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HEALTH
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Australian Journal of Rural Health

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The importance of birthing in the bush

A submission to the
National Maternity Services Review

30 October 2008

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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Introduction

The National Rural Health Alliance is the peak non-government rural and remote health organisation. Its membership is broad and its vision is equal health for the people of rural and remote Australia by the year 2020. A full list of its Members is at Attachment A.

The Alliance exchanges and collects information and develops policy positions on issues that affect health outcomes in those areas.

Questions of access to services for rural families and equity in health outcomes are of major concern to the Alliance.

Women everywhere should have birthing options, with the health and wellbeing and safety of mother and child being the overriding determining factors.

The fact that rural birthing options are becoming increasingly limited is of concern to families and rural communities and ought to be a matter of concern to the health sector, the Treasury and society at large. A healthy pregnancy, a birth that is managed with appropriate care, and an optimum beginning to life are key determinants of the longer-term health of the child. Investment in maternity services¹ therefore yields returns for individuals, families and the nation. The obverse is that poor prenatal and birthing experiences impose costs for life, and are likely to involve many in the health care sector who are not directly involved in maternity services.

Equity and choice are also affected by financial means and family circumstances. People with private health insurance and/or with good income are better able to afford to travel and stay away from home if there are no local birthing facilities. Many people in rural and remote areas cannot readily afford such travel and accommodation costs. For those people the absence of local birthing services imposes particular costs and logistical difficulties, and may actually increase the health risks of the pregnancy and birth.

It is desirable for all women, in rural Australia as elsewhere, to have local access to good management and support for a healthy pregnancy, safe delivery and good post-natal care. Some graphic and valuable insights into the personal and family costs incurred when this is not the case are reported in recent research by Elaine Dietsch and others from Charles Sturt University.²

Support for a new Plan

The National Rural Health Alliance welcomes the Government's intention to establish a National Maternity Services Plan. The Plan will be a key element of what needs to be achieved in order to have more widespread access to maternity services and more equitable and better health outcomes for people in rural and remote Australia.

¹ 'Maternity services' are an integrated sequence of services including antenatal care, childbirth, parenting skills, post-natal services and specialised services needed by very young babies.

² *'Luckily we had a torch': Contemporary birthing experiences of women living in rural and remote NSW*, Elaine Dietsch, Carmel Davies, Pamela Shackleton, Margaret Alston and Margaret McLeod, School of Nursing and Midwifery, Charles Sturt University; 2008.

Key concepts

The Alliance welcomes the underpinning philosophy expressed in the Discussion Paper that women should be able to feel in control of what is happening during pregnancy, childbirth and the postnatal period, and that they and their babies should be able to access high quality, safe maternity services, as close to home as possible, in line with their assessed level of risk.

It is pleasing that the issue of increased risk factors and poorer health outcomes for rural and Aboriginal and Torres Strait Islander women, and models of maternity service care in rural and remote settings, are front and centre in the Review's considerations.

Effective coordinated interdisciplinary birthing services focused on the needs of individuals and their families provide the cornerstone on which rural health services should be built. Current models of care that succeed in providing good outcomes for both families and health professionals need to be identified and promulgated around the country.

Given overall poorer access to health services and poorer health outcomes for rural Australians, the Alliance also strongly supports the focus in the Discussion Paper on improving the health and wellbeing of the mother during and after pregnancy, with particular reference to maternal nutrition, alcohol and smoking rates, breastfeeding rates and support for women with depression and with their psycho-social and emotional health.

This submission will discuss the need for:

- a national approach;
- consultation with women and local communities;
- investing and re-investing in rural hospitals and infrastructure;
- enhancing the quality and safety of antenatal, birthing and postnatal care;
- identifying and establishing effective models of service;
- improving workforce planning and capacity;
- improved indemnity arrangements;
- supporting locum and fly in/fly out support;
- patient travel assistance;
- improved data and research; and
- provision for the special needs of Aboriginal and Torres Strait Islander Women.

The need for a national approach

The Alliance has an agreed position paper on principles for maternity services which is attached to this submission. Another key document is the National Consensus Framework for Rural Maternity Services agreed by six organisations representing doctors and midwives, which is “a codified body of principles” for use in policy and planning.

There is widespread agreement of the principles which should apply for maternity services, including those in rural and remote areas. These principles should be enshrined in the new National Maternity Services Plan to be developed, and inform the development of targets and indicators, with governments held accountable for meeting them.

