AMA Queensland Feedback on *Queensland Women's Health Strategy Consultation Paper* Submitted 19 December 2022

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AMA Queensland thanks Queensland Health for the opportunity to provide feedback on the *Queensland Women's Health Strategy Consultation Paper* (the 'Strategy').

It is acknowledged that the Strategy is intended to provide a high-level framework for improving women's health in Queensland and that some issues raised by AMA Queensland members may be more detailed than can be specifically targeted in the Strategy. Nonetheless, AMA Queensland submits that the Strategy's guiding themes, and focus areas must be framed and articulated in a manner that ensures these issues are addressed in programs and policies implemented under it. Submissions on relevant aspects of the Strategy are set out in the following paper.

Key Gaps in the Strategy

AMA Queensland welcomes the Strategy's focus on aspects of women's health that have historically been neglected, including First Nations and Culturally and Linguistically Diverse (CALD) women's health; and the disproportionate impacts on women from chronic disease, disability and domestic and family violence. That said, there are some key gaps in the Strategy that must be prioritised, including greater investment, focus and support for:

- Maternity care, including general practitioner (GP) shared care.
- Non-metropolitan services.
- General practice.
- Termination of pregnancy services.
- Alcohol and other drug treatment services.

These key and other identified gaps are set out below.

1. Maternity Services

The overarching *Queensland Women's Strategy 2022-2027* which underpins the Strategy has a health-specific commitment of 'focusing on collaboration and consultation between women and clinicians to improve health outcomes for pregnant and parenting women'.[1] Despite this, the Strategy's consultation paper does not mention the current failure of Queensland maternity services such as has occurred in Mackay, Gladstone and many other communities throughout Queensland.

A failure to adequately invest in maternity services by successive State and Federal governments has resulted in a chronic lack of resources and significant gaps across Queensland. This is harming all patients, including women, birth-parents and babies. Particularly concerning is the lack of:

- Queensland Health's support for medical leadership in the overarching governance framework of maternity services state-wide.
- A multidisciplinary team focus and structure to manage complex maternity needs.
- Well-structured GP shared care maternity collaboration incorporating contraception, pre-pregnancy and post-natal care (e.g. as occurs in gestational diabetes mellitus endocrine collaborative services; discussed further under 1.1 below).
    - AMA Queensland notes the Strategy references Metro South Hospital and Health Service's (MSHHS) Community Maternity Hubs as a program directly seeking to 'enhance the health of Queensland women and girls'. Contrary to this statement, doctors have advised this model is exceptionally expensive, not cost-effective, only covers 25% of the MSHHS maternity population and is compromising hospital base quality multidisciplinary team maternity care. AMA Queensland does not support any expansion of this model and calls for an immediate, independent, external review of its effectiveness to justify any continued funding over more appropriate and effective services, including GP shared care.
- Sufficient funding for rural and low socio-economic metropolitan maternity services, especially for:
    - maternal fetal medicine;
    - dedicated obstetrics medicine physician and support services; and
    - surgical theatre availability to manage early, late and postnatal surgical complications:
        - insufficient surgical theatre availability means miscarriages are postponed; and the absence of dedicated obstetric surgery lists means theatres are poorly utilised.
- Proper forward planning by Queensland Health for the growth of Queensland's population and requisite maternity services.[2]

[1] https://www.publications.qld.gov.au/dataset/womens-strategy/resource/95357068-d24b-4565-a991-7b8be088ced9, page 31.

[2] For example, between 2011 and 2026 it is projected that the population of the Logan Local Government Area will increase by approximately 34% compared to 28% for Queensland. Logan Hospital already delivers approximately 4000 births each year. The Clinical Services Capability Framework for a Level 5 Maternity Service requires immediate access to one dedicated 24-hour obstetric theatre and obstetric anaesthetic service for every 4000 births, with capacity to open a second operating theatre concurrently. Whilst the planned refurbishment of Logan Hospital's maternity unit is welcomed, the operating theatre expansion is not anticipated until 2027-2028. Given approximately 4000 births are

The Strategy likewise does not specifically focus on the need for an increased maternal health workforce, particularly obstetricians and GP-obstetricians, to ensure the safety of women, birth-parents and babies. It suggests, however, as an issue to consider, 'a need to increase access to health care, noting costs and location as barriers, and to consider increased nursing and community-led care'.[3] This appears to indicate a bias for midwife- over obstetrician- and GP-led care and AMA Queensland objects to this preference as unprofessional and not in line with best practice, evidence-based models of care.

