



australian
nursing federation

Submission to Department of Health & Ageing Maternity Services Review

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Introduction

- 1.1 The Australian Nursing Federation (ANF) was established in 1924. The ANF is the national union for nurses and midwives with branches in each Australian state and territory.
- 1.2 The ANF is the largest professional nursing and midwifery organisation in Australia with a membership of over 170,000 nurses and midwives employed in a wide range of urban, rural and remote locations in the private and public sectors. The core business of the ANF is the industrial and professional representation of nurses and midwives and nursing and midwifery.
- 1.3 The ANF participates in policy development for nursing and nursing regulation, midwifery and midwifery regulation, health, community services, veteran's affairs, education, training, occupational health and safety, industrial relations, immigration, social justice and law reform.
- 1.4 The ANF is pleased to have the opportunity to make a submission to the Department of Health and Ageing on the state of maternity services in Australia. Over 30 federal and state government reports since 1984 have recommended reform of maternity services with a significant emphasis on enhanced roles for midwives, but little has changed to realise this in service delivery.¹
- 1.5 The ANF supports the view that women should feel in control throughout their pregnancy to the postnatal period and have their individual needs and right to choice of maternity carer respected. As the *Primary Maternity Services in Australia* Report outlines, enabling midwives to work to the full scope of their practice to provide care across the continuum provides women with an increased opportunity to access a woman-centred maternity service.²
- 1.6 The predominant midwifery view is that maternity services in Australia should be woman-focused, and based on the principle of universal access to safe, quality and comprehensive care. Midwives also want a maternity system that is fair, efficient, sustainable, adequately funded and adequately staffed.
- 1.7 Midwifery education and the professional and regulatory frameworks that support midwifery practice in Australia enable midwives to safely care for the woman's emotional and physical needs from conception to post-delivery.

- 1.8 Legislative and regulatory barriers to the expansion of midwifery services must be removed in order to improve access to maternity services, particularly in rural and remote areas. This includes removing the barriers that impede the introduction of prescribing rights for appropriately educated midwives, and access to publicly funded subsidies for the medications and services prescribed/provided by midwives. The ANF views the future of a sustainable maternity service as one which is a collaborative model of care, where women can choose their lead maternity health carer and receive care as appropriate from members of the multidisciplinary team who work collaboratively to provide the full range of maternity services to secure the best and safest outcomes for mothers and babies.
- 1.9 Supporting the development of families through access to the services of maternal and child health services must be improved.
- 1.10 With this submission, the ANF seeks to allow midwives to practise to their internationally defined role and full scope of their practice, which is to care for women from conception to the postnatal period.

2. Summary of Recommendations

- 2.1 That this review considers ways to ensure midwives are able to:
- Utilise their skills and knowledge in a professional and respectful working environment;
 - Access publicly funded reimbursement for the delivery of midwifery services;
 - Have the opportunity to be fully consulted and involved in the planning and implementation of new models of midwifery-led care in hospital and community based locations;
 - Have the capacity to order routine diagnostic tests and to prescribe routine medicines within the scope of midwifery practice;
 - Have such medicines ordered, subsidised through the Pharmaceutical Benefits Scheme (PBS);
 - Practise autonomously with the support of collaborative multidisciplinary teams to provide care to the well woman and baby; and
 - Provide continuity of care to women as the lead health professionals.
- 2.2 That the Australian Government commit to:
- Increasing the professional recognition of midwives through the promotion of midwifery services to the community;
 - Establishing alternative funding methods to remove the financial rewards for unnecessary interventions;

- Implementing strategies to increase professional recognition of midwives;
- Implementing strategies to address workplace stress and workload issues for midwives;
- Implementing strategies to attract midwives back to the profession;
- Addressing the funding inequities that exist between nursing and medical education;
- Providing funding for additional undergraduate and postgraduate midwifery scholarships;
- Ensuring professional development programs for midwives are adequately funded and available by ensuring funds are available for travel and relief midwives;
- Intervening to ensure midwives have access to professional indemnity insurance in all settings;
- Evaluating the most effective models of collaborative midwife-led care and establishing an innovation hub to assist replication of these models where appropriate;
- Implementing effective collaborative models of maternity care that maximise the skills of midwives to deliver continuity of care in all settings; and
- Commissioning or conducting research to regularly evaluate health outcomes, including intervention rates, of midwife-led care and other models of maternity care.

