peoples are distinct and viable cultural groups with our own cultural beliefs & practices, law & social needs. Secondly, it recognises that every woman has the right to participate fully in her pregnancy & childbirth care, and determine the environment and nature of such care. Finally, it recognises that every Aboriginal woman has the right in pregnancy and childbirth to maintain and use her own heritage, customs, language and institutions.*⁷¹

- Nganampa Health Council provides a range of services including an antenatal care program, health education to young mothers, and child health including immunisation, nutrition education, growth monitoring and targeted health screening.
- Ngua Gundi Mother Child Project, Woorabinda, Queensland, is a midwifery model of care provided in culturally sensitive settings, with home visiting by the Aboriginal Health Worker and midwife.
- Aboriginal Maternal and Infant Health Strategy (AMIHS), New South Wales, is a community-based maternity service that includes a midwife working in partnership with an Aboriginal Health Worker or Aboriginal education officer to provide care to pregnant Aboriginal women, new mothers and their babies in a culturally safe environment.
- Strong Women, Strong Babies, Strong Culture program, Northern Territory, aims to increase infant birth weights and improve maternal weight status by encouraging earlier attendance for antenatal care. The program is under the control of community women and is culturally based.

\$107 million over 5 years from 1 July 2009 to the states and territories to: increase access to and use of antenatal services in the first trimester by young Indigenous mothers; support young Indigenous teenagers to make informed decisions about family planning; and drive improved data collection and reporting by states and territories on outcomes for Indigenous children. States and territories will focus their efforts in areas with significant numbers of young Indigenous women and high numbers of births by teenagers.

This Agreement builds on the existing Commonwealth election commitment of \$90 million for *New Directions: An Equal Start in Life for Indigenous Children* which will provide: improved access to antenatal care; standard information about baby care; practical advice and assistance with parenting; monitoring of developmental milestones; and health checks for Indigenous children before starting school.

The Australian Government is continuing to invest in early childhood initiatives to improve maternal and child health outcomes for Aboriginal and Torres Strait Islander people. The Australian Nurse Family Partnership Program will provide structured and sustained nurse-led home visiting services in targeted regions to women pregnant with an Aboriginal and/or Torres Strait Islander child. Home visits will commence during the antenatal period, and will continue until the child is two years old.

Recent Related Initiatives

The Australian Government has committed to halving the gap in mortality rates for Indigenous children under five within a decade. The National Partnership Agreement for Indigenous Early Childhood Development, signed by COAG leaders on 2 October 2008, will make a significant contribution to this target. The Agreement, which comprises \$564 million of joint funding over six years, includes a focus on increasing access to and use of antenatal services by young Indigenous women. The Commonwealth is providing

Discussion

It is well recognised that Indigenous women suffer a disproportionate burden of illness in pregnancy and childbirth and that their babies can also be less healthy. While some of these issues are linked to broader issues such as substance misuse, nutrition and social determinants, there are also factors directly linked to the organisation and delivery of maternity services.

Like other women, Indigenous women seek access to safe, high-quality, evidence-based care in their own community and from their choice of health practitioner. Indigenous women are more likely to access services and will experience better outcomes from services that are respectful and provided in culturally safe places.⁷² Submissions to the Review have identified a number of effective models for maternity services that have demonstrated significant outcomes for Indigenous people in urban, rural, and remote communities. Some of these programs have been evaluated and documented. These models have focused on midwife and Aboriginal Health Worker care that is culturally appropriate and delivered in a community-based setting.

In contrast, where services are not culturally appropriate, women are less likely to attend. This applies to antenatal and postnatal services as well as to childbirth. Research by Charles Darwin University suggested that between 5 per cent and 22 per cent of births were occurring on site in the three largest remote Indigenous communities because women are avoiding the system or having preterm babies.⁷³

Although a number of previous reviews as well as Indigenous participants in this Review have advocated greater scope for 'birthing on country', travel to birth and the involvement of hospital services is and will remain a core part of service delivery—with both cultural awareness and integration of community-based services important.

It is clear that models for maternity care for Indigenous women should involve mechanisms to ensure ongoing consultation with Indigenous communities and sufficient flexibility to respond to the individual needs of Indigenous women given the variability within and across their communities. It is important that models of care include strategies to address the high rates of risk factors such as smoking, substance misuse, poor nutrition, poor dental health and domestic violence.

Conclusions

The Review Team concluded that:

- Expanding the range of collaborative care models responsive to local needs will provide greater choice for all women in Australia, including Indigenous women. The expansion of collaborative models of care should take account of the successful models for Indigenous women that have been developed in various rural, remote and urban areas.
- Maternity services should acknowledge—and, where possible, accommodate—the particular cultural beliefs concerning childbirth held by many Indigenous families, including a preference for 'birthing on country'.
- Maternity care health professionals who work with Indigenous women and their families, including those who work in hospital settings, should have appropriate cultural awareness training.

Recommendations

6. That provision of maternity services be considered in the context of all governments' commitment to close the gap on Indigenous disadvantage, and be developed in partnership with Indigenous people and their representative organisations.
7. In consultation with relevant state or territory governments, that consideration be given to funding expansion of Indigenous maternity care programs, based on current successful models, within a research and evaluation framework.
8. That, in any initiatives that are aimed at supporting an expansion or upskilling of the maternity services workforce, particular focus is given to supporting an increased number of Indigenous people as members of the maternity workforce, across a range of roles.
9. That all professional bodies and employers ensure that all health professionals and other staff involved in the delivery of maternity care receive cultural awareness training.
10. That all professional bodies involved in the education and training of the maternity workforce ensure that cultural awareness training is a core component of their curricula.

4. Information and Support for Women and Their Families

Current Context

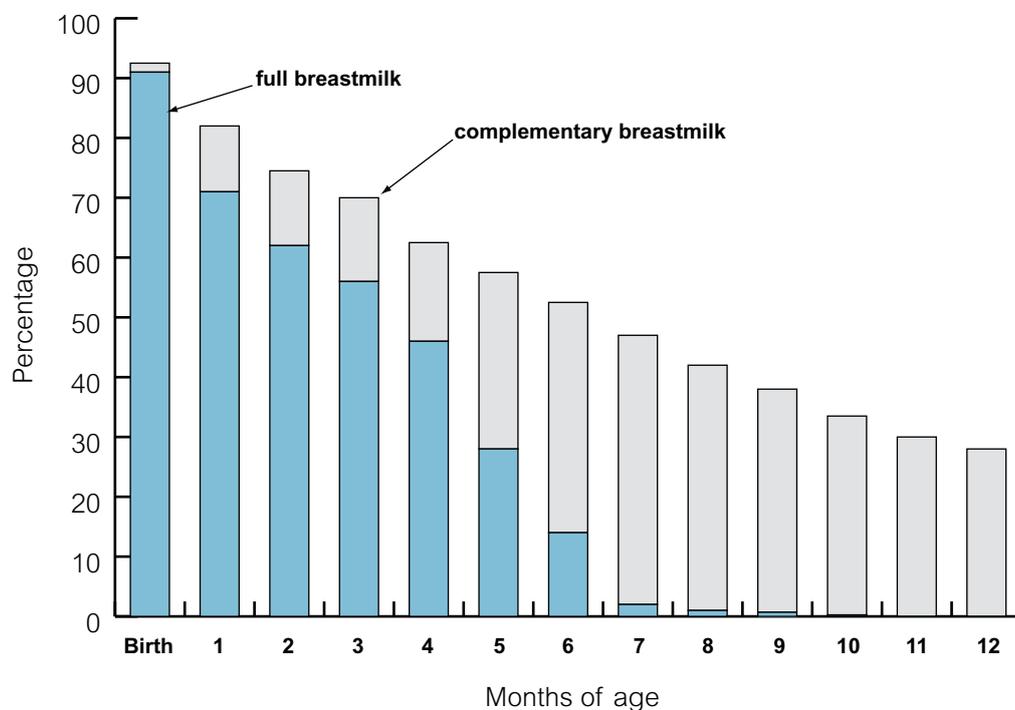
Information and support for women assists them in making decisions at all stages of their pregnancy: prior to becoming pregnant, during pregnancy, birthing and in the postnatal period. These decisions can have short and long-term impacts on health outcomes for mothers and babies alike. Some women have difficulty accessing evidence-based information about pregnancy, birth and the postnatal period. Furthermore, another important aspect of informed decision making is that perceptions of risk are different for each woman and for each maternity care provider. This adds complexity to the provision of information and support for women.

The need for information and support strategies to address obesity, alcohol and smoking has a particular relevance for pregnancy. Average smoking rates of pregnant women are 17.4 per cent of all pregnancies, 42 per cent during teenage pregnancies, and 52 per cent for Indigenous pregnancies. There is a reported 59 per cent of women drinking

at some time during their pregnancy and an increasing prevalence of obesity in young women. These factors pose serious risks to the developmental prospects of affected children and their lifelong health.⁷⁴

Similarly, exclusive breastfeeding duration rates are of concern. Australia's dietary guidelines recommend exclusive breastfeeding of infants until six months of age, with the introduction of solid foods at around six months and continued breastfeeding until the age of 12 months and beyond if both mother and infant wish. The NHMRC considers that an initiation rate for breastfeeding in excess of 90 per cent and a rate of infants being breastfed at age six months of 80 per cent are an achievable goal for Australia.⁷⁵ The 2006–07 report of the Longitudinal Study of Australian Children found a breastfeeding initiation rate of 92 per cent, which compares favourably with the NHMRC's suggested goal.⁷⁶ However, the breastfeeding rate declined steadily after birth, with 71 per cent of infants fully breastfed at age one month, 56 per cent at age three months and 14 per cent at age six months. At 12 months, 28 per cent of children were still receiving some breastmilk. Figure 9 shows the percentage of infants receiving full breastmilk and complementary breastmilk (supplemented with other food or drink) to 12 months of age.

Figure 9: Breastfeeding: the first 12 months



Source: Australian Institute of Family Studies, 2008, *Growing up in Australia: the Longitudinal Study of Australian Children: 2006-07 Annual Report*, available <http://aifs.org.au/growingup/pubs/ar/ar200607/breastfeeding.html>

A myriad of factors influence why mothers stop breastfeeding or do not continue to breastfeed exclusively for the first six months. There is a complex relationship between individual-level factors such as the health and risk status of mothers and infants, socioeconomic status, education level, knowledge, attitudes and skills; group-level factors such as home and family environment, support from hospital and health services, workplace flexibility, community attitudes and the public policy environment; and social, cultural and economic factors which affect child feeding and parenting behaviour and the roles of women and men in society.⁷⁷

Recently published Australian research investigated the relationship between socioeconomic status and breastfeeding and reported a widening gap in breastfeeding rates between families living in the most advantaged and disadvantaged areas.⁷⁸ The relationship between breastfeeding and returning to work is complex. A 2004–05 Australian survey(s) found a relatively small proportion of women returned to work in the early months following childbirth—11 per cent at 3 months, 21 per cent at 6 months and 42 per cent by 12 months—and most of those who returned to work did not work full time.⁷⁹ Employment alone did not account for declining breastfeeding in the early months, however; the study found that mothers who were not employed or who

worked fewer than 10 hours per week had the highest breastfeeding rates at each of 3, 6, 9 and 12 months.⁸⁰ The type of work also mattered, with self-employment and more flexible jobs being associated with higher rates of breastfeeding.⁸¹ A recent Californian study found a positive association between the length of maternity leave taken and the duration of breastfeeding, and that mothers taking shorter maternity leave, working in inflexible or non-managerial jobs or experiencing psychosocial distress were more likely to stop breastfeeding earlier.⁸²

Perinatal depression has been identified as a priority by the Commonwealth, state and territory governments given that approximately 15 per cent of new mothers in Australia each year experience perinatal depression.⁸³ Evidence strongly indicates that mothers who have good mental health in the perinatal period have positive impacts upon the cognitive, emotional and behavioural consequences of their children. Children of mothers with perinatal depression have been shown to have increased risk of depression and anxiety disorders.⁸⁴

Another group requiring particular support are women who experience adverse pregnancy outcomes, including stillbirth. Stillbirth, for example, affects almost one per cent of all births in Australia; 2,091 pregnancies of at least 20 weeks' gestation ended in a stillbirth in 2006.⁸⁵ This represents one stillborn baby for every 134 births.