1.1. GP Shared Care Antenatal Model

AMA Queensland members advocated for the Strategy to set the environment for increased use of GP shared care antenatal models. GP shared care provides high quality, safe and continuous care (including for contraception, mental health and postnatal care) and has the potential to reduce health system costs in comparison to other models.[4]

Doctors advocated for all low-risk women to be specifically offered referral to GP shared care in addition to other models and Queensland Health to actively address policies and materials that inappropriately promote midwifery models over GP shared care. In addition, the following was suggested to increase connections between hospital obstetricians, midwives and GPs:

- A dedicated phone line for GPs to contact patients' treating hospital team.
- Guidelines to ensure timely, structured written communication between GPs and hospital staff.
- A GP education program.
- Consistent, routine completion of the Pregnancy Health Record for each patient at every visit (this is not being done at all hospital maternity clinics and leads to information gaps and communication breakdowns between GPs and hospitals and is particularly critical for women who relocate and First Nations women).
- Improved access for GPs to antiD injections.

Finally, the Strategy consultation paper does not reference the Queensland Maternal and Perinatal Quality Council 2021's recent *Queensland Mothers and Babies 2018-2019* report which showed an increasing average maternal age. AMA Queensland submits this indicates an urgent need for increased involvement of obstetricians in public maternity care given the risks associated with higher maternal age and this should be prioritised in the Strategy.

2. Non-Metropolitan Services

AMA Queensland submits that the Strategy must recognise and correct the failure to establish a clear, whole-of-system governance and strategy for rural and remote health services, for both women and all

already occurring at Logan Hospital, the delayed operating theatre expansion must be factored into maternity service planning and development as an urgent priority.

[3] Refer page 14.

[4] For example, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6473196/

Queensland patients. The current health system funding and performance management model is geared towards urban-based specialist hospital services, operating efficiently at scale with a focus on performance measures for emergency departments, elective surgery and specialist outpatient wait times. This does not suit the circumstances of small hospitals with generalist medical workforces, limited access to support services and the need to deliver 24/7 operations.

Queensland Health must develop specific system governance to ensure the needs of rural communities and providers are met. A clear whole-of-system governance framework and strategy for rural health services is required which brings together education and training; workforce; planning, funding and performance management; sustainability; and safety and quality.

Following on from section 1 above, a comprehensive system-wide plan must be made within the framework for rural maternity services with the aim of bringing rural maternity services closer to home for all Queenslanders. This is essential, especially in planning for existing Level 2 and 3 services, for the following reasons:

- The rates of babies born before arrival (BBA) at hospital is increasing.
- The rate of BBA is highest amongst women who live between one and two hours' drive of a maternity service with caesarean section capability.
- The provision of maternity services close to where patients live delivers improved health outcomes for mothers, birth-parents and babies and reduces associated clinical, social, family, cultural, spiritual and financial risks.

3. General Practice

Multiple studies have shown that long-term, regular patient engagement with a general practitioner (GP) is the most cost-effective healthcare measure.[5] It is the consistency of care that results in:

- reduced incidence of all cause and cause-specific mortality such as cancer, heart disease and stroke;
- significant reductions in maternal, neonatal and child mortality; and
- improved mental health outcomes.[6]

For women, engagement with a trusted, experienced GP also provides a unique opportunity to reduce harms associated with domestic and family violence.[7] AMA Queensland submits the Strategy must include a stronger emphasis on the critical importance of general practice for all women, and a commitment to increased funding for GP services, especially in regional, rural and remote Queensland.