2.3 That this review considers how the health system can respond to ensure all communities have the best maternity care available through:

- Reforms to funding mechanisms to allow funding to follow the consumer and not the provider.

2.4 That all Australian Governments ensure rural and remote communities have access to collaborative midwife-led maternity services by:

- Addressing all necessary strategies to staff a sustainable rural and remote midwifery workforce;
- Investigating those rural and remote services that may be able to be reopened and adapted to establish a collaborative maternity service model; and
- Providing relocation and employment incentives to attract midwives to rural and remote areas that are of equitable value to those incentives available to other health professionals.

2.5 That a national maternity services framework address:

- The provision of maternal and child health services to improve their visibility within the community;
- That these services are adequately staffed and appropriately funded; and
- That referral pathways to these services are clearly defined.

3. Triggers for change

3.1 The World Health Organisation (WHO) recognises midwives as the most appropriate and cost effective health care provider to care for a normal pregnancy and normal birth, including risk assessment and the recognition of complications.

3.2 Anecdotal evidence suggests some midwives in some settings are frustrated that they cannot work to the full scope of their practice. This may be one of the factors influencing the impending national shortage of midwives.

3.3 Total and per capita funding for the education of midwives is currently inadequate, with the funds available for universities to provide midwifery courses much less per student per year than that for medical courses, despite the course delivery costs being equivalent or even more expensive than medical courses. Providing funding for additional places for the education of current and future midwives is vital to ensuring a safe and sustainable midwifery workforce. This must be accompanied by additional funding for supported clinical placements and for mentoring of new or inexperienced midwives.

3.4 Intervention rates for maternity services in Australia are very high compared with other OECD countries. Caesarian section (CS) rates in Australia in 2005 were 30.3%, up from 18% in 1991. The 2004 OECD average for CS was 22%. The WHO however recommends that CS should only be necessary in fewer than 10% of births, with 15% being the upper limit for surgical intervention. There is also a disparity in CS rates in Australia between public (27.1%) and private (40.3%) patients, as well as other interventions such as forceps and vacuum extraction for vaginal births. There are also differences in intervention rates across Australia's States and Territories.³

3.5 A number of reports over the last decade have drawn attention to the need for reform of maternity services in Australia, but few of their recommendations have been implemented.

- 3.6 Current funding mechanisms for maternity services may be inhibiting best practice and, in fact, encouraging intervention. The 1999 report: *Rocking the Cradle: A report into childbirth procedure* by the Senate Community Affairs References Committee identified the perverse incentives that exist in the situation whereby an obstetrician is paid the same for a delivery regardless of whether it is a vaginal birth or by caesarian section. There is unfortunately also another incentive to intervene which is that of convenience - this report concluded that: "... one of the financial incentives for caesarian sections is the physician convenience - that you can do five deliveries in a day fairly readily if they are all lined up to go into the theatre..... So part of the financial incentive comes in time management of a busy practice." ⁴
- 3.7 Rates of medical intervention have been shown to be greater than average in privately insured women, who receive care from a specialist obstetrician. This phenomenon, described as the 'inverse care law', is contributing to an inequitable distribution of health funding, and inhibiting equitable access to quality maternity care for many women.⁵
- 3.8 A Joint Committee for Maternity Services in 2002 considered opportunities for change in the delivery of maternity services, but according to an article in *The Medical Journal of Australia*, was hampered by lack of funding and a lack of support for the process of change from the medical profession.⁶
- "Positioned at the top of the health care occupations' hierarchy, the medical profession has as its main goal the maintenance of its monopoly over general health policy, control over its work and the number in its profession, and the ability to set its own fees. In this position of power, the medical profession's interests are served by the existing social, economic and political structures".⁷*
- 3.9 A recently published Cochrane Review (2008) concluded that, based on the available studies, all women should be offered midwife-led models of care.
- 3.10 The current funding arrangements for maternity services may serve to discourage continuity of care and make little provision for services delivered by multidisciplinary teams.
- 3.11 The Primary Maternity Services in Australia report identified the preferred practice for a maternity service is continuity of care. The report identified strong evidence that demonstrated continuity of midwifery care in pregnancy, birth and the post-natal period is as safe as the traditional models of care and has the following positive outcomes:⁸ reduced interventions in labour, particularly augmentation of labour, analgesia and electronic foetal monitoring; reduced caesarean section rates; reduced need for neonatal resuscitation at birth; reduced health care costs; enhanced experiences and satisfaction with care during pregnancy and childbirth including psychological aspects of care; greater preparedness for birth and early

parenting and increased participation in decision-making; and a positive influence on women's sense of self-confidence and self-esteem in the early postnatal period which may have an important role in the prevention of postnatal distress or depression.

- 3.12 The comprehensive review of midwife-led care by the recent Cochrane Review considered studies of midwives providing care antenatally, during labour and postnatally. It compared this care with models of medical-led care and shared care through 11 trials involving 12,276 women.⁹ The Cochrane Review found that midwife-led care led to benefits with no identified adverse effects. These benefits included: reduced risk of losing a baby before 24 weeks; reduced use of regional analgesia, with fewer episiotomies or instrumental births; increased chance of a spontaneous vaginal birth and initiation of breastfeeding; increased chance of being cared for in labour by a known midwife; and more women feeling in control during labour.
- 3.13 The review concluded that all women should be offered midwife-led models of care.
- 3.14 An Australian study of more than one million births, published in 2007, found babies born in midwife-run birth centres had significantly lower death rates than those born in hospitals. The review of all births in Australia from 1999 until 2002 confirmed that the centres provided care that is as safe as standard maternity units.¹⁰
- 3.15 The majority of antenatal care in Australia is currently provided in the private sector where care is generally managed by medical professionals - regardless of the level of risk to the woman - with midwives providing only secondary assistance.¹¹ There is strong evidence that midwife-led births lead to fewer hospital admissions, fewer epidurals or any need for analgesia, fewer episiotomies, fewer forceps and vacuum births and increases in normal vaginal births. Midwife-led deliveries also lead to greater feelings of control by the woman during labour and birth, higher breastfeeding rates and shorter stays in hospital for babies.¹²
- 3.16 There appears to be correlation between intervention in birth and the incidence of postnatal depression. In particular, caesarean section and other medical intervention can cause some men and women to choose a smaller family than they might otherwise have had.¹³
- 3.17 Investing in community midwifery programs and providing funding for services provided by collaborative maternity care teams would reduce some of the burdens of the medical maternity profession, allow midwives to work to the full extent of their practice and improve access to maternity services. This would have greatest impact for women in rural and remote areas who may be able to remain in their communities under the care of a midwife instead of travelling to the nearest medical facility.¹⁴

- 3.18 Currently, there is inequitable access to the collaborative model of midwife-led care within a multidisciplinary team. Evaluation of services in Australia that offer primary midwifery care demonstrate that women are very satisfied with the care and would choose the program again for subsequent pregnancies. Where midwifery services exist they are always oversubscribed.¹⁵
- 3.19 Self-employed midwives are unable to secure professional indemnity insurance within the private sector insurance market. It may be that the reluctance of successive governments to assist self-employed midwives with insurance issues is underpinned by the medical profession's entrenched monopoly over the provision of obstetric services.¹⁶
- 3.20 The inability of self employed midwives to secure professional indemnity insurance in Australia is preventing the expansion of services by this group of maternity service providers. Consideration should be given to government intervention to provide professional indemnity insurance to all midwives.
- 3.21 Midwives professional contribution to maternity services sector is undervalued. While costs of doctors delivering maternity services are able to be quantified due to the current funding arrangements, care provided antenatally, during labour, birth and the postnatal period provided by midwives is mostly uncosted and invisible. While GP's and obstetricians are paid a delivery fee, midwives provide almost all the labour and postnatal care.
- 3.22 In the main, childbirth involves healthy women experiencing a normal life event. The obstetric profession and procedural GPs may not always be the most appropriate maternity care provider for women giving birth. Facilitating an expansion of midwifery led services would allow obstetricians and GP proceduralists to focus on complex and complicated maternity care, improving access to a broader range of maternity services for more women, and using the workforce more effectively.

Recommendations

That this review considers ways to ensure midwives are able to:

- Utilise their skills and knowledge in a professional and respectful working environment;
- Access publicly funded reimbursement for the delivery of midwifery services; and
- Have the opportunity to be fully consulted and involved in the planning and implementation of new models of midwifery-led care in hospital and community based locations.

That the Australian Government commit to:

- Increasing the professional recognition of midwives through the promotion of midwifery services to the community; and
- Establishing alternative funding methods to remove the financial rewards for unnecessary interventions.

4. The role of midwives in Australia

- 4.1 Midwives have specialist skills and knowledge relating to the care of women including preparing for pregnancy, during the pregnancy, childbirth, the postpartum period and in the care of a newborn infant(s). Midwives are licensed to practice midwifery at entry point of qualification and registration, according to the role and sphere of practice of a midwife.¹⁷ They are the most appropriate carers for women with uncomplicated pregnancies, labour and birth.
- 4.2 Midwives must be endorsed by the nursing and midwifery regulatory authorities in the State or Territory in which they work, and must comply with the Australian Nursing and Midwifery Council *National Competency Standards for the Midwife* the *Code of Professional Conduct for Midwives in Australia*, and the *Code of Ethics for Midwives in Australia*.¹⁸
- 4.3 There are 12,000 endorsed or registered midwives in Australia mostly working in state and territory public sector employment.¹⁹ Many midwives consider their skills and knowledge are under-utilised and under-valued, leading to professional dissatisfaction and subsequent loss of midwives from the maternity care workforce.^{20,21}
- 4.4 The Australian Health Workforce Advisory Committee estimates there is a current national shortage of 1850 midwives, with that figure expected to rise further.²²
- 4.5 In 2005, most Australian births (97.5%) were in a hospital and just 1.9% in a birth centre. Only 0.2% of women in Australia had a midwife-led home birth, compared to New Zealand at 2.5% and the UK at 1.9%.²³ 85% of women in Australia have no medical reason to go to a doctor for care in childbirth, yet just over 2% are able to access the same midwife for their maternity needs.²⁴
- 4.6 Due to the current baby boom, there is an increased demand for midwifery services in Australia - birth centres are over-booked and midwifery-led models are expanding to respond to this demand. Many continuity of care models demonstrate positive health outcomes and lead to reductions in birth interventions, including caesarean section. Where it is not clinically indicated, there should be no reason for women to undergo major abdominal surgery in order to have a baby in Australia.
- 4.7 It is important for the effective functioning of multidisciplinary maternity care teams for midwives to be able to refer women to specialists when necessary, order and interpret diagnostic tests and prescribe a specified range of medicines commonly used in the maternity care of the well woman.
- 4.8 Some of the difficulties in recruiting and retaining midwives have been attributed to lack of professional recognition, stress and workload issues, and limited opportunities to practise as primary carers providing continuity of care to women.²⁵

- 4.9 Retaining midwives and providing incentives to stay to provide a stable and sustainable workforce must include removing the barriers that prevent some midwives from working to the full scope of their practice. Improving the nurses' work environment improves recruitment and retention, improves the professional satisfaction of all staff, and improves safety and quality of care.

Recommendations

That this review considers ways to ensure midwives are able to:

- Have the capacity to order routine diagnostic tests and to prescribe routine medicines within the scope of midwifery practice;
- Have such medicines ordered, subsidised through the Pharmaceutical Benefits Scheme (PBS);

That all Australian Governments commit to implementing strategies to:

- Increase professional recognition of midwives;
- Address workplace stress and workload issues for midwives;
- Attract midwives back to the profession.

5. Midwifery education

- 5.1 Undergraduate nursing and midwifery education is currently funded at \$9,316 per Equivalent Full Time Study Load (EFTSL) compared to \$14,000 per EFTSL for medical students. However, the resources required to teach the health sciences to nursing and midwifery students are the same as those for medical students who receive a far greater proportion of funds. This is based on an outdated funding model developed in the 1980's and which needs reform.²⁶
- 5.2 The funding available to universities to provide nursing and midwifery courses also needs to be increased to reflect the true costs of course delivery.
- 5.3 This current inequity in funding relativities is resulting in some universities considering discontinuing nursing and midwifery courses in favour of those which produce greater income. Increasing the funding by \$5000 per nursing/midwifery student per annum, at a cost of \$140 million per annum, would reflect the importance of the discipline and the urgency required to prevent further increases in national nursing and midwifery workforce shortages.
- 5.4 The critical shortage of midwives and nurses in Australia warrants a significant increase in education places which should be supported through increased undergraduate and postgraduate scholarships, with additional funding for supported clinical placements. Many current midwifery scholarship schemes are oversubscribed with many more eligible applicants than available funding.