The Alliance recognises that States and Territories have given substantial attention in recent years to their maternity services, and in some cases now have detailed plans for addressing the deficiencies of those services. So, although many maternity services have been lost, with the

States/Territories and the Commonwealth now committed, there is scope for considerable benefit to accrue from a cooperative national approach that is embodied in a new National Plan. These benefits will include:

- the establishment of national and nationally-agreed principles and practices which will help ensure equity in the provision of maternity services;
- a national approach for workforce planning, education and support across the spectrum of health professionals who can play a role in maternity services;
- identification of and national funding for the promulgation of good practice in effective models of service;
- an explicit national focus on key services to enhance the health and wellbeing of women and their babies in their pregnancy and after birth (this approach complements major policy thrusts on early childhood development and preventative health);
- making the best use of resources in undertaking research, for example in looking at ways to address climbing rates of caesarean section and in considering nationally applicable guidelines for such things as risk assessment and monitoring; and
- a framework of national accountability for the achievement of results.

It will be critical for the proposed National Plan to lead to early action. While it will necessarily have longer-term goals, and some elements may take time to negotiate and come to fruition, its top priorities must be immediate initiatives to enhance maternity services, including for Aboriginal and Torres Strait Islander women and women in rural and remote Australia. This submission includes proposals for immediate action in those areas.

The need to consult with women and local communities

Maternity services must be planned and operated in close consultation with local communities, particularly the families who are their clients.

Women-centred care and informed consent are the means by which individuals can choose to balance choice with safety and quality. To exercise informed consent, consumers need access to the full range of information and a good understanding of the services available and their associated risks.³

The report by Elaine Dietsch and others asserts “the urgent need to develop a model of birthing care for women in rural and remote areas that provides women with a supportive environment, free of fear.” The authors argue that its essential elements include it being woman-centred and community based.

Further evidence of women’s attitudes to the provision of maternity services will be available from the results of a national survey undertaken by the National Rural Women’s Coalition. There were 560 respondents to the survey and some 1700 written comments.

³ One of the Alliance’s correspondents points out that it is essential that informed consent is driven by and for the patient, so that the professionals’ concern for gaining informed consent does not dominate the relationship and the transactions. “We need a more empowered society, starting with new mothers and families.”

The need to invest and re-invest in rural hospitals and infrastructure

The Alliance held a Workshop on *Birthing in the Bush* in December 2004, and produced a first draft paper on the subject in May 2005. In response to that draft, one woman was moved to write:

“people in rural areas may have more resources and even assets and money than their predecessors, but they can no longer be born or die with dignity in their own communities – so how are we going to define ourselves ... when no-one from now on can say ‘I was born in my town’. Is this progress?”

The continual and seemingly inexorable loss of maternity services in rural and remote areas for more than a decade is a matter of great concern to the Alliance. Some 130 maternity wards have been closed in the past 10 years. The loss of these services, with the attendant loss of infrastructure, health professionals and accessibility, is not consistent with the principles of the National Health and Hospitals Reform Commission that recognise the importance of family-centred services, of equity, of strengthening wellness and prevention and of providing for future generations. Neither is it consistent with the philosophy of the Discussion Paper that *“women and their babies should be able to access high quality safe maternity services as close to home as possible, in line with their assessed level of risk.”*

This loss of maternity services is seen in some quarters as a most serious social experiment, given the higher risks and costs that the closures have imposed on rural and remote women, their babies and their families. It is likely that the higher costs borne by women who have to travel substantial distances to have their babies or, worse still, face the real risk of birthing in unsafe environments, such as in transit by the roadside, result in even greater costs to society stemming from the poor lifetime health trajectories of their children.⁴

“These stories describe the extraordinary circumstances in which many women living in rural and remote areas give birth. Expectations are that they will travel several hours to their nearest regional centre in order to give birth but in the process they face risks from unsafe road travel. They also face separation and isolation from partners, children, families and community support as well as financial hardship, and the negative impact on emotional wellbeing and family cohesion.” (Elaine Dietsch et al, 2008)

The Alliance accepts that there will always be centralisation of services in tertiary hospitals for rural women with high-risk pregnancies. However the provision of maternity services in smaller hospitals is a key part of the service mix they provide, and contributes to the critical mass of service, throughput and funding that can keep such facilities in operation. Being able to provide maternity services is part of the overall attraction for GPs to come, stay and practise as proceduralists in smaller towns. Small rural hospitals are also key training facilities for future generations of rural health professionals and a centre in which a range of health professionals can maintain their skills and safety levels.

On top of this, the hospital is a key part of the local economic base, providing jobs and incomes. The existence of a local hospital or alternative centre for acute care can also be a key to attracting and retaining other business sectors and professionals to a town.

⁴ The question of improved data is discussed in a later section.

For these reasons an isolated facility that provides acute and emergency care, as well as local birthing services for a significant proportion of mothers who are thus not burdened with the costs and risks of referral to distant centres and to carers unfamiliar with their history, should not be closed as a result of a simple economic analysis.

The key challenge for rural Australia is not just to maintain the current level of maternity services but, rather, to reinvest substantially in such services so that greater proportions of women in those areas have local access to high-quality, safe, women- and family-centred, culturally secure and holistic maternity services. Preservation of the existing service capacity and a firm, well-funded commitment to reinvest and rebuild maternity services is therefