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AMA submission: draft Strategic Directions for Australian Maternity Services

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The Australian Medical Association (AMA) welcomes this opportunity to contribute to the development of a national approach to public sector maternity services in Australia.

The AMA commends the work of the Department of Health, the Project Reference Group and the stakeholder advisory group in developing the national strategy to this point. The AMA acknowledges the considerable improvement in the direction, detail and outcomes articulated in the draft circulated for public comment.

The AMA has used the following principles – stated in its previous submissions – as the main measure to assess the draft strategy.

- The primary objective of all maternity services should be healthy mothers and babies.
- Ideology and practitioner-specific agendas should not determine maternity policies and services.
- Policies and services should be evidence-based.
- Policies and services should consider the woman, her baby and family.
- Funding should follow models of care which improve the health and survival of mothers and babies, is cost effective and improves women's experiences.

Using these principles, the AMA still has concerns about specific aspects of the draft which are expanded below.

Section 1.2 Collaboration between health professionals

The AMA recommends an additional practical 'enabler' should be added: embedding electronic and digital communication systems which enhance and streamline the sharing of

information between professionals and settings, with the goal of decreasing time spent on 'paperwork' and increasing time spent with women on direct patient care.

Section 2.1 Improving access to continuity of care

Principle

The AMA recommends dropping the word 'improved' from the principle 'Women have improved access to continuity of care with the care provider(s) of their choice', in order to strengthen and emphasise the intention.

Rationale

The AMA does not support the emphasis on midwife-led continuity of care in this section. The World Health Organisation (WHO) recommendation quoted here arises from a paper focusing on 'women's preferences', which are important but have been considered as part of a bigger picture. Further, the recommendation is taken out of context: the WHO paper is aimed at low to middle income countries in terms of achieving 'Sustainable Development Goals' and where access to medical practitioners is limited.

Australian women are fortunate to have subsidised access to highly trained general practitioners (GPs), obstetricians and other medical practitioners, as well as midwives. Australia can do better.

Midwives have a key role to play in maternity services, but this should not be to the exclusion of other health care providers. Regional differences across the country will affect access to different models of care and we should encourage a team-based approach using the strengths of each discipline.

Maternity care services are one part of the 'life-cycle' of health services provided to women and their families. Most Australian models of midwife maternity care begin at around 20 weeks gestation to a few days post-partum. Midwives are therefore not in a position to provide continuous care.

Midwife-led continuous care would likely fragment long term care arrangements and may distance the primary care provider, who will have sole responsibility of the longer-term care of both mother and baby after delivery.

GPs are best placed to take the lead in providing continuity of care and are accessible in nearly all parts of Australia. GPs are the key health practitioners, already providing care to women before, during and long after their pregnancies.

GPs are especially crucial in the provision of whole of maternity care for rural and hard to access groups. Strengthening and supporting the role and ability of GPs to be involved in whole holistic maternity care will increase the ability of women to have continuity of care, whole person care and quality maternity care in their community.

The importance of midwives, obstetricians, etc, in the perinatal period should be recognised but the emphasis should be on teamwork and collaboration, consistent with Section 1.2.

Enablers

Regarding the listed 'enablers' in this section, any research on the cost-benefit of different models of care must take into account 'intention to treat'. The cost of care needs to be calculated based on how women were initially assessed, rather than where they end up in the health care system.

Too often, AMA obstetrician members find themselves caring for women who were assessed as low risk or decided to access low risk models of care. High risk features of their health and/or environment were either missed or not disclosed resulting in preterm birth and complications. This results in increased costs to the health care system as well as trauma for a preterm baby, mother and family. Any research comparing different models of care should ensure women in this situation are assessed based on their initial model of care.

Early assessment by an obstetrician or other specialist medical practitioner helps prevent adverse outcomes. This is why, when possible, all women should be assessed by an obstetrician as part of their first antenatal visit to a public sector maternity service. This is supported by the Australian Institute of Health and Welfare (AIHW) 2016 report on National Core Maternity Indicators stage 3 and 4 results from 2010-13, which showed that critical obstetrician assistance is subsequently required in almost half of all births amongst mothers from a 'low-risk' group.

Early assessment by an obstetrician is also supported by independent Queensland Government commissioned reviews. These reviews specifically identified delays in accessing specialist obstetrician input in midwifery models of care in a large public hospital as contributing to a number of adverse outcomes. An explicit recommendation was that obstetricians be involved earlier during both pregnancy and labour.

The description of the 'enabler' regarding research into the cost-benefit of models should be expanded to clarify that research should be conducted into the economic benefits of various models of care, including:

- tracking the initial 'intention to treat' model to the final care actually required,
- the effect of increased private health care to ease the pressure on public hospitals, and
- the costs of adverse outcomes, such as medicolegal and other compensations, and the long-term impact on women and their babies.

Section 2.2 Improving access to maternity care

It is admirable to aim for women-centric services by designing services around the needs of women and communities. The AMA fully supports this goal. However, in achieving this aim, it is also important to acknowledge the needs of the health care practitioners caring for women and their babies. When women cannot or will not leave their community for specialist care, health care workers also suffer when things go wrong, bearing the burden of considerable grief, stress

and medico-legal complexities. Models of health care services need to support health care practitioners as well.