- 5.5 The number of postgraduate and midwifery education scholarships available must also increase to reflect the true costs to the student. Poor access to the funds necessary for registered nurses to undertake postgraduate midwifery education limits their opportunity to upgrade their skills and further exacerbates workforce shortages.
- 5.6 Postgraduate diploma and masters' courses for midwives and nurses cost around \$10,000 per annum. An additional 100 scholarships provided in key areas of nursing workforce shortages, such as midwifery, would cost just \$1 million annually.

Recommendations

That the Australian Government commit to:

- Addressing the funding inequities that exist between nursing and medical education;
- Providing funding for additional undergraduate and postgraduate midwifery scholarships; and
- Ensuring professional development programs for midwives are adequately funded and available by ensuring funds are available for travel and relief midwives.

6. Obstacles to collaborative practice in the current maternity care system

- 6.1 There appears to be two distinct cultures in maternity services in Australia. One is that of midwives and many women, which views pregnancy, labour and birth as a normal like event, while another views birth as "potentially high risk" in an "intervention" paradigm, requiring medical care and access to technology.²⁷
- 6.2 The current maternity system is predominantly medically dominated and based on a 'medical model' of care. This focus may inhibit choice for some women and hamper reform efforts to develop new collaborative models involving autonomous care provided by midwives within multidisciplinary teams.²⁸
- 6.3 It is inefficient and costly to involve obstetricians in the routine care of low-risk women.²⁹ Private obstetric antenatal consultations account for 30% of all antenatal services in Australia, and Australia's birthing intervention rates are very high compared to other OECD countries. This imposes significant burden on health care budgets, and is responsible for childbirth being responsible for one of the largest proportions of hospital separations per annum in Australia.³⁰
- 6.4 Allowing midwives to work to the full scope of their practice with the support of obstetricians and procedural GPs where appropriate will achieve safe outcomes for mothers and babies, possibly with fewer interventions.

- 6.5 Collaborative maternity care should be supported in all settings by the use of common protocols and clinical guidelines.
- 6.6 Indemnity insurance arrangements and the lack of a system of no-fault insurance is considered partly responsible for high caesarian rates among Australian obstetricians.³¹ Tort law reform e.g. removing responsibility for long term care costs of severely disabled/catastrophic injury from the insurance of individuals to that of the community, such as that available through schemes such as Worker's Compensation may assist in addressing the real and perceived risk of liability, and may help reduce intervention rates.
- 6.7 The current fee-for-service system is not appropriate in all settings and can add to the costs of maternity services, as it creates a perverse incentive to provide more, but not necessarily better or appropriate services and acts as a barrier to integrated services.
- 6.8 The current funding arrangements support and encourage childbirth to be managed in a fragmented way and to be viewed as a medical/hospital event rather than as a normal physiological process. These arrangements hamper a woman's continuity of care as the journey from conception to birth is broken into 'episodes' that are centred around the groups which provide the service and the settings in which care is delivered. Consequently, women may have to navigate their way through the maternity care system without professional support. This may further marginalise disadvantaged and minority groups, and may mean many of these women do not receive the level of care required, especially in the early antenatal period.
- 6.9 This approach does not encourage the most effective use of scarce resources or the most appropriate care. The 1999 Senate Committee Inquiry concluded:
- "Existing funding arrangements for antenatal, intrapartum and post natal care are seriously flawed. They encourage fragmentation in service provision, cost shifting and over servicing and direct a disproportionate amount of funding to those who least require it. They encourage a level of intervention for the majority of women for whom this is not necessary and indeed for whom it may be inappropriate".³²*
- 6.10 It is important that any future reforms do not allow doctors to be 'gatekeepers' to maternity services. This would perpetuate the current inefficiencies that prevent equity of access to maternity services in Australia. The choice of carer must be made by the woman, not the doctor. The ability to choose a midwife as a lead carer is available to women in many other OECD countries but not to women in Australia.

Recommendations

That this review considers ways to ensure midwives are able to:

- Practise autonomously with the support of collaborative multidisciplinary teams to provide care to the well woman and baby; and
- Provide continuity of care to women as the lead health professional.

That this review considers how the health system can respond to ensure all communities have the best maternity care available through:

- Reforms to funding mechanisms to allow funding to follow the consumer and not the provider.