Also important are the links for women between maternity services and those services that will provide ongoing health care for mothers and their babies, particularly primary health care services, including GPs and child health services.

What the Review Team Heard

- A range of issues and perspectives were provided to the Review concerning the scope and adequacy of support services available to assist women. These included professional postnatal services as well as professional and peer support services including pregnancy education, pregnancy counselling, depression counselling and support, grief and loss counselling and support, breastfeeding support, early parenting adjustment and child health support.

Peer support which provides non-medical support and information over an extended time and professional support are complementary.⁸⁶

Birth is a social and physiological function with biological consequences, and therefore managing the emotional wellbeing of women is paramount to ensuring successful delivery and efficacy of maternity services ... There is good evidence that building the availability and utilisation of community and peer support at a national level can lead to improved outcomes for women in the perinatal period.⁸⁷

- The need for more extensive professional postnatal support, specifically in the first 10 days postnatally, was raised with the Review. In particular, a number of submissions suggested the need for greater professional support in initiating and establishing breastfeeding, including greater access to support from midwives, including those trained as lactation consultants.

The crucial issues of supporting the new mother in the postnatal period really hinge on integrating her into the social and health care networks in the community.⁸⁸

- A particular focus of submissions as well as discussion at the Peer and Social Support Forum was the care and support provided to families whose babies had died before, during or after birth. The need for a more consistent approach to ongoing care through the provision of resource materials and access to support (professional and non-professional) was identified. Highlighted to the Review was the limited adoption of the Perinatal Society of Australia and New Zealand Clinical Practice Guideline for Perinatal Mortality Audit.⁸⁹

*We lost a baby in traumatic circumstances in early pregnancy and my clearest memory of this is being placed in the maternity ward of the local public hospital alongside mothers who had just given birth ... it took me months to recover and grief counselling would have been a very welcome option.*⁹⁰

- Submissions advised of the need for evidence-based information to assist consumers in making decisions about their care.

*Looking back, we now realise that during this pregnancy we experienced a lack of information and support in making our own choices. It seems that in order to find information you must track it down yourself, and being first-time parents that information can be very hard to find, especially if you do not know what information you seek.*⁹¹

- Many consumer submissions received by the Review reflected poor communication on the part of hospital staff, particularly obstetricians. This contributed to the dissatisfaction of these women, who described feeling patronised, bullied and coerced and told what to do, rather than being seen as an equal partner in deciding on care options.

- In this context, there was also discussion throughout the consultation process about differing perceptions of risk, and the fact that many women may place greater importance on factors not taken into account in a biomedical assessment of risk.
- The lack of evidence relating to effective care for this period was also raised, highlighting the need for evaluation of existing programs and services and targeted research in this area.

*There is little evidence to guide early postnatal care including routine approaches to maternal and infant health assessment; planning for the postnatal period in pregnancy; identification and management of complex psychosocial issues; the impact of early postnatal discharge on maternal and infant health; the value of routine domiciliary visiting; the impact of linkages between acute and primary care services.*⁹²

Recent Related Initiatives

The House of Representatives Standing Committee on Health and Ageing report on breastfeeding—*The Best Start: Report on the Inquiry into the Health Benefits of Breastfeeding*—recognised the health benefits of breastfeeding for both babies and mothers in terms of the physiological, nutritional and cognitive aspects of infant development as well as maternal wellbeing.⁹³ The Australian Government response to the inquiry agreed to:

*provide national leadership in promoting and supporting breastfeeding by inviting state and territory governments, through the Australian Health Ministers' Conference, to collaborate on the development and implementation of a National Breastfeeding Strategy.*⁹⁴

It is envisaged that a National Breastfeeding Strategy will provide a framework for priorities and action for promoting and supporting breastfeeding, including areas of cross-jurisdictional responsibility and best practice.

Since taking office in 2007, the Australian Government has committed funds to various initiatives to support breastfeeding:

- An infrastructure upgrade to the Australian Breastfeeding Association's Breastfeeding Helpline is providing mothers, their partners and families, including those in rural and remote areas, with access to breastfeeding advice and peer support via a national toll-free number 1800 MUM 2 MUM (1800 686 2 686).
- The Australian Breastfeeding Association has been contracted to develop increased breastfeeding education opportunities for health professionals (including nurses and midwives) and nationally recognised courses for Breastfeeding Helpline volunteers.
- An Australian National Infant Feeding Survey will interview a representative sample of families with young babies, provide data on the prevalence and duration of breastfeeding, explore the barriers to initiating and continuing breastfeeding, and collect data on other foods consumed by Australian infants.
- A qualitative research project will explore attitudes towards, and perceptions of, breastfeeding among mothers, pregnant women, their partners and health professionals.

Through AHMAC, state and territory governments together with the Australian Government have agreed to collaborate on the development of a National Perinatal Depression Initiative to improve the prevention and early detection of antenatal and postnatal depression, and to provide better care, support and treatment for expectant and new mothers experiencing perinatal depression.

The Australian Government has committed \$55 million over five years to this national initiative to strengthen service pathways through additional funding under the Access to Allied Psychological Services Initiative, to support the role of *beyondblue* as a national centre of excellence on perinatal depression, and to contribute to state and territory government screening, workforce training and development and care pathways. In this context, the Perinatal Depression Working Group established to advise AHMAC on a national framework for perinatal depression has agreed on the importance of quality peer support provided through NGOs in supplementing care pathways for women diagnosed with perinatal depression. The working group comprises representatives of all jurisdictions, *beyondblue*, and consumer and carer representatives.

Discussion

A number of submissions to the Review and discussions at the forums pointed to the need for objective and readily accessible information on many aspects of pregnancy, including information about best practice in maternity care and the risks and benefits of different interventions. The need to make such information readily available via the internet was also highlighted. In 2006, the National Health Service (NHS) in the United Kingdom launched an NHS- accredited website aimed at providing consumers with objective, detailed information about all aspects of pregnancy, birth and postnatal care and support. The scope for improved telephone support in Australia is discussed below.

The Department of Health and Ageing has recently commissioned breastfeeding research and data collection projects. They will provide information on how and who to communicate with to promote breastfeeding and assist in identifying further research priorities and strategies to increase breastfeeding rates. Given the Review's findings about

contemporary Australian birthing practices, perinatal support mechanisms and inequality of outcomes and access, additional investigation is warranted on the extent to which breastfeeding promotion messages and support mechanisms are effective in reaching women from diverse cultural and socioeconomic backgrounds.

In any approach to improving accessibility of information, the needs of population subgroups in our community, including Indigenous mothers, should not be overlooked. These subgroups may need particular information and support targeting nutrition, smoking and alcohol consumption.

In assisting consumers in making decisions about their maternity care, it is important to provide information regarding the risks associated with those decisions. Informed decision making should consider safety and effectiveness as well as the values and circumstances of individual women.⁹⁵ However, communication of the risks associated with those decisions is not necessarily straightforward.⁹⁶ Studies have shown differences between women's self-rated pregnancy risk and their biomedical risk score. A range of factors can influence women's perceptions of risk. Importantly, from a woman's perspective, this can include factors that are not part of a biomedical risk assessment. For Indigenous (and non-Indigenous) women, risk is considered within a framework of cultural and community needs and values.

Risk communication is essential; however, there is no 'one size fits all' guideline. Some work has been done on decision support aids in this area.⁹⁷ One of the key challenges is to develop methods of communicating risks (and choices) to women who are faced with rapid decision making in an acute setting.

Research indicates that peer support is an important element in reducing the likelihood of mental illness; along with professional assistance, it is an effective intervention

in reducing symptoms of postpartum depression.⁹⁸ Evidence indicates that grief can trigger the onset or recurrence of mental disorder and that poor social support is a risk factor for bereavement-related depression.⁹⁹ In addition, treatment for complicated grief and bereavement-related depression, which includes broader support mechanisms, is more likely to result in a successful outcome for the individual.¹⁰⁰

It is clear from the submissions to the Review and the discussion at the Peer and Social Support Forum, in particular, that there are a range of organisations, large and small, involved in the provision of peer and social support services in their communities, in the areas of perinatal depression and grief and loss support. It is also clear from consultations associated with this Review that compassionate and timely support from professionals and peers for women experiencing grief and loss during the perinatal period is considered to be a vital component of a humane system of care.

Also evident from discussions was that these services were not always well integrated with, or well known by, local clinical care providers. It was suggested that a lack of integration between clinical and non-clinical services providing care can lead to fragmentation of care delivery, confusion and dissatisfaction for women, and an increased risk that critical elements in a woman's care will be overlooked. This would suggest the need for improved quality assurance and triage arrangements to ensure that the right individuals have access to the right sort of support at the right time. The Australian and New Zealand Stillbirth Alliance (recently established through seed funding from the Department of Health and Ageing) includes professional colleges, parent-based research foundations and support organisations, and data collection agencies. Part of its intended role is to serve as a centralised resource for sharing information, consulting and connecting organisations and individuals.

The Review Team also considered the operation of the National Pregnancy Telephone Counselling Helpline. The helpline is a national (Australia-wide) helpline that operates 24 hours a day, seven days a week; it is staffed by trained counsellors who provide women who are experiencing an unintended pregnancy and/or their partners with non-directive, non-judgmental, independent pregnancy counselling that explores three pregnancy options (raising the child, having the child adopted or termination of the pregnancy). It does not provide referrals to service provider agencies. The helpline also receives calls from women who are seeking general pregnancy information (for the period July–October 2008, 30 per cent of calls were for general information).

One possible approach that could be considered would be to reorient the existing helpline service to provide a broader range of counselling and advice to women during the antenatal period and following the birth of a child. This service could be provided as an additional service, potentially using the National Health Call Centre infrastructure. An expanded service could, in addition to providing advice relating to pregnancy and the demands of a new baby, support triaging and redirection of calls to existing specialist lines, such as the Australian Breastfeeding Association's 24-hour national helpline as appropriate. The provision of some targeted support for other specialist NGO peer support organisations, such as those providing grief counselling, to enable them to have the

capacity to receive and handle telephone referrals from an expanded national line, may be desirable. Underpinning such an arrangement for referral would be agreed protocols and quality assurance arrangements for referrals and the telephone service provided by the NGO.

For those women and their families who experience the death of a baby, it is particularly important that the information and support provided be appropriate and timely. Training and ongoing skill development for all health professionals who care for families following the death of a baby, including those responsible for conducting autopsies, was identified as a crucial element of support and care. The allocation of dedicated spaces and resources within hospital/healthcare settings to allow for privacy and space for counselling and the provision of support to bereaved families is important.