[5] https://www.ama.com.au/sites/default/files/2022-11/AMA-Research-and-Reform-General-practitioner-workforce-why-the-neglect-must-end-final_1_1.pdf
[6] World Health Organization (2018). Technical Series on Primary Health Care, Building the economic case for primary health care: a scoping review. Retrieved 1/9/2022 from https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.48
[7] https://www1.racgp.org.au/ajgp/2022/november/recognising-and-responding-to-domestic-and-family

AMA Queensland also notes the statements in the Strategy that:

- '47.6 per cent of Queensland women born 1973-1978 indicated that they had not been asked about their mental health and wellbeing at any stage before or after their pregnancy'; and
- 'One in three women has had their health concerns dismissed by doctors'.

The need for improved mental health screening and treatment would be dramatically improved by enabling doctors to spend more time with women by increasing the Medicare rebate for longer consultations. Funding should also be targeted to support GP-led models of care which incorporate nurses and registered nurses. Current Medicare rebates are far too low for general practices to remunerate nurses appropriately and compete with hospitals for nursing staff. This would greatly improve services for women including antenatal care, contraception, cervical screening tests and sexual health checks.

4. Termination of Pregnancy Services

Doctors have raised concerns about the absence of dedicated pregnancy termination services in many MSHHS facilities. At present, such services are only available at Logan Hospital where demand is very high and must compete with the similarly high demand for obstetric services.

AMA Queensland submits that each MSHHS hospital must have a dedicated pregnancy termination service or alternative, including pregnancy choice clinics to provide contraception and termination services in close collaboration with primary care services.

5. Alcohol and Other Drug Treatment Services

Medical practitioners noted the Strategy does not contain any significant focus on pregnant women with alcohol and other drug problems or associated interventions. This is notable due to the Queensland Clinical Senate's acknowledgment that evidence shows a person's health trajectory is highly influenced, and can be dictated, by the first 2000 days of life including from conception. This means that if a mother has alcohol and other drug issues at conception, both the mother and baby are likely to have life-long, associated health impacts.

AMA Queensland submits that this must be a focus of the Strategy and its omission is a glaring oversight given the Strategy's focus on First Nations women who are disproportionately affected by alcohol and tobacco smoking in pregnancy.[8]

In addition to increasing support for existing alcohol and other drug services, consideration must also be given to supporting programs which encourage partners to quit smoking and/or harmful alcohol use. Such

[8] https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/alcohol-consumption-during-pregnancy; https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/aboriginal-and-torres-strait-islander-people

services aim to increase the pregnant parent's likelihood of likewise successfully quitting smoking and/or harmful alcohol use which benefits both the woman's and baby's health, particularly in the first 2000 days.

6. Avoidance of Gendered Characterisations

AMA Queensland members wished to see acknowledgement and advocacy in the Strategy that contraception is not solely a 'women's issue'. Whilst women must be empowered and protected to make their own choices about their bodies, targeting education and medical teaching at women or through a women's-health lens forfeits the opportunity to address a wider audience and unhealthy relationship issues.

Doctors, particularly GPs, noted that being able to approach contraception in a non-gendered manner enabled them to more readily identify intimate partner violence. It also assisted in removing barriers created by partners to more effective contraception methods, including Long Acting Reversible Contraception (LARC).

The ability to approach men during consultations about all contraceptive options was viewed as increasing the likelihood that the most suitable contraceptive method would be chosen, unplanned pregnancies would be reduced and relationship issues may be identified and appropriately addressed. Doctors also noted the need to reduce barriers to training and improve access for GPs to insert hormonal intrauterine devices, such as Mirena.

Similarly, AMA Queensland members indicated the need for more partner information to be included in the Pregnancy Health Record to assist with identification of ways to better support couples both in giving birth and parenting. This was seen as an effective means of identifying couples who may benefit from specific supports.

General Comments

As stated, AMA Queensland welcomes the Strategy's focus on priority communities, particularly First Nations and CALD women. These groups have been neglected by government policy for too long and are rightly prioritised in the Strategy. Specific strategies are required to reduce the prevalence of modifiable risk factors and improve services, particularly for First Nations women living in remote communities. In particular, maternity services must address the psychosocial determinants of health, incorporating a primary healthcare approach in an overarching First Nations governance framework to ensure cultural safety and active recruitment of First Nations and CALD staff.