That the Australian Government commit to:

- Intervening to ensure midwives have access to professional indemnity insurance in all settings.

7. Successful models of collaborative midwife-led maternity services

7.1 Primary maternity services need to be organised to address the needs of individuals within their communities with the aim of offering continuity of primary carer for women with normal pregnancy risk.³³ The following are examples of collaborative maternity services featuring midwife-led care successfully operating in Australia.

7.2 **Ryde Midwifery Group Practice (RMGP)** is a caseload midwifery-led unit associated with Ryde Hospital in Sydney. Launched in March 2004, it offers the benefits of continuity of midwifery care to women with low-risk pregnancies who have a midwife assigned throughout their pregnancy, birth and postnatal period.

7.3 The RMGP does not offer epidural anaesthetic or caesarean sections. If antenatal problems arise or a full obstetric service is required at the time of birth, the woman's care is transferred to the Royal North Shore Hospital (RNSH) which is 15 km away, or specialist staff from RNSH travel to Ryde.

7.4 The RMGP registered a significantly higher rate of spontaneous vaginal birth, lower caesarean section rate and lower instrumental birth rate compared with the Australian national data (2002). This is believed to be associated with the lack of induction and epidurals available.

7.5 Evaluation of the RMGP model has demonstrated that it is as safe as hospital-based services, has improved outcomes of satisfaction and reduced interventions.³⁴

7.6 **South Gippsland Hospital (SGH)** operates a shared-care model of midwifery care in Foster, Victoria. Planning for this facility was a collaborative process involving midwives, local obstetric GP's and community members.

- 7.7 In this model, pregnant women consult both doctors and midwives equally for antenatal care. After an initial consultation with a GP, the women are referred to the midwifery clinic, located at the Foster Medical Centre, and the birth is attended by the midwife on duty and the GP.
- 7.8 This team-based approach has led to greater individual care from a small group of health professionals, and affords midwives the opportunity to utilise their extensive range of skills which has increased work satisfaction.³⁵
- 7.9 **Goondiwindi Midwifery Group Practice (GMGP):** In response to the closure of 36 out of 84 public sector maternity services in rural Queensland over a 10 year period from 1995, a new model of midwifery-led care was developed in Goondiwindi to try and encourage women to have their babies locally.
- 7.10 Introduced in March 2008, the model was developed by a range of organisations including the Australian College of Midwives, Australian Rural Nurses and Midwives, the Maternity Coalition, the Goondiwindi Medical Clinic and the Queensland Nurses' Union (Australian Nursing Federation, Queensland Branch), with additional input from local woman, GPs and the Indigenous community.
- 7.11 This model allows pregnant women to be cared for according to their level of risk. Low-risk women are managed by a midwife and GP, moderate-risk women by a midwife and GP obstetrician, and high-risk women by a midwife and specialist obstetrician, usually outside Goondiwindi.
- 7.12 This model provides care to women by the same small group of health professionals and allows midwives to work outside the hospital setting in homes, ante-natal care rooms and Indigenous health centres. It is also recognised as a sustainable health service for local women.
- 7.13 Goondiwindi region's maternity services were at risk of closure before this model was implemented. Bookings for births have increased and pregnant women, advised and reassured by their midwives, are staying at home longer before presenting for birth.
- 7.14 **The Community Midwifery Program in Western Australia** was established in 1995 to provide a caseload midwifery home birthing service for about 70 women per year in the South Metropolitan Area Health Service. This was expanded to 150 women in the wider Perth metropolitan area in 1999. This model of maternity care reports improved consumer satisfaction and an economic benefit due to significantly reduced rates of medicalisation and associated maternal and neonatal morbidity.³⁷

- 7.15 **Northern Women's Community Midwifery Program (NWCAP)** is a publicly funded midwife-led continuity of care model which has operated since 1999. It offers Aboriginal and socially disadvantaged women in Adelaide's northern suburbs access to a team of six community midwives. The services offered are home birth, birthing centre and hospital birth options, while the continuity of care model allows the social isolation and disadvantage issues to be addressed by midwives, with women being referred to ancillary support services as required.

Recommendations

That the Australian Government commit to:

- Evaluating the most effective models of collaborative midwife-led care and establishing an innovation hub to assist replication of these models where appropriate;
- Implementing effective collaborative models of maternity care that maximise the skills of midwives to deliver continuity of care in all settings; and
- Commissioning or conducting research to regularly evaluate health outcomes, including intervention rates, of midwife-led care and other models of maternity care.

8. Rural and remote maternity care

- 8.1 Around 130 rural maternity services were closed across Australia between 1995 and 2005. This roughly equated to one closure per month.
- 8.2 While there is a longstanding shortage of appropriately qualified health professionals in some rural and remote areas, there is little evidence that the maternity service closures were the result of workforce shortages. However, the implications of these closures included: an increased chance of birth occurring outside the most appropriate care setting; an increased risk of associated complications; greater costs in time and money borne by the mother and her family; and inequity of access to maternity services for rural and remote women.³⁹
- 8.3 Reinstating and reinvesting in sustainable rural and remote area maternity services will require a substantial economic and social commitment from the government. It will also need to be a collaborative venture involving all stakeholders to determine a model that best suits each particular region. Midwives are the backbone of such services and must be viewed as important stakeholders with an integral role in planning sustainable maternity services in rural and remote areas. Consequently, allowing midwives to operate to the full scope of their professional practice, as primary carers with clear referral pathways for all at risk pregnancies and events, is vitally important to ensuring safe and equitable maternity services in rural and remote communities.

Recommendations

That all Australian Governments ensure rural and remote communities have access to collaborative midwife-led maternity services by:

- Addressing all necessary strategies to staff a sustainable rural and remote midwifery workforce;
- Investigating those rural and remote services that may be able to be reopened and adapted to establish a collaborative maternity service model; and
- Providing relocation and employment incentives to attract midwives to rural and remote areas that are of equitable value to those incentives available to other health professionals.

9. Linkages to maternal and child health services

9.1 The transition of care from midwives to nurses in maternal and child health services is a critical step in the postnatal care of a woman. The transition should be a collaborative process and should occur according to the individual needs of the woman and child.

9.2 Due to the current fragmented nature of maternity service delivery, many women are left to their own devices to access these services once they leave hospital. If these same women had access to continuity of care from a midwife who formed a relationship with them during pregnancy, the birth and post natal period, then they could be directed to these services at the most appropriate time for their individual case. This includes ensuring support for breastfeeding mothers as well as identifying social and emotional issues that may need to be addressed such as post natal depression (PND).

9.3 Each year around one in 10 Australian women suffer depression in the lead up to the birth of their baby, and almost one in five experience depression in the weeks and months after birth. Like other forms of mental illness, the stigma attached to PND often means many women do not seek the treatment that they need. If these women are involved in a continuous care relationship with a midwife, then PND is more likely to be diagnosed and the mother given the support and treatment they need.

Recommendations

That a national maternity services framework address:

- The provision of maternal and child health services to improve their visibility within the community;
- That these services are adequately staffed and appropriately funded; and
- That referral pathways to these services are clearly defined.

10. Conclusion

- 10.1 The future of sustainable maternity care in Australia must be provided through a continuity of care model by midwives working collaboratively with other health professionals including, GPs, obstetricians, paediatricians, physicians, Aboriginal health workers and maternal and child health nurses. A team caseload approach has been proven to be sustainable as midwives are not overworked and burnt-out. Such models can be implemented in rural and urban settings, with rural areas setting up their own referral pathways as required for their individual circumstances.
- 10.2 Continuity of care models are effective in rural, remote and urban settings, can save health dollars, reduce intervention rates and improve outcomes. The effectiveness of midwifery continuity of care models is built on the relationship of mutual trust developed between a midwife and a woman during the antenatal period. This allows the midwife to care for the woman's individual emotional, psychological, cultural and physical needs. This model of care has also been found to produce better outcomes for both mothers and babies, and is associated with lower intervention rates while still delivering a service as safe as the existing standard services.

References

- 1 Reibel T et al.2005. Providing better birth care. *Health Issues*. 84, 10-13.
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- 3 A discussion paper from the Australian Government 2008. *Improving maternity services in Australia*.
- 4 Senate Community Affairs References Committee 1999. *Rocking the Cradle: A report into childbirth procedures*.
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- 6 Weaver E et al. 2005. Obstetricians and midwives and modus Vivendi for current times. *MJA*. 182(9) 436-437
- 7 ibid
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