The AMA urges that services also acknowledge the needs and safety of health care workers, who, particularly in rural and remote communities, are also part of the local community.

In relation to the subsection titled 'Improve care in the postnatal period', this is again where the role of GPs is ignored. GPs already provide almost all postnatal care. GPs undertake the 6 week check of mothers and their babies, provide immunisation, contraception, screening and interventions referral. As the average time in hospital after birth is decreasing, women are now seeking advice from GPs much earlier, with issues such as breastfeeding, sleeping and parenting.

Section 3.1 Providing information about local maternity services

The AMA commends the further development of information about maternity services to help women make informed choices. Women should be aware of the full range of care models available in their local area including: midwife services, obstetrician services, shared-care models, GP obstetricians, etc.

In relation to the 'Pregnancy, Birth and Baby' website supported by the Department of Health, the AMA agrees that considerable further work is required before this website could be promoted as a comprehensive source of information about local maternity services. The services currently listed, following local searches, do not reflect the spectrum of services available. Additionally, those services that are listed are not described in a way that allows refinement to maternity services specifically. The Department of Health should work with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), National Association of Specialist Obstetricians and Gynaecologists (NASOG), the Royal Australian College of General Practitioners (RACGP) and other health practitioner groups to improve the website.

Section 3.2 Supporting informed choice

The AMA agrees that 'Having prior knowledge about the risks and benefits of different ways of giving birth enables women to make informed choices during labour'. It is also important to ensure that 'simple to understand' information about models of care is accompanied by a careful assessment of the woman in early pregnancy.

All women should be assessed early in their pregnancy by an obstetrician or GP obstetrician where possible, and provided with ongoing medical monitoring as necessary. This is essential if women are to be fully and comprehensively informed about the potential implications of their health care decisions and the options available to them.

This will ensure that a woman's decision-making about her model of care, is made in the context of her own health and pregnancy and her specific circumstances. The 'simple' information must be personalised so that women can truly make an informed choice.

Having an initial consultation with a medical practitioner also ensures a woman has an opportunity to meet with, and ask questions of, the doctor who may need to respond in a medical emergency. It does not enhance a woman's experience if she only meets an obstetrician or GP obstetrician for the first time in the middle of a deeply personal crisis when complex decisions need to be made.

Section 4.2 Supporting the maternity care workforce

The AMA fully supports the listed 'enabler': 'Support the development of generalists in rural settings to promote the maintenance of services'. This should be one of the highest priorities for governments in order to improve health care in regional and rural communities. Skills maintenance or upskilling of non-urban GPs is the key to safe and effective maternity care for the 25% of women who live outside of our major cities.

Increased support for GP obstetricians should also be a priority. The gradual exclusion of experienced GP obstetricians from rural and regional public hospitals in certain states, only reduces the choice of women in these areas and fragments their care. This is a short-sighted policy that is strongly opposed by the AMA.

It makes no sense for women not to be able to be cared for by the GP obstetrician who has delivered her previous babies, simply because the local hospital no longer 'supports' this model of care.

In addition, regardless of the models of care provided in public hospitals, there should be no reduction in the training opportunities for obstetrician and gynaecologist registrars. Medical registrars need experience caring for mothers and babies throughout pregnancy and beyond, not just at crisis points.

Section 4.3 Supporting safety and quality in maternity care

In addition to 'reducing the still birth rate', it is essential that the draft strategy articulates a 'strategic direction' that 'service providers should maintain low rates of maternal and infant mortality and reduce maternal morbidity'. This is, after all, the ultimate measure of the safety and quality of public sector maternity services in Australia.

State maternal mortality review committees should be supported. Their role should be expanded, to include the review of key measures of maternal morbidity which are also markers of quality health care, such as rates of post-partum depression, 3rd and 4th degree perineal tears, admission to neonatal intensive care units, etc.

Longitudinal research should also be funded and supported to better inform evidence-based maternity care models.

Other issues

There is no mention in the draft document of funding or the impact of insufficient funding on health outcomes. While it may not be possible to mandate minimum funding levels, it should be acknowledged that insufficient financial support for public and private sector maternity services, has a significant impact on women's choices and the quality of care women can access.

State government hospital funding is an ongoing issue. Federal government funding for maternity services has also fallen considerably in real terms. Medicare Benefit Schedule (MBS) rebates for maternity related services should be realistic and adequately indexed to cover the increasing costs now being borne by women themselves. Furthermore, government subsidies for only independently practising midwives must be reviewed, as escalating indemnity insurance for obstetricians and gynaecologists is a main driver of increasing costs which are rising 2-3 times the rate of the consumer price index.

MBS rebates for imaging and pathology associated with maternity care also need urgent attention. These areas of maternity care are rapidly expanding. For example, emerging technologies such as non-invasive prenatal testing and genetic carrier status testing, will identify and help prevent large numbers of chromosomal and genetic disease in children, as well as ultimately saving families and governments significant expenditure.

Increased and sustained funding into women's health is needed for Australian women to continue to enjoy some of the best health outcomes in the world. Both public and private health systems need to be supported, as neither on its own has the capacity to meet demand.

NOVEMBER 2018

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