AMA Queensland also notes, however, that health outcomes for women throughout Queensland are unacceptable, even in metropolitan areas, and the Strategy must ensure it delivers better outcomes for all Queensland women, particularly in the key gap areas identified above.

Urinary Tract Infection Focus

The Strategy places significant emphasis on Urinary Tract Infections (UTIs) as the key 'preventable hospitalisations for females', particularly for older women in residential aged care settings.[9] Medical practitioners questioned the grounds and suitability of this focus.

Specifically, the Strategy's presentation of most UTIs as preventable was regarded as oversimplified and lacking in evidence. Doctors agreed there is a high frequency of elderly patients presenting to emergency departments with fevers, confusion or nonspecific symptoms, however, diagnosis of such patients was often difficult, especially those with cognitive impairment. Doctors advised that UTIs are often over-diagnosed due to the presence of asymptomatic bacteriuria and the absence of another obvious diagnosis in vague, elderly presentations.[10] GPs noted that many aged care patients who present to hospital with a behaviour change often return with a UTI diagnosis but normal MCS (microscopy, culture and sensitivity).

In addition, the Strategy states 'Access to pharmaceuticals in remote areas can be challenging'.[11] AMA Queensland submits that this indicates Queensland Government programs, such as the recent implementation of state-wide pharmacist-prescribing for UTIs, are highly inappropriate and do not benefit key target populations despite claims to the contrary.[12] These programs are not designed to provide safe care to those at increased risk of hospitalization with UTI including:

- older women in residential aged care settings (who are the most common group admitted hospital for UTIs);[13]
- patients with recurrent UTI in the last 12 months;
- patients hospitalised in the previous four weeks;
- immunocompromised patients;
- diabetic patients;
- patients with symptoms or signs suggestive of kidney infection;
- pregnant patients;
- patients with a risk of a sexually transmitted infection;
- patients with a history of urinary tract obstruction;
- patients with urinary catheterization;
- renally impaired patients;

[9] Refer page 17.
[10] Australian Commission on Safety and Quality in HealthCare, 'The Fourth Australian Atlas of Healthcare Variation' (2021), pp133-152: https://www.safetyandquality.gov.au/sites/default/files/2021-04/The%20Fourth%20Australian%20Atlas%20of%20Healthcare%20Variation%202021_Full%20publication.pdf.
[11] Refer Appendix 1.
[12] Australian Commission on Safety and Quality in HealthCare, 'The Fourth Australian Atlas of Healthcare Variation' (2021), pp134: https://www.safetyandquality.gov.au/sites/default/files/2021-04/The%20Fourth%20Australian%20Atlas%20of%20Healthcare%20Variation%202021_Full%20publication.pdf.
[13] Australian Commission on Safety and Quality in HealthCare, 'The Fourth Australian Atlas of Healthcare Variation' (2021), pp133-152: https://www.safetyandquality.gov.au/sites/default/files/2021-04/The%20Fourth%20Australian%20Atlas%20of%20Healthcare%20Variation%202021_Full%20publication.pdf.

- spinal cord injury patients; and
- women living in remote communities since they cannot access such programs due to an absence of pharmacies.

Other information

In addition to this specific feedback on the Strategy, AMA Queensland submits the following documents for Queensland Health's consideration:

- AMA Federal Position Statement on Women's Health (2014): https://www.ama.com.au/position-statement/womens-health-2014
- Insight, 'Women's health scorecard highlights need for institute', 5 December 2022: https://insightplus.mja.com.au/2022/47/womens-health-scorecard-highlights-the-challenges/
- AMA Federal, 'The general practitioner workforce: why the neglect must end', November 2022: https://www.ama.com.au/sites/default/files/2022-11/AMA-Research-and-Reform-General-practitioner-workforce-why-the-neglect-must-end-final_1_1.pdf
- Wilson et al, 'Sex differences in allometry for phenotypic traits in mice indicate that females are not scaled males', *Nat Commun* 13, 7502 (2022): https://doi.org/10.1038/s41467-022-35266-6.