Conclusions

The Review Team concluded that:

- The need to support women in making informed choices concerning their pregnancy and birthing options is an important issue. Women need to be well informed about the risks to themselves and their babies that their decisions may involve.
- While support services exist, in some instances they could be better integrated with clear referral protocols.

Recommendations

- 11. That consideration be given to improving the range of birthing and other pregnancy-related information and resources, including those on the internet, that is made available to assist women in informed decision making; with any information materials specifically recognising the needs of population subgroups such as culturally and linguistically diverse communities, women with a disability, Indigenous and teenage mothers.**
- 12. That consideration be given to the establishment of a single, integrated pregnancy-related telephone support line for consumers, possibly as part of the National Health Call Centre, providing both clinical and non-clinical support services, complemented by triage to a number of existing specialised support services.**
- 13. That in order to lengthen the duration of breastfeeding, further evaluation be undertaken to identify the health care or community settings in which breastfeeding information and support are most effectively received, with a particular priority on consulting and supporting women from diverse cultural and socioeconomic backgrounds.**
- 14. That the development of national maternity care guidelines (Recommendation 3 above) consider the Perinatal Society of Australia and New Zealand Clinical Practice Guideline for Perinatal Mortality Audit.**

5. The Maternity Workforce

Current Context

As discussed earlier, a range of health workers are involved in the provision of maternity care. These include obstetricians, procedural GPs (obstetricians and/or anaesthetists), midwives, nurses, anaesthetists, paediatricians, Aboriginal Health Workers, allied health professionals and lactation consultants.

The maternity workforce, as with the overall health workforce, is faced with existing and worsening shortages. The ageing of the population and the increase in chronic illnesses are placing increasing demands on an ageing health workforce. Traditional professional boundaries can reinforce traditional roles of health professionals and limit the flexibility of responses to meet increasing demands for health services. Rural and remote Australia has experienced medical workforce shortages for a considerable period, particularly in terms of general practice services and some specialist services, such as obstetrics and gynaecology.

In 2006, there were 1,241 specialists who spent most of their time as obstetric and gynaecology clinicians in Australia.¹⁰¹ This number has remained fairly constant over recent years, despite population growth: 1,119 specialists in 2002; 1,179 specialists in 2003; 1,137 specialists in 2004; and 1,168 specialists in 2005.

Twenty per cent of rural and remote GPs are proceduralists, providing non-referred services normally in a hospital theatre, maternity setting or other appropriately equipped facilities. GP proceduralists often provide services that in urban areas are typically provided by specialists, most commonly in the fields of surgery, anaesthetics and obstetrics. Rural Health Workforce Australia publishes an annual minimum dataset report on medical practice in

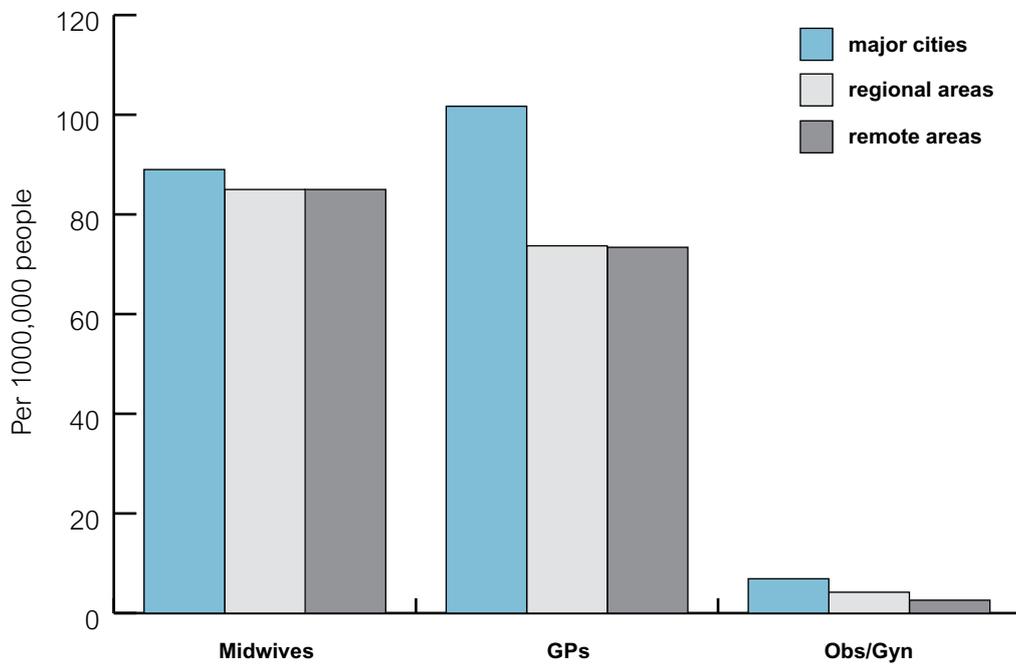
rural and remote Australia. Its report for 2007 shows that 896 rural GPs undertook procedural work. Of interest to this Review is the fact that, between 2002 and 2007, the number of procedural GPs providing obstetric services fell from 706 to 599. In 2007, 290 procedural GPs provided obstetric services only, 154 provided obstetric and anaesthetic services, 75 provided obstetric and surgery services, and 80 provided obstetric, anaesthetic and surgery services.¹⁰²

The midwife population is reasonably well distributed on a per capita basis in regional and remote parts of Australia compared with metropolitan areas, especially when compared with the distribution of other health professionals such as doctors and dentists. Nevertheless, access to midwife services in rural and remote areas is also affected by distance. In 2005, there were 18,297 registered midwives employed in Australia. Remote centres employed 77.2 registered midwives per 100,000 population; major cities, by comparison, employed 88.8 registered midwives per 100,000 population. The supply and distribution of health professionals, in particular throughout rural and regional areas, parallels to a great extent the distribution of state and territory health services across Australia.¹⁰³

The ageing of the maternity workforce is a major issue; the proportion of health professionals approaching retirement age is increasing. The average age of clinicians employed in obstetrics and gynaecology is 51.3 years. The average age of midwives is 45.6 years, and almost two-fifths (39.6 per cent) of midwives are aged between 45 and 54 years.¹⁰⁴

Figure 10 shows an indicative distribution of the maternity workforce for major cities and regional and remote areas.

Figure 10: Indicative maternity services workforce



Sources: Midwife numbers are from Australian Institute of Health and Welfare 2008, *Nursing and midwifery labour force 2005*, National health labour force series no. 39. Cat. no. HWL 40, Canberra: AIHW, additional spreadsheet *Registered nurses—clinical area by selected characteristics*, table 2; GP numbers are from Australian Institute of Health and Welfare 2008, *Medical labour force 2006*, National health labour force series no. 41. Cat. no. HWL 42, Canberra: AIHW, spreadsheet table 2.2; obstetrician/gynaecologist numbers are from Australian Medical Workforce Advisory Committee (2004), *The Specialist Obstetrics and Gynaecology Workforce—An Update 2003–2013*, AMWAC Report 2004.2, Sydney, p 31, and refers to 2003 data for capital city, other metro and rural/remote areas.

Since 2006, there have been increases in the number of university places for medicine and nursing to address workforce shortages as well as initiatives to encourage nurses back into the workforce. Increases in numbers do, however, require an equivalent investment in clinical training to ensure all graduates receive the appropriate level of experience during their education.

The majority of currently practising midwives are registered nurses with an additional postgraduate qualification in midwifery. The introduction of direct entry undergraduate midwifery programs, for people without an undergraduate nursing qualification, is relatively

recent; the first programs were introduced in 2002. Midwives are represented professionally by both the Australian College of Midwives and the Royal College of Nursing, Australia. The Australian College of Midwives operates the Midwifery Practice Review, a peer review mechanism that is part of the College's continuing professional development framework.

Educational requirements and continuing professional development for health professionals are regulated by relevant professional colleges and state and territory registration boards. A National Registration and Accreditation Scheme is scheduled to commence in July 2010.

What the Review Team Heard

- The availability of a suitably skilled workforce was considered the key to maintaining or improving maternity services. In the forums, the fact that an effective workforce was a prerequisite to providing adequate maternity care was a consistent theme. A lack of overall workforce planning was also highlighted by a number of stakeholders.
- Shortages of midwives were identified by a number of submissions and forum participants. At the same time, participants highlighted the possibility of attracting midwives back into the profession if opportunities to work under different models of care were available.
- Also highlighted to the Review was the important role played by procedural GPs (obstetricians and anaesthetists) in providing maternity services in rural communities. The issues involved in attracting and retaining GPs to these positions in rural communities were also considered.

Obviously such an army of professionals will be only available in the most advanced urban units. In suburban and particularly rural and remote Australia, the team might only consist of a single midwife and a GP obstetrician with the possibility of anaesthetic cover also available. While the range and number of professionals available may vary, the principles of teamwork, cooperation and assessable, up-to-date practice must remain constant.¹⁰⁵

- Issues involving cultural sensitivity for some overseas-trained doctors were raised by some contributors.
- The RDAA suggests that maintaining a rural maternity workforce requires adequate training and proper incentives, remuneration and support (both professional and personal).¹⁰⁶

- The need to encourage obstetricians to regional centres, and the pressures faced by the public sector in attracting obstetricians, were raised.
- The important role played by Aboriginal Health Workers in providing care for Indigenous women and their babies was raised. The need to train more Indigenous people as Aboriginal Health Workers, midwives and doctors was emphasised in the Indigenous Perspectives Forum.
- Alongside issues of workforce availability, the range of supports, such as locum relief, and accessible training were highlighted as being essential to maintain the workforce in rural areas.
- The importance of appropriate professional standards for all health professionals involved in maternity care was raised.
- Submissions suggested that within the nursing and midwifery profession there is some disagreement about the most appropriate training pathway and related education standards for midwives—whether through a direct entry midwifery program or via nursing with a graduate midwifery qualification.

Education of midwives currently follows two differing paths with undergraduate direct entry Bachelor of Midwifery programs being available in some areas and postgraduate Diploma or Master of Midwifery programs for registered nurses also available. There are also a variety of courses which have varying durations and requirements. The Australian Nursing and Midwifery Council are in the process of developing national standards for midwifery education. There is concern that the finalised standards will not achieve international comparability in terms of course length and mandatory clinical experiences ... The pathway through nursing to midwifery is fraught for a number of reasons.¹⁰⁷

*RCNA urges the Maternity Services Review to recognise the need to ensure that the Australian health system continues to be supported and sustained by comprehensively educated registered nurse/midwives. It is a health care imperative that this model remains the preferred option for the bulk of midwifery education to ensure that the midwifery workforce is not just flexible but well equipped to provide holistic family-centred services.*¹⁰⁸

- Many submissions from consumers, midwives and their representative organisations advocated comprehensive access for midwives to MBS rebates, referring and ordering and Pharmaceutical Benefits Schedule (PBS) prescribing rights, and hospital admitting rights. There was also a view put forward by some midwives and medical practitioners that the qualifications and experience of some midwives were insufficient to support the scope of practice that may be implied by direct access to these schemes—and that, in a manner similar to that established for nurse practitioners, advanced practice needed to be linked to additional qualifications and experience.
- Issues were also raised regarding the availability of appropriate clinical placements for midwifery students, including placements that allow continuity of care and access to delivery experience.
- In the context of poor interprofessional relationships that are reported to exist in some areas, the need to improve harmony within the maternity workforce is a high priority in achieving maternity reform.¹⁰⁹

Recent Related Initiatives

The issues of ensuring an adequate health workforce to meet our future needs have been recognised by Australian governments. At the COAG meeting on 29 November 2008, Commonwealth and state and territory governments responded to the challenges posed by health workforce shortages by committing \$1.6 billion to a health workforce reform package. This includes the establishment of a National Health Workforce Agency and health workforce statistical register to drive a more strategic, long-term plan for the whole of the health workforce. This investment will have a focus on improvements for the health workforce in rural and regional areas.

