31 October 2008

The Secretariat
Maternity Services Review
MDP 94, GPO Box 9848
Canberra
ACT 2601

‘Starting as we mean to go on’

The Victorian Healthcare Association Submission on:
Improving Maternity Services in Australia –
A Discussion Paper from the Australian Government

The Victorian Healthcare Association welcomes the opportunity to respond to the paper "Improving Maternity Services in Australia"

The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. Our members are public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes the interests of its members.

This submission remains the position of the VHA and does not supersede any submission or position stated by any member agency.

Maternity Services

The quality of Maternity care is an important contributor to positive health outcomes for both mothers and their newborn infants. As citizens of a developed country, Australians are lucky to be in receipt of high-quality maternity services. Despite this, intra-country inequalities exist which factor in rates of morbidity and mortality.

The VHA agrees with evidence that shows health outcomes can be affected by:

- Access – specifically issues of rurality
- Quality of care across the pregnancy continuum
- Appropriateness of care

Intra-country inequalities are evident in maternity services across Australia. Use of health services is universally lower in more disadvantaged populations. This can be further hindered by access to skilled care and the appropriateness of care for both the mother and her unborn child.

Specific to Australia, inequalities suffered by Indigenous woman and their babies are considerably more marked than for other Australians. Maternal mortality, foetal death and neonatal death are all unreasonably high. This is exacerbated by substantially higher birth rates in this population group coupled with higher levels of risk-taking behaviours (e.g. smoking) during pregnancy(AIHW, 2005, AIHW, 2007, AIHW, 2008). The VHA's members note that many migrant women suffer substantial peri natal complications. It is thought that this may be reduced by improved access to appropriate pre-natal care.

The VHA commends the Federal Government's move to improve the standard of care provided to mothers during pregnancy and the clear identification made of the inequalities being suffered by Indigenous Australians. A model of maternity care which works to reduce inequalities must, inherently, be designed for the community it serves.

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Rural Maternity Care in Victoria

In 2004, the Victorian Department of Human Services released the Rural Birthing Framework. The framework was designed to:

> "...assist rural services plan to provide a service appropriate to their individual circumstances. [Providing] the impetus for all clinicians and practitioners involved in a birthing service to work together to determine the level of care offered in their community and to put the structures and guidelines in place to ensure this meets quality standards".(DHS, 2004)

The planning framework assists rural health agencies to make decisions on the structure and appropriateness of their birthing services; and led to a range of models being adopted across rural Victoria. Many Health Services have commenced the delivery of Maternity Services outside of the remit of Commonwealth Funding.

The involvement of health service midwifery staff in pre-natal care has shown anecdotal reductions in peri-natal complications. Many Health Services remain concerned about shifting away from involvement of local General Practitioners in birthing care because of the financial burden that this may bring. Many of the reforms mentioned in the 'reforming service delivery' section of the submission would ameliorate services' concerns.

The Rural Birthing Framework also established the Peri-natal Emergency Referral Service (PERS) providing 24/7 access to tertiary level consultation and if required referral to a higher level facility. However, health services remain grossly underfunded for the transfer of critically ill mothers and neonates.

For one service in the north of the state it costs $1200 to transport a patient in an ambulance to the nearest regional hospital. This cost increases to $6000 if the patient requires transport to Melbourne. This cost is borne by the service that initiates the transfer.

<u>The Rural Maternity Initiative</u>

The Rural Maternity Initiative (RMI) in Victoria funded 27 health services to implement a different model than had previously been possible in their community(Edwards and Gale, 2007). This initiative focussed on models which enhanced continuity of care within rural health services and included pregnancy care, caseload, modified caseload and team midwifery.

Clinical outcomes for women and their babies were significantly and substantially better in a number of areas. The evaluation of the RMI found that the initiative achieved:

- Higher rates of spontaneous cephalic birth
- Lower rates of epidural analgesia
- Lower rates of caesarean deliveries
- Better rates of intact perineum
- Lower rates of interventions including episiotomy, induction and forceps births (Edwards and Gale, 2007).