Discussion

The recent decisions by COAG on 29 November 2008 address a number of the issues relating to the maternity workforce raised in the Review. For example, the need for more clinical placement opportunities will be addressed as new clinical placement arrangements for undergraduate students, including doctors, nurses and midwives, are introduced as part of the COAG Workforce Package.

However, in the shorter term, the workforce, particularly but not exclusively in rural and remote Australia, remains under pressure. If, as suggested in this Report, new arrangements to encourage an expanded role for midwives within collaborative models of care are developed and implemented, it is nevertheless uncertain that there will be sufficient midwives with the appropriate skills and training for this role.

Procedural GPs (obstetricians and anaesthetists) will be key to improving services in rural Australia. Improved access to training and ongoing support will encourage GPs to improve their skills in relation to the provision of maternity care.

It is important that all members of the maternity care team meet appropriate professional standards for registration. The credentialing process for a GP or obstetrician wishing to access Medicare-funded services, for example, involves completion of postgraduate studies and clinical placements with the relevant medical college.

Currently, midwives work within their full scope of practice as defined by the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Midwife (2006). The Australian College of Midwives (ACM) encourages midwives to participate in its Midwifery Practice Review every three years.

The Review Team noted that midwives work in a variety of settings—for example, in hospitals, birthing centres, employed by medical practitioners and in private practice—and that the skills required may therefore vary. However, if new Commonwealth funding arrangements were implemented, the Review Team considers that midwives accessing those arrangements would need to meet an advanced practice level of professional education and experience to ensure the requisite level of professional knowledge and skill.

The Review Team noted that this will be an important issue to be addressed as part of the introduction of the National Registration and Accreditation Scheme. This Scheme will, for the first time, create a single national registration and accreditation system for ten

health professions, including nurses and midwives. The Review understands from the consultation paper on the proposed registration arrangements for the Scheme that the nursing and midwifery register will have separate divisions for midwives, registered nurses and enrolled nurses. In addition, ‘midwife’ is proposed as a title to be protected under legislation. Further consideration by governments is being given to additional titles to be protected in the nursing and midwifery profession, such as ‘nurse practitioner’.

Conclusions

The Review Team concluded that:

- Further strategies are required to attract and retain health professionals for maternity services in rural and remote areas.
- Leadership by the professional organisations is vital in encouraging an understanding of the benefits of national cross-professional guidelines for collaborative maternity care. Interdisciplinary continuing education activities are an important factor in improving interprofessional collaboration in clinical care.
- Between governments and within the nursing and midwifery professions, issues relating to professional education will need to be addressed for national registration and to facilitate a greater role for midwives in maternity care.

Recommendations

- 15. That consideration be given to support for the rural maternity workforce to obtain and maintain appropriate training and skills.**
- 16. That consideration be given to identifying the competencies and credentialing required for advanced midwifery practice.**

6. Financing Arrangements

As with other areas of health care, maternity services in Australia are services that represent a mix of Commonwealth, state and territory and private funding and delivery. The Commonwealth funds maternity services through four major channels: the MBS and PBS; state governments, through the national healthcare agreement for public hospitals; Private Health Insurance (PHI) through the 30 per cent rebate; and through a range of specific targeted programs.

The AIHW reports that \$1,672 million was spent on maternity services in Australia in 2004–05. Of this, over \$1,539 million (92 per cent) was spent on hospital-admitted services associated with deliveries taking place in hospital, with 70 per cent of this expenditure being for public hospital patients.¹¹⁰ In addition, \$456 million was spent on neonatal care.

These financing arrangements, combined with the traditional case mix approach to public hospital funding, have tended to direct maternity care in Australia towards an acute care setting that uses specialist care and, particularly in the private sector, limits the role of midwives.

State, territory and local governments provide or fund a range of community health services in a variety of settings. Community health services include antenatal and postnatal parenting support services and early childhood nursing programs as well as health promotion programs for women across a range of health-related areas. A comprehensive national picture of community health services is not available; collection of statistical information on these services is not as highly developed as that on other services (such as hospitals) and there is no nationally agreed basis for describing the nature of the services or for measuring the amounts of service provided.¹¹¹

The primary focus of the following discussion is on Commonwealth funding arrangements, particularly those funded through the MBS, and the impact of these arrangements on the models of subsidised care available to mothers and their babies.

6.1 Commonwealth Funding

Current Context

A substantial component of the Commonwealth's expenditure on obstetric services is funded through the MBS. Between 2003–04 and 2007–08, the amount of MBS funding for obstetric services increased from \$77 million to \$211 million.¹¹² Of the \$134 million increase in funding over the four years, \$109 million was due to MBS item 16590, for the 'Planning and Management of Pregnancy', and of this 97 per cent was claimed for services provided by obstetricians. The proportion of total Medicare funding of these services increased over the four years from 0.9 per cent to 1.6 per cent.

Existing MBS items for obstetric services are medically focused and are primarily concerned with the provision of antenatal care and labour/delivery services. Items focus almost exclusively on services provided by obstetricians, GP obstetricians and GPs, with provision for the involvement of others, such as anaesthetists and paediatricians, as the clinical need arises. Since November 2006, midwives' services have been covered by Medicare, but only in certain prescribed circumstances, including that the service is provided on behalf of, and under the supervision of, a medical practitioner in a regional or remote area. This item also funds such care when it is provided by suitably qualified nurses or Aboriginal Health Workers.¹¹³ In 2007–08, 22,825 of these services were supported at a cost to Medicare of \$457,540. Midwives currently have limited scope to prescribe under State and Territory legislation and no capacity to prescribe medicines supplied through the PBS.

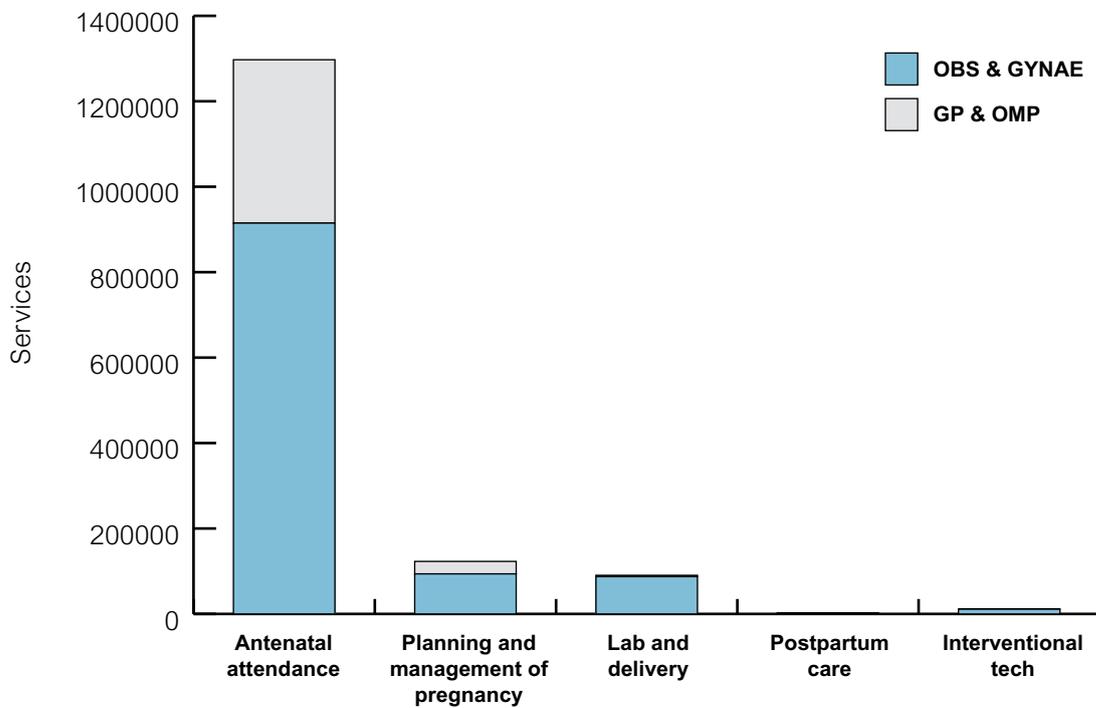
While there is a suite of MBS items that covers post-partum pregnancy elements, these items also have a medical focus and cater predominantly for immediate after-birth care and/or postnatal interventions that address medically related complications. While the medical side of pregnancy should not be downplayed, there is potentially scope for additional Medicare service options that address the therapy needs of women, particularly during the immediate postnatal phase of a pregnancy. To the extent that this type of postnatal service is funded under

Medicare, it is largely performed by GPs under generic standard and long consultation items.¹¹⁴

Figures 11 and 12 show obstetric services and benefits provided through the MBS in 2007–08.

Figure 11 shows that 85 per cent of obstetric services are for antenatal attendances, of which 70 per cent is provided by obstetricians. Eight per cent of obstetric services are for the planning and management of pregnancy, 6 per cent are for labour and delivery, and less than 1 per cent is for post-partum care.

Figure 11: Obstetric services under Medicare, 2007–08

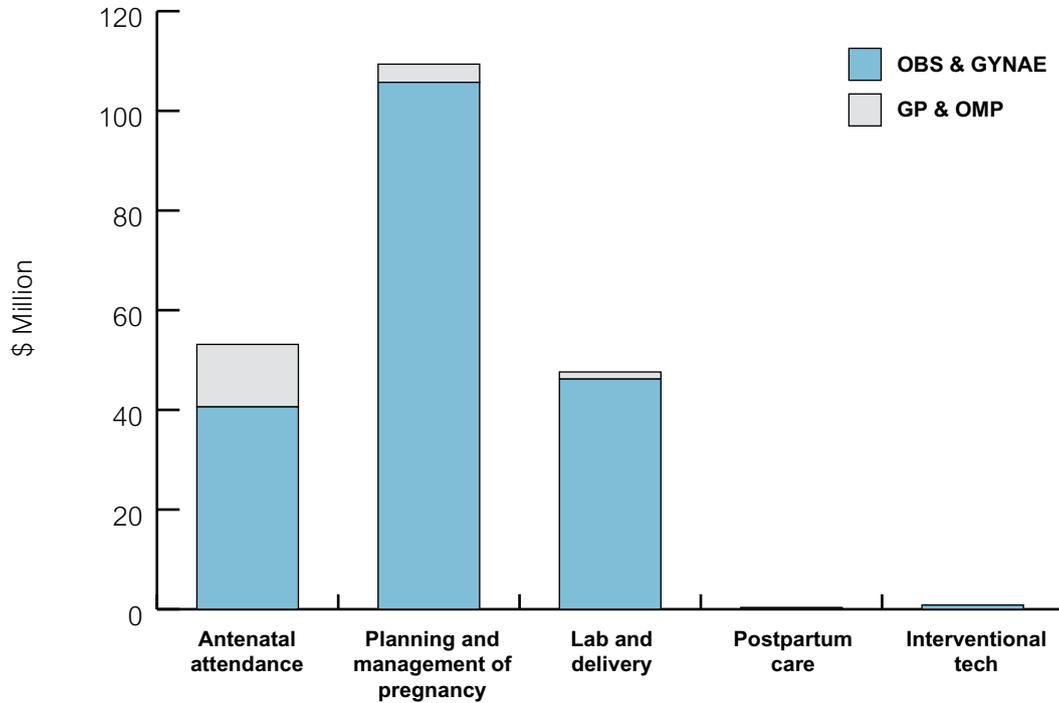


Source: Commonwealth of Australia, unpublished Medicare statistics.

Figure 12 shows the benefits paid under the MBS for obstetric services. In contrast with what is shown in Figure 11, 52 per cent of benefits are paid for the planning and management of pregnancy, of which 97 per

cent is for services provided by obstetricians; 25 per cent of benefits are paid for antenatal attendances; 23 per cent for labour and delivery; and less than 1 per cent is for post-partum care.

Figure 12: Obstetric benefits under Medicare, 2007–08



Source: Commonwealth of Australia, unpublished Medicare statistics.

Medicare Safety Net

A significant proportion of total MBS funding for obstetrics services is through the Extended Medicare Safety Net (EMSN), introduced in 2004.¹¹⁵

Prior to the introduction of the EMSN, many patients seeing a private obstetrician were charged a 'booking fee'. This covered such things as the doctor committing to attend the birth and arranging for the patient to be booked into hospital as well as other out-of-hospital costs that were not covered by existing MBS items. The 'booking fee' was not claimable from the MBS or PHI.

In September 2004, a new MBS item (16590) was introduced for the 'Planning and Management of Pregnancy'. It provided MBS funding for the costs of the long-term

management of a pregnancy that are not limited to the individual patient visits, or by the delivery itself, such as being on call. This item was to cover the activity previously provided by the 'booking fee'. The item could be charged for a patient beyond 20 weeks of pregnancy, and claimed once for each pregnancy.

After the introduction of the EMSN, there was a significant increase in the fees charged for specialist consultations and antenatal attendances by some obstetricians and gynaecologists, as many specialists sought to offset the booking fee for patients against item 16590.

The fee charged for item 16590 has increased steadily and significantly. Currently, around 30 per cent of all expenditure through the EMSN is for the 'Obstetrics' Broad Type of

Service Group. In addition, there is significant expenditure through the EMSN on other pregnancy-related services such as pregnancy ultrasounds and ART.

It is difficult to assess whether or not the introduction of the EMSN has reduced out-of-pocket costs for women having private obstetrics services as data is not available on how much doctors were charging for the 'booking fee' prior to the introduction of the EMSN.

Once a person has qualified for the safety net, it covers 80% of any increase in the fee charged by doctors. Many women who choose to see a private obstetrician qualify to receive safety net benefits. If their obstetrician increases their fees by \$100, the patient only pays an additional \$20. This enables obstetricians to increase their fees and their income significantly. Anecdotally, there is evidence that these arrangements have resulted in some obstetricians charging patients excessive fees to take advantage of Commonwealth funding support through the safety net.

Under the current structure of funding, there is the potential for a wide disparity between out-of-pocket expenses for patients, and in the incomes earned by doctors working in the private sector in metropolitan areas compared with those of doctors working in rural areas or in the public sector.

Under legislation, a review of the EMSN is currently being conducted and will be finished in 2009.

What the Review Team Heard

- Current financial constraints on private service delivery by midwives were identified as a barrier to increasing the range of models of maternity care available in Australia, with consequential limitations on women's choice.

- These constraints include the lack of availability of government funding (such as MBS and PBS), lack of access to professional indemnity insurance, and lack of hospital admitting rights.
- The predominance of the provision of obstetric services by specialist obstetricians for women who elected to deliver privately was highlighted to the Review, alongside the higher intervention rates associated with this care.
- A number of submissions highlighted the current level of funding on the EMSN and questioned whether it was well targeted and provided possible options for change.
- In relation to possible funding models to support an expanded midwifery role, issues raised included the importance of maintaining quality and safety, supporting continuity of care, ensuring effective collaboration between members of the maternity team, providing no disincentive (financial or otherwise) to appropriate and timely referral, and ensuring government resources were targeted at areas of greatest need.
- The existing Medicare item 16400, which allows antenatal care to be delivered for and on behalf of a GP or obstetrician in rural areas, also attracted comment.
- Also raised was the desirability of allowing obstetricians as well as GPs to refer patients to services covered by the Pregnancy Counselling items that allow access to psychology services provided by (item 4001), psychologists (81000), social workers (81005) and mental health nurses (81010). In 2007–08, 4,656 of these services were provided (98.5 per cent of them by GPs) at a cost to the Australian Government of \$313,000.
- The limited information available about the costing of maternity services, including in the public sector, was a point raised, as were the consequent constraints to examining models of care from a costing perspective.

Recent Related Initiatives

The implementation of a new National Healthcare Agreement (on 1 July 2009) will have the potential to help increase the range of maternity health care models available to Australian women. The new Agreement extends beyond hospital care to encompass a wide range of outcomes over the broader health system, including the primary and community health sector (in which maternity health services can also be delivered). For instance, the new Agreement sets the outcome that 'children are born and remain healthy' and includes the policy direction to 'encourage public and private investment in initiatives that support children getting a good start in life.' The new Agreement also sets a policy direction to 'better connect hospitals, primary and community care to meet patient needs.'¹¹⁶

Discussion

One of the drivers for maternity reform in Australia is the desirability of women having a greater range of maternity care options available to them and be supported in their choice of practitioner and their preference for continuity of care. As discussed earlier in the Report, it is clear that greater choice for women could be provided in part by a greater recognition of the role that midwives can play in collaborative models of maternity care. Within the public sector, to varying degrees, states and territories are expanding their maternity services to support a wider range of care.

Supporting giving midwives a greater role as part of the maternity care team has the potential to improve service delivery by making better use of the existing workforce, creating opportunities that increase participation rates among midwives and assisting in retaining those currently practising. This in turn would increase access and choice for women, particularly in rural and remote communities where maternity services are limited. It could reduce the pressure on rural GPs providing

maternity services and enable the development of new, more innovative models of care that meet local needs.

A number of issues would bear on any decisions to extend Commonwealth funding support for more extensive roles for appropriately skilled and qualified midwives.

- Women can currently access midwives' services but, outside of the public sector, this is often at their own expense. Improving access to midwife care must necessarily involve relieving women of at least a part of this private cost. It is almost certain that any program of support for midwives' services would involve a net increase in the range of services supported (postnatal care through midwives, for example) and, with it, an increase in government spending.
- Arrangements that would allow midwives to undertake an expanded role including prescribing appropriate pharmaceuticals in their own right would need to be resolved having regard to issues of safety and quality of care as well as financial cost to the PBS. The states and territories have the responsibility of regulating the prescribing of prescription medicines. To date, there are only limited prescribing rights for midwives in some states and territories and no prescribing rights in others. The issuing of consistent prescribing rights in jurisdictions would be a prerequisite for midwives having authority to prescribe certain medicines subsidised under the PBS. PBS access would require amendments to the *National Health Act 1953*.
- Similarly, arrangements that would allow midwives to undertake an expanded role including making referrals and ordering appropriate tests would need to be resolved having regard to issues of safety and quality of care as well as financial cost to the MBS. Feedback through the consultations supported the view that, if midwives were to undertake an expanded

role as part of broader collaborative teams, then, to be fully effective for some aspects of care, they would need to be able to refer patients to other providers, including medical specialists, and to request certain imaging and pathology tests. Under current legislation there is only very limited authority under Medicare (the *Health Insurance Act 1973*) for some allied health providers to refer (e.g. optometrists to ophthalmologists) and to request tests (e.g. physiotherapists, chiropractors and osteopaths for certain relevant diagnostic radiology).

- Almost half of Australia's registered private health insurers (PHI) currently provide benefits for midwife services, including antenatal care, hospital/birthing centre delivery, except where a medical practitioner is involved, homebirth and/or postnatal care. Under the provisions of the *Health Insurance Act 1973*, if MBS items were introduced for out-of-hospital antenatal and postnatal care by midwives this would prevent insurers from continuing to provide benefits for these services. Depending on the schedule fee, some privately insured women might receive lower benefits under the MBS than they currently receive from their insurer. Potentially, funding through the MBS for these services could also lead to a small reduction in costs under general treatment policies to insurers, with a corresponding positive impact on premiums.
- If MBS items were introduced for midwife services provided in hospital, then under the provisions of the *Health Insurance Act 1973*, an insurer would be required to pay at least 25 per cent of the MBS fee for services provided by a midwife (whether or not its policies currently cover midwife benefits) for women insured under hospital treatment policies that cover pregnancy and birth services. Insurers may respond to the introduction of MBS items for in-hospital

services provided by midwives in several ways, depending upon a range of factors, including the anticipated costs associated with models of care which involved midwives in the delivery.

- As mentioned previously, the MBS funds a range of maternity services including antenatal care, planning and management, labour and delivery, and postpartum surgical services (such as repair of the cervix). A number of submissions highlighted the perceived fragmentation of postnatal care for women and their families post-discharge, and the need to address this, particularly given the prevalence of early discharge policies. As postnatal care provided under the Medicare arrangements is claimed under existing consultation items, gaps in such services are not easily identified. However, there is considerable support for coordinated care being provided to women and their families in the first six weeks by a known carer, to assist with such things as early parenting, breastfeeding and detection of postnatal depression. A number of submissions recognised that midwives could have a significant role in this area.
- The consultations and submissions revealed strong and uniform support for collaborative models of care, as distinct from models that privilege the role of one professional group over another. Extending Commonwealth funding to midwives as primary maternity care providers was thought to be one mechanism for enhancing collaborative care, by providing support for and recognition of the role and skills of midwives as members of the team. The development of innovative incentives for collaborative private sector care, through mechanisms such as regulation, accreditation and models of funding, would also need to be considered.

- The public health sector is a major provider of obstetric care including services provided by midwives. Any additional support for care involving midwives through the private sector should consider how such private services would mesh with existing public sector provision, including any effects on the available workforce. It would be vital that any changes introduced would complement and enhance and not compete with services funded and delivered by state and territory governments.
- A further consideration would be the effect of any new method of funding on midwives who are already employed in obstetricians' rooms, and on the interaction with the existing antenatal MBS item 16400 (the 'for and on behalf of' item relating to midwives, nurses and registered Aboriginal Health Workers, described above).
- Under current Medicare safety net arrangements, the funder may bear a significant proportion of any risk of increased total fees for maternity services.
- Fee-for-service based–reimbursement may not be the most effective means of encouraging collaborative care.

Salary-based funding arrangements may suit some midwives who value continuity and predictability of employment, but these may not be a preferred option for midwives seeking to operate as private providers in their own right. While this approach could provide some certainty of cost to funders and patients, other issues include how funding would be distributed, on what basis, and to whom.

Other forms of financing—linked to an enrolled patient population, for instance—could be considered. As well, some submissions have advocated block payments for individual components of maternity care (antenatal, labour, delivery and postnatal care) or a single maternity payment for the total episode of care. While this may provide some certainty of cost to governments and—depending on the conditions—to patients, again, how funding would be distributed would need to be carefully considered, particularly where multiple practitioners are involved in the woman's care, to ensure that opportunities for collaboration are not undermined.

On balance, the Review Team believe a fee-for-service model is considered the most appropriate mechanism to extend funding to incorporate an expanded scope for midwifery care.

While most submissions suggested that any expanded funding for midwives should be through the MBS, this view was not universal. In general terms, the three main financing choices available are fee-for-service (such as through Medicare), salary, and capitation-based funding.

Fee-for-service models have the advantage that there is a well-established and efficient infrastructure in place (through Medicare Australia) to generate reimbursement for patients. Patients continue to be primarily responsible for paying the provider unless the provider chooses to direct bill the insurer, with a discount on the schedule fee. However, there are other considerations to be kept in mind.

- Costs to the patient may continue to be a barrier. Under Medicare, this could be alleviated through an arrangement similar to that which applies to optometric services, whereby providers enter into an undertaking to charge no more than the schedule fee as a condition of participation in insurance arrangements.

Conclusions

The Review Team concluded that:

- Changes to Commonwealth funding arrangements could support the expansion of collaborative models of care, with an expanded role for midwives. Any new Commonwealth funding arrangements would need to be carefully considered
- to ensure an expanded role of midwives occurred within collaborative, multidisciplinary maternity care models and maintained appropriate quality and safety.
- Importantly, changes to Commonwealth funding arrangements need to occur in a manner that complements the services provided by state and territory governments.

Recommendations

- 17. That, noting the potential issues to be resolved including the potential interaction with Private Health Insurance arrangements, the Australian Government gives consideration to arrangements, including MBS and PBS access, that could support an expanded role for appropriately qualified and skilled midwives, within collaborative team-based models.**

6.2 Professional Indemnity

Current Context

Most people who provide professional services and/or advice to the general public take out a form of insurance cover that protects them and their clients against adverse incidents that may lead to injury and/or some kind of financial loss. Civil engineers, for example, take out professional indemnity cover against the possibility that the structures that they build will become unsafe and may cause injury to people. Doctors take out medical indemnity cover against the possibility that they may injure their patients during the course of a medical procedure or perhaps as the result of a prescribed course of treatment.

Usually, professional indemnity cover is sold in the form of a contract between an insurer and the professional person, where the terms and conditions of the cover are detailed in the contract. The amount of money that the professional person pays to the insurer to maintain the agreed amount of cover for a given period (usually one year) is called the premium. The amount of money paid as a premium is determined largely by the amount of risk that the insurer carries on behalf of the professional person. Generally speaking, the higher the risk, the higher the premium.

In some professions, it is a condition of registration that some level of professional indemnity cover is in place at all times. This requirement varies greatly between professions and sometimes between states and territories. For medical practitioners, most states and territories now require that medical indemnity cover is in place before registration is allowed. For privately practising midwives, it is not currently a requirement in most jurisdictions to have professional indemnity cover in place before registration is granted. However, this situation is expected to change under the proposed new National Registration and Accreditation Scheme.

In 2002–03, Australia faced a medical indemnity crisis, with large increases to insurance premiums causing some doctors to consider leaving the profession or ceasing to practise in high-risk areas. The government intervened by passing legislation to stabilise the medical indemnity industry, which was characterised by ‘captive’ insurers that were owned by medical defence organisations. The government also took action to subsidise premiums paid by doctors practising in higher risk areas, including obstetrics, to ensure affordability of professional indemnity cover and the continued provision of the full range of medical services for the community.

The *Medical Indemnity Act 2002* and the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* brought a more robust prudential structure to the Australian medical indemnity industry and tighter regulation of the indemnity products that were able to be sold. For example, cover had to be provided as a contract that described, in specific terms, which incidents were to be included. Obstetrics was one specialty that generally attracted a very high premium because of the relatively high incidence of claims and the potential for those claims to reach very high amounts in terms of payments for damages. The Government’s suite of programs included the Premium Support Scheme, which provided financial relief to specialists such as obstetricians so that their premium costs relative to other specialties became more affordable.

Most midwives in Australia are employed by a hospital (public or private) or medical practice and do not currently need to hold their own professional indemnity insurance. Their professional liability tends to be covered by the insurance arrangements for the relevant health care institution, supervising private medical practitioner or private medical practice. Each state and territory government has arrangements through their respective Treasury Managed Funds (TMFs) for vicarious liability of all staff employed in their public hospitals, including midwives.

In the mid- to late 1990s, an indemnity product was available to Australian privately practising midwives through a provider of professional indemnity insurance, but this is no longer offered. Currently, privately practising midwives who provide birthing services independently of a medical practitioner are unable to access professional indemnity cover as no insurers are currently willing to offer suitable products for the full range of maternity services. It is difficult for insurers to come up with a suitable premium for midwives because the provision of birthing services by privately practising midwives is perceived to be a high-risk activity. No adequate and reliable data is available to develop an accurate risk profile for privately practising midwives who provide birthing services. Accordingly, midwives operating privately in Australia who wish to provide the full range of maternity services are currently not able to do so with the protection of professional indemnity cover.

What the Review Team Heard

- The lack of midwife access to professional indemnity insurance cover was raised, both in submissions and during the forums. Many consumers and midwives who participated in the Review reported that they chose to proceed despite the absence of indemnity cover.

Currently there is no indemnity insurance available for midwives to access at all. To protect myself and my family, I have had to make sure that I own nothing, I choose clients very carefully and the clients have to sign a contract and disclaimer. I find this distasteful as I feel that all families should have access to funds to cover injury during the birth process.¹¹⁷

- Contributors to the Review also highlighted the risks for other practitioners in a collaborative model if midwives do not have comparable insurance protection for catastrophic events.

We need to avoid a situation where any proposed reforms impact on the indemnity premiums of the existing medical indemnity premiums (particularly obstetricians and anaesthetists) by increasing the quantity of 'fire brigade' or 'emergency response' obstetrics in the system. This would arise when doctors are called in at the last minute for an obstetric complication without any prior engagement in assessment or management of the patient.¹¹⁸

- Some insurers commented on the very small premium pool and the high level of perceived risk. Some commented on the lack of reliable claims data for privately practising midwives, especially those involving homebirths.
- A number of submissions, as well as discussion during forums, proposed a 'no fault' scheme as an alternative approach to cover catastrophic risk in obstetrics.

Discussion

Currently, midwives who provide support for birthing privately do so without professional indemnity insurance. This means that they do so at their own financial risk or, depending on the midwife's financial circumstances, the risk transfers to their clients should an adverse event occur, leaving a woman with no recourse to financial compensation.

A situation where a health professional operates without appropriate professional indemnity cover is not considered acceptable.

Additionally, lack of professional indemnity cover for midwives is a barrier to the development of collaborative models of maternity care involving privately practising midwives. It is clear that other health professionals are concerned about the potential transfer of risk to them, should an adverse event occur in a collaborative team model. In such circumstances, legal claims may be more likely to be brought against the health professional who has the means of settling any successful claim.

Furthermore, the issue of professional indemnity cover for midwives is an issue associated with registration, with most states and territories having professional indemnity insurance requirements for the registration of health practitioners.¹¹⁹ This issue is currently

being highlighted by the introduction of the National Registration and Accreditation Scheme from 1 July 2010. The Scheme will create a single national registration and accreditation system for ten health professions, including midwives. A proposal currently under consideration would require all health practitioners covered by the Scheme, including midwives, to have professional indemnity insurance cover at all times as a condition of registration.¹²⁰

Conclusion

The Review Team concluded that:

- Lack of professional indemnity insurance will inhibit the expansion of collaborative models of midwifery care.

Recommendations

- 18. That, in the interim, while a risk profile for midwife professional indemnity insurance premiums is being developed, consideration be given to Commonwealth support to ensure that suitable professional indemnity insurance is available for appropriately qualified and skilled midwives operating in collaborative team-based models. Consideration would include both period and quantum of funding.**

NEXT STEPS: DEVELOPING A NATIONAL PLAN

Support for the Australian Government's commitment to develop a National Maternity Services Plan was strongly indicated in submissions to the Review, including those from state and territory governments, professional organisations representing health care providers, consumer bodies and other organisations. State and territory governments and stakeholder organisations alike expressed their commitment to working with the Australian Government in developing the Plan.

While many of the areas for future work identified in this Report will require considerable further development to progress to implementation, there are areas where implementation could commence more quickly. In all areas, the collaboration of both levels of government, in consultation with health professionals, consumers and other organisations, will be important.

Some participants in the Review have suggested a fundamental realignment of Commonwealth and state funding and accountabilities for maternity services as the mechanism to address identified concerns. As discussed above, the Plan may need to consider any proposed realignment of responsibilities over the longer term that may come from the report of the National Health and Hospitals Reform Commission.

Throughout the review process, the willingness of participants to engage collaboratively in examining the issue of maternity reform was strongly evident. To progress further, and to develop the Plan, arrangements that will support the ongoing engagement of states and territories and other stakeholders are considered essential.

ATTACHMENT A: SUMMARY OF RECOMMENDATIONS

Recommendation 1:

That the Australian Government, in consultation with states and territories and key stakeholders, agree and implement arrangements for consistent, comprehensive national data collection, monitoring and review, for maternal and perinatal mortality and morbidity.

Recommendation 2:

That the Australian Government, in consultation with states and territories and key stakeholders, initiate targeted research aimed at improving the quality and safety of maternity services in select key priority areas, such as evidence around interventions, particularly caesarean sections, and maternal experience and outcomes, including from postnatal care.

Recommendation 3:

As a priority, that the National Health and Medical Research Council (NHMRC) develop national multidisciplinary guidelines for maternity care to promote consistent standards of practice, quality and safety in collaborative team models. These guidelines are to be agreed by the professions involved, in consultation with consumers and state and territory governments.

Recommendation 4:

That, in developing the National Maternity Services Plan, consideration be given to the demand for, and availability of, a range of models of care including birthing centres.

Recommendation 5:

That, given the role of the states and territories in the provision of maternity services in rural areas, the availability of rural maternity services is a priority area for the Plan, requiring the engagement of states and territories.

Recommendation 6:

That provision of maternity services be considered in the context of 'all governments' commitment to close the gap on Indigenous disadvantage, and be developed in partnership with Indigenous people and their representative organisations.

Recommendation 7:

In consultation with relevant state or territory governments, that consideration be given to funding expansion of Indigenous maternity care programs, based on current successful models, within a research and evaluation framework.

Recommendation 8:

That, in any initiatives that are aimed at supporting an expansion or upskilling of the maternity services workforce, particular focus is given to supporting an increased number of Indigenous people as members of the maternity workforce, across a range of roles.

Recommendation 9:

That all professional bodies and employers ensure that all health professionals and other staff involved in the delivery of maternity care receive cultural awareness training.

Recommendation 10:

That all professional bodies involved in the education and training of the maternity workforce ensure that cultural awareness training is a core component of their curricula.

Recommendation 11:

That consideration be given to improving the range of birthing and other pregnancy-related information and resources, including those on the internet, that is made available to assist women in informed decision making; with any information materials specifically recognising the needs of population subgroups such as culturally and linguistically diverse communities, women with a disability, Indigenous and teenage mothers.

Recommendation 12:

That consideration be given to the establishment of a single, integrated pregnancy-related telephone support line for consumers, possibly as part of the National Health Call Centre, providing both clinical and non-clinical support services, complemented by triage to a number of existing specialised support services.

Recommendation 13:

That in order to lengthen the duration of breastfeeding, further evaluation be undertaken to identify the health care or community settings in which breastfeeding information and support are most effectively received, with a particular priority on consulting and supporting women from diverse cultural and socioeconomic backgrounds.

Recommendation 14:

That the development of national maternity care guidelines (Recommendation 3 above) consider the Perinatal Society of Australia and New Zealand Clinical Practice Guideline for Perinatal Mortality Audit.

Recommendation 15:

That consideration be given to support for the rural maternity workforce to obtain and maintain appropriate training and skills.

Recommendation 16:

That consideration be given to identifying the competencies and credentialing required for advanced midwifery practice.

Recommendation 17:

That, noting the potential issues to be resolved including the potential interaction with Private Health Insurance arrangements, the Australian Government gives consideration to arrangements, including MBS and PBS access, that could support an expanded role for appropriately qualified and skilled midwives, within collaborative team-based models.

Recommendation 18:

That, in the interim, while a risk profile for midwife professional indemnity insurance premiums is being developed, consideration be given to Commonwealth support to ensure that suitable professional indemnity insurance is available for appropriately qualified and skilled midwives operating in collaborative team-based models. Consideration would include both period and quantum of funding.

ATTACHMENT B: THE CONSULTATION PROCESS

The Review was conducted over the latter part of 2008, formally commencing with the release of the Discussion Paper on 10 September 2008.

The Discussion Paper, *Improving Maternity Services in Australia: A Discussion Paper from the Australian Government*, drew on existing data and available research, both domestic and international. It was prepared by the Department of Health and Ageing and was published on the Department's website (www.health.gov.au/maternityservicesreview).

The Discussion Paper set the context for the consultation process, outlining current service delivery arrangements for antenatal, delivery and postnatal phases of maternity services in Australia.

Stakeholder Submissions

The general public and stakeholder groups were invited to respond to questions posed in the Discussion Paper, or on any other matter of relevance to the Review, through a written submission process. The submission period commenced on the day of the Discussion Paper's release and formally closed seven weeks later, on 31 October 2008. Responses were invited through advertisements placed in metropolitan and national print media and by direct email to known stakeholders.

More than 900 submissions were received from individuals, health professionals, industry groups, researchers, professional organisations and national peak bodies. Submissions ranged in content from personal birth stories and descriptions of the experience of providing maternity care from those who supply it, to examples of existing effective models of care within Australia and internationally, research

into many aspects of pregnancy, birthing and postnatal care and strategic policy papers.

The personal stories of individual women made up 407 of the submissions received. A significant proportion (53 per cent) of the women contributing to the Review had personally experienced homebirth. This is a much higher proportion than the proportion in the population overall. In 2006, for example, 708 women (0.26 per cent of all women giving birth in Australia) had a homebirth.

Round Table Forums

A second, parallel process provided key stakeholders with the opportunity to participate in a series of invitation-only round table forums (the forums) investigating six key issues identified in the Discussion Paper:

- Effective Data Collection, Monitoring, Reporting and Research;
- Assessing and Managing High-Risk Pregnancy;
- Workforce Standards, Quality and Interprofessional Collaboration;
- Alternate and Midwife-led Models of Care;
- Indigenous Perspectives; and
- Peer and Social Support in the Perinatal Period.

Consensus on issues was not necessarily an expected outcome of the forums; rather, they provided an opportunity for key stakeholders to engage in a more detailed discussion of the issues and identify barriers to, and enablers of, any maternity service reform. Stakeholders invited to the forums were drawn from a cross-section of consumers and consumer

groups, health professionals, professional organisations, researchers, non-government organisations and industry representatives. The forums were held in Canberra over three weeks in October 2008.

Feedback provided to the Review Team indicated that forum participants found the experience beneficial from both a professional and a personal perspective. Some feedback suggested that consumer groups felt underrepresented in some of the forums.

Summary information on the forums is available on the departmental website (see above).

References

- 1 Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit, 2008, *Australia's mothers and babies 2006*, Perinatal statistics series no. 22, Cat. no. PER 46, Australian Institute of Health and Welfare, Sydney, p. 6.
- 2 Commonwealth of Australia, 2008, *Improving Maternity Services in Australia: A Discussion Paper from the Australian Government*, Commonwealth of Australia, Canberra, p. 10, available from <http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview-discussionpaper>
- 3 Organisation for Economic Co-operation and Development (OECD), 2007, *Health at a Glance 2007: OECD Indicators*, available from <http://titania.sourceoecd.org/vl=21736909/cl=18/nw=1/rpsv/health2007/4-13.html>
- 4 Australian Institute of Family Studies, 2008, *Growing up in Australia: the Longitudinal Study of Australian Children: 2006–07 Annual Report*, available from <http://aifs.org.au/growingup/pubs/ar/ar200607/breastfeeding.html>
- 5 Buist A, & Bilszta J, 2001–2005, *The beyondblue National Postnatal Depression Program: Prevention and Early Intervention 2001–2005* (Vol 1 National Screening Program), p. 8, available from www.beyondblue.org.au/index.aspx?link_id=4.665&tmp=FileDownload&fid=348
- 6 Commonwealth of Australia, 2008, *Improving Maternity Services in Australia: A Discussion Paper from the Australian Government*, p. 16.
- 7 Australian Bureau of Statistics, *Deaths Australia* (ABS Cat. No. 3302.0), [various issues]; *ABS Demography Bulletins*, (ABS Cat. No. 3102.0), [various issues from 1908], available from <http://www.abs.gov.au/>
- 8 AIHW, 2008, *Australia's mothers and babies 2006*, p. 49. Maternal deaths are classified into 'direct deaths' (deaths from pregnancy complications such as embolisms and obstetric haemorrhage) and 'indirect deaths' (deaths from pre-existing diseases exacerbated by pregnancy, such as cardiac disease).
- 9 Number of maternal deaths, all causes, per 100,000 live births.
- 10 The ratio of deaths of children within one week of birth (early neonatal deaths) plus fetal deaths of a minimum gestation period of 28 weeks or minimum fetal weight of 1,000 g, expressed per 1,000 births (OECD definition).
- 11 Organisation for Economic Co-operation and Development, 2008, *Health Data 2008*.
- 12 AIHW, 2008, *Australia's mothers and babies 2006*, p. 30.
- 13 OECD, 2007, *Health at a Glance 2007: OECD Indicators*.
- 14 AIHW, 2008, *Australia's mothers and babies 2006*, p. 30.
- 15 Centre for Epidemiology and Research, NSW Department of Health, 2007, *New South Wales Mothers and Babies 2005*, NSW Public Health Bulletin 2007; 18(S-1), pp. 95–6, available <http://www.health.nsw.gov.au/pubs/2007/pdf/mdc05.pdf>
- 16 Submission from the Australian and New Zealand College of Anaesthetists.
- 17 Submission from the Health Care Consumers Association, ACT.

- 18 Severe maternal morbidity refers to a range of conditions, primarily related to hypertension, obstetric haemorrhage and severe psychiatric morbidity, which can affect mothers.
- 19 Submission from the Australian Institute of Health and Welfare, National Perinatal Statistics Unit.
- 20 Submission from the Stillbirth Foundation Inc.
- 21 Lavender T, Hofmeyr GJ, Neilson JP, Kingdon C, Gyte GML, *Caesarean section for non-medical reasons at term; Cochrane Database of Systematic Reviews 2006*, Issue 3., Art. No.:CD004660. DOI:10.1002/14651858.CD004660.pub2
- 22 Brown HC, Paranjothy S, Dowsell T, Thomas J, *Package of care for active management in labour for reducing caesarean section rates in low-risk women; Cochrane Database of Systematic Reviews 2008*, Issue 4, Art. No.:CD004907. DOI:10.1002/14651858.CD004907.pub2
- 23 Submission from the WA Health—Women's and Newborns Health Network Executive Advisory Group.
- 24 AIHW, 2008, *Australia's mothers and babies 2006*, p. 20.
- 25 This is collected as the place intended at the time of booking in Victoria, South Australia, Tasmania, or the place intended at the onset of labour in other states.
- 26 AIHW, 2008, *Australia's mothers and babies 2006*, pp. 20–1.
- 27 South Australian Department of Health, *Pregnancy Outcome in South Australia 2006*, South Australian Department of Health, Adelaide, p. 34.
- 28 AIHW, 2007, *Australia's Mothers and Babies 2005*, Canberra, p. 22.
- 29 United Kingdom Office of National Statistics, 2008, *Home Births in the UK, 1955 to 2008*, Population Trends 133, available from www.statistics.gov.uk/statbase/Product.asp?vlnk=6303
- 30 New Zealand Information Service, 2007, *Report on Maternity Maternal and Newborn Information 2004*, p. 64, available from <http://www.nzhis.govt.nz/moh.nsf/pagesns/73>.
- 31 National Center for Health Statistics, 2007, *National vital statistics reports; Births: Final Data for 2005*, vol. 56, no. 6, available from http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_06.pdf
- 32 Perinatal Data Collection Unit, Victorian Government Department of Human Services, 1999, *Report on Models of Antenatal Care*, Perinatal Data Collection Unit, Victorian Government Department of Human Services, p. 24.
- 33 Bruinsma, F; Brown, S; and Darcy, MA, *Having a baby in Victoria 1989–2000: women's views of public and private models of care*, Australian and New Zealand Journal of Public Health; vol. 27, no. 1, p. 22.
- 34 Australian Health Ministers Advisory Council (AHMAC), 2008, *Primary Maternity Services in Australia: A Framework for Implementation*, p. 9, available from www.ahmac.gov.au
- 35 AHMAC, 2008, *Primary Maternity Services in Australia: A Framework for Implementation*, p. 9.
- 36 Hatem M, Sandall J, Devane D, Soltani H, Gates S, *Midwife-led versus other models of care for childbearing women; Cochrane Database of Systematic Reviews 2008*, Issue 4, Art. No.:CD004667. DOI:10.1002/14651858.CD004667.pub2

- 37 Personal submission.
- 38 Submission from the Rural Doctors Association of Australia.
- 39 Submission from the Maternity Coalition.
- 40 Submission from Homebirth Australia.
- 41 New Zealand Information Service, 2007, *Report on Maternity Maternal and Newborn Information 2004*, p. 64.
- 42 New South Wales Department of Health, Policy Directive, *Maternity—Public Homebirth Services*, June 2006, http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_045.pdf
- 43 Kildea S, Polack WE, Barclay L, *Making Pregnancy Safer in Australia: The importance of maternal death review*, Australian and New Zealand Journal of Obstetrics and Gynaecology, 2008; 48, p.130–6.
- 44 Australian Institute of Health and Welfare (AIHW), 2005, *Rural, regional and remote health-indicators of health*, Series 5, AIHW Cat. No. PHE59, Canberra, p. 12.
- 45 Australian Institute of Health and Welfare (AIHW), 2008, *Rural, regional and remote health-indicators of health*, Series 9, AIHW Cat. No. PHE97, Canberra, p. 7.
- 46 Submission from the National Rural Health Alliance.
- 47 Australian Institute of Health and Welfare (AIHW) National Perinatal Statistics Unit, *Australia's mothers and babies 1991*, p. 36, *Australia's mothers and babies 1999*, p. 49, *Australia's mothers and babies 2006*, p. 39, available at www.aihw.gov.au
- 48 Personal submission.
- 49 Submission from the Rural Doctors Association of Victoria.
- 50 Submission from the Victorian Healthcare Association.
- 51 Submission from the Women's Hospitals Australasia.
- 52 Submission from the Australian and New Zealand College of Anaesthetists.
- 53 Submission from Queensland Health.
- 54 Submission from the Rural Doctors Association of Australia.
- 55 AIHW, 2008, *Australia's mothers and babies 2006*, p. 68.
- 56 AIHW, 2008, *Australia's mothers and babies 2006*, p. 69.
- 57 AIHW, 2008, *Australia's mothers and babies 2006*, p. 53.
- 58 AIHW, 2008, *Australia's mothers and babies 2006*, p. 57.
- 59 AIHW, 2008, *Australia's mothers and babies 2006*, p. 49.
- 60 AIHW, 2008, *Australia's mothers and babies 2006*, p. 19.
- 61 AIHW, 2008, *Australia's mothers and babies 2006*, p. 10.
- 62 Australian Health Ministers' Advisory Council (AHMAC), 2008, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2008*, Australian Health Ministers' Advisory Council, Canberra, p. 142.
- 63 AHMAC, 2008. *Aboriginal and Torres Strait Islander Health Performance Framework Report 2008*, p. 142.

- 64 Australian Institute of Health and Welfare, 2007. *Indigenous mothers and their babies, Australia 2001–2004*, AIHW cat. no. PER 38, Perinatal statistics series no. 19, p. 12, available at <http://www.aihw.gov.au/publications/per/imatba01-04/imatba01-04.pdf>
- 65 AHMAC, 2008. *Aboriginal and Torres Strait Islander Health Performance Framework Report 2008*, p. 180.
- 66 *Close the Gap: Indigenous Health Equality Summit: Statement of Intent, 2008*, available at http://www.hreoc.gov.au/social_justice/health/statement_intent.html
- 67 The Close the Gap Steering Committee for Indigenous Health Equity submission recommended 'that any new strategy in relation to the provision of maternity services to Indigenous women (in the broader context of a national plan of action towards achieving Indigenous health equality by 2030) is developed in partnership with Indigenous Australians and their representatives'.
- 68 Submission from the Australian Indigenous Doctors' Association.
- 69 Submissions from Charles Darwin Graduate School for Health Practice, the Women's Hospitals Australasia and the Australian College of Midwives.
- 70 Participant at the Indigenous Perspectives forum.
- 71 Submission from the Central Australian Aboriginal Congress Inc.
- 72 Submission from the Australian Indigenous Doctors' Association.
- 73 As reported in the Submission from the Council of Remote Area Nurses of Australia.
- 74 National Preventative Health Taskforce, *Technical Report No 2 Tobacco Control in Australia: making smoking history*, 2008, p. 8; *Technical Report No 3 Preventing Alcohol-related Harm in Australia: a window of opportunity*, 2008, p. 12; *Technical Report No 1 'Obesity in Australia: a need for urgent action'*, 2008, p. 45, available from <http://www.preventativehealth.org.au>
- 75 National Health and Medical Research Council (NHMRC), 2003, *Food for Health—Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers*, Commonwealth of Australia, Canberra, Page 2, available from <http://www.nhmrc.gov.au/publications/synopses/dietsyn.html>
- 76 Australian Institute of Family Studies, 2008, *Growing up in Australia: the Longitudinal Study of Australian Children: 2006–07 Annual Report*, p. available from <http://aifs.org.au/growingup/pubs/ar/ar200607/breastfeeding.html>
- 77 Hector D, King L, Webb K & Heywood P, 2005, *Factors affecting breastfeeding practices: applying a conceptual framework*, NSW Public Health Bulletin, vol. 16, no. 3–4, pp. 52–55, available from <http://www.publish.csiro.au/nid/227/issue/4216.html>
- 78 Amir LH and Donath SM, 2008, *Medical Journal of Australia*, 189(5) 254–6, available from http://www.mja.com.au/public/issues/189_05_010908/ami11480_fm.html
- 79 Australian Institute of Family Studies, 2008, *Growing up in Australia: the Longitudinal Study of Australian Children: 2006–07 Annual Report*.

- 80 Australian Institute of Family Studies, 2008, *Growing up in Australia: the Longitudinal Study of Australian Children: 2006–07 Annual Report*.
- 81 Australian Institute of Family Studies, 2008, *Growing up in Australia: the Longitudinal Study of Australian Children: 2006–07 Annual Report*.
- 82 Guendelman S, Lang Kosa J, Pearl M, Graham S, Goodman J and Kharrazi M, *Juggling Work and Breastfeeding: Effects of Maternity Leave and Occupational Characteristics*, Pediatrics Vol. 123 No. 1 January 2009, pp. e38–e46, available from <http://pediatrics.aappublications.org/cgi/reprint/123/1/e38>
- 83 Buist & Bilszta, *The beyondblue National Postnatal Depression Program: Prevention and Early Intervention 2001–2005* (Vol 1 National Screening Program).
- 84 Caplan HL, Cogill SR, Alexandra H, Mordecai Robson K, Katz R and Kumar R, *Maternal depression and the emotional development of the child*, British Journal of Psychiatry, 1989, 154: pp. 818–22; Murray L, *The impact of postnatal depression on infant development*, Journal of Child Psychology and Psychiatry, 1992, 33(3): p. 543–61.
- 85 AIHW, 2008, *Australia's Mothers and Babies 2006*, p. 56.
- 86 Submission from the Australian Breastfeeding Association.
- 87 Submission from *beyondblue*.
- 88 Submission from the Royal Australian College of General Practitioners.
- 89 The Clinical Practice Guideline for Perinatal Mortality Audit provides a sound structure and guidance for any health professional to care for a newly bereaved family and is available from www.psanz.org.au
- 90 Personal submission.
- 91 Personal submission.
- 92 Personal submission.
- 93 House of Representatives Standing Committee on Health and Ageing, 2007, *The Best Start: Report on the Inquiry into the Health Benefits of Breastfeeding*, chapter three, available from <http://www.aph.gov.au/house/committee/haa/breastfeeding/index.html>
- 94 Australian Government, 2008, *Australian Government Response to: The Best Start: Report on the inquiry into the health benefits of breastfeeding*. House of Representatives Standing Committee on Health and Ageing's Inquiry into the Health Benefits of Breastfeeding, Tabled in the House of Representatives, 4 December 2008.
- 95 *Evidenced Based Maternity Care: What It Is and What It Can Achieve*, Millbank Memorial Fund, 2008, available from <http://www.milbank.org/reports/0809MaternityCare/0809MaternityCare.html>
- 96 The following discussion relies heavily on Risk Perception and Analysis in Australia, Jennifer Cameron and David Ellwood, in *Risk and Choice in Maternity Care An International Perspective*, Edited by Andrew Symon, Churchill, Livingstone, Elsevier, Sydney, 2006, Chapter 11.
- 97 *Risk and Choice in Maternity Care An International Perspective*, Edited by Andrew Symon, 2006, Chapter 11.
- 98 Dennis C-L, Hodnett E, *Psychosocial and psychological interventions for treating postpartum depression*. *Cochrane Database of Systematic Reviews 2007*, Issue 4, Art. No.: CD006116, DOI: 10.1002/14651858.CD006116.pub2

- 99 Shear MK, and Clayton P, *Editorial. Psychiatric Annals, 2008, 3810: p.643–646*; Auster, T, Moutier C, Lanouette N, and Zisook S, *Bereavement and Depression: Implications for Diagnosis and Treatment, Psychiatric Annals, 2008, 3810: pp. 655–61.*
- 100 Auster et al, *Bereavement and Depression: Implications for Diagnosis and Treatment. Psychiatric Annals, 2008, 3810: pp. 655–61.*
- 101 Australian Institute of Health and Welfare (AIHW), 2008, *Medical Labour Force 2006*, National health labour force series no. 41, Cat. no. HWL 42, additional spreadsheet *Specialists and specialists-in-training*, table 5.2, Canberra.
- 102 Health Workforce Queensland and New South Wales Rural Doctors Network, 2008, *Medical practice in rural and remote Australia: National Minimum Data Set report as at 30th November 2007*, Brisbane: HWQ, p. 9.
- 103 Midwife numbers are from Australian Institute of Health and Welfare (AIHW), 2008, *Nursing and midwifery labour force 2005*, National health labour force series no. 39, Cat. no. HWL 40, Canberra; AIHW, additional spreadsheet *Registered nurses—clinical area by selected characteristics*, table 2. The Australian rate of midwives was 90.0 per 100,000 population; this is higher than component parts because it includes 526 midwives with an ‘unknown’ remoteness location.
- 104 Australian Medical Workforce Advisory Committee (AMWAC), 2004, *The Specialist Obstetrics and Gynaecology Workforce—An Update 2003–2013*, AMWAC Report 2004.2, Sydney, p 35; AIHW, 2008, *Nursing and midwifery labour force 2005*, National health labour force series no. 39. Cat. no. HWL 40, Canberra; AIHW, additional spreadsheet *Registered nurses—clinical area by selected characteristics*, table 3.
- 105 Personal submission.
- 106 Submission from the Rural Doctors Association of Australia.
- 107 Submission from Griffith University School of Nursing and Midwifery.
- 108 Submission from Royal College of Nursing, Australia.
- 109 Submission from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
- 110 Australian Institute of Health and Welfare (AIHW), 2008, *Australia’s Health 2008*, Cat. No. AUS 99. Canberra: AIHW, p. 411.
- 111 AIHW, 2008, *Australia’s Health 2008*, p. 342.
- 112 This is funding for the MBS group ‘obstetrics’, which includes a range of antenatal, labour and delivery and postnatal care items.
- 113 MBS Item 16400 ANTENATAL CARE—Antenatal service provided by a midwife, nurse or a registered Aboriginal Health Worker if:
- (a) the service is provided on behalf of, and under the supervision of, a medical practitioner;
 - (b) the service is provided at, or from, a practice location in a regional, rural or remote area RRMA 3–7;
 - (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day);
 - (d) the service is not provided for an admitted patient of a hospital; and to a maximum of 10 services per pregnancy. Fee: \$22.90 Benefit: 85% = \$19.50.

- 114 As GPs do not record the nature of their consultations for Medicare purposes, we do not know the number of GP standard and long consultations that are devoted to maternity care (generally) or postnatal care (specifically). The AIHW provides a small sense of GP maternity servicing in its *General Practice Activity in Australia 2006–07* publication, however, where it suggests that 0.8% of the problems managed by GPs relate to pregnancy matters. This would translate to around 800,000+ GP Medicare consultations per year.
- 115 It provides an additional rebate to patients for Medicare eligible out of hospital services of 80 per cent of the gap between the fee charged by the doctor and the standard MBS rebate, once the person has passed the appropriate threshold. In 2009, singles and families qualify once their out of pocket costs on out of hospital services exceeds \$1,111.60, or \$555.70 in a calendar year for concession card holders and recipients of Family Tax Benefit (Part A) payments. Most families having their second or subsequent child would be in receipt of FTB(A) payments, and therefore would qualify once their out of pocket costs on out of hospital services exceeds \$555.70.
- 116 National Health Care Agreement, 2009, available from Council of Australian Governments (COAG) website: <http://www.coag.gov.au/> 2009
- 117 Personal submission.
- 118 Submission from the Australian Medical Association.
- 119 National Registration and Accreditation Scheme for the Health Professions, 2008, *Consultation Paper: Proposed Registration Arrangements*, Issued by the Practitioner Regulation Subcommittee, Health Workforce Principal Committee, Australian Health Ministers' Advisory Council, 19 September 2008, available at www.nhwt.gov.au
- 120 National Registration and Accreditation Scheme for the Health Professions, 2008, *Consultation Paper: Proposed Registration Arrangements*, Issued by the Practitioner Regulation Subcommittee, Health Workforce Principal Committee, Australian Health Ministers' Advisory Council, 19 September 2008, available at www.nhwt.gov.au