It is important that maternity care is accessible close to home. An interesting outcome of the RMI evaluation was that women were comfortable accessing labour services away from home providing that pregnancy and post-natal services were accessible close to home.

The VHA believes that the RMI model is clear evidence of how locally focussed programmes can deliver healthy outcomes for the populations they serve. Health Services should be resourced to design and implement models of maternity care that uniquely meet the needs of their population. The VHA would be disappointed in a 'one-size fits all' approach to maternity services delivery.

Reforming Service Delivery

The VHA agrees with research that the over-medicalisation of maternity services leads to service and funding inefficiencies and high rates of peri-natal interventions including caesarean section and forceps delivery(Johanson et al., 2002).

Johanson et al note that, in many countries women who have straightforward pregnancies are subjected to extensive interventions. Women without obstetric complications are encouraged to have electronic foetal monitoring and epidural analgesia. Further than this, labour will often be in the dorsal position and delivery in lithotomy with perineal injury becoming 'standard' (Johanson et al., 2002).

As labour intervention has become more widespread, so too have assisted delivery rates and major surgery. Caesarean section rates in the United States, Canada, Italy, and the United Kingdom are all about 20%(Johanson et al., 2002). Rates of caesarean section in Australia have increased from 19.5% in 1996 to 30.3% in 2005(AIHW, 2007).

The increasing rates of caesarean section receive regular media coverage without recognition of the cause of the increased rates. The VHA would like to see clear analysis of the cause of increased rates within Australia.

The issue of medicalisation must be balanced against a mother's right to choose what interventions she is comfortable with during her pregnancy and labour. It is the government's role to ensure that pregnant women are properly informed about the options and implications of different peri-natal interventions.

Alternative models of service delivery need to be planned and resourced to improve outcomes for mother and baby which are evidence-based and allow for informed and timely choices by mothers.

As an example, the Lead Maternity Carer model adopted in New Zealand provides greater flexibility and allows more consumer input by mothers in their maternity care. Increasing individual responsibility for decision-making in maternity care provides for greater health literacy in mothers and will result in more appropriate and responsive care.

To shift towards such a model, Australia needs substantial health service reform including restructuring of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) items making them accessible to professions like Midwifery. The VHA recently released their position statement **Optimising primary healthcare: Refreshing the MBS.** Within this Position Statement, the VHA recommends the restructuring of MBS funding so that health care plans are funded to meet the needs of the individual, not the practitioner (VHA, 2008).

Further, the VHA would see incentive payments being adopted to facilitate access for clients with complex needs and those who are seen as 'difficult'. This must include specific groups who are socially disadvantaged including, but not limited to: Indigenous Australians, the homeless, refugees and drug and alcohol clients. These programmes must be appropriate, culturally sensitive, affordable and incorporate strategies to promote health and wellbeing.

A copy of the VHA's position paper 'Optimising primary healthcare: Refreshing the MBS' is included for your reference.

Actioning such reform is outside of the remit of this review, but the VHA believes it should be included within the recommendations of the review.

Reforming Workforce and Infrastructure

Any discourse in the health system must focus on the health workforce and the pressures currently being faced. The VHA believes that to reduce the impact on the health workforce,

maternity systems must be structured to use the available workforce more effectively. Both the RMI model from Victoria and the Lead Maternity Carer model from New Zealand are examples of safe, effective workforce models which deliver high quality outcomes.

The Federal Government must follow through on its promises of workforce reform and deliver broader scope and responsibility to a range of health professionals involved in the maternity system. Models external to Australia provide much greater autonomy to Midwives within their area of speciality, achieving safe and appropriate outcomes for the majority of expectant mothers.

Conclusion
The VHA supports the intent of the paper and welcomes the focus placed on individual responsibility for decision-making in maternity care. If changes are to have a significant impact:

- Health services must be resourced to design and implement a service that meets local needs. A one size-fits-all approach is not acceptable
- The Federal Government must be willing to undertake significant reform of the MBS, PBS and relevant legislation to provide for a service which meets growing demand coupled with a shrinking workforce

Please contact the VHA for any more information regarding this response. We welcome the opportunity to represent the Victorian public healthcare sector throughout the review process.

Kind Regards

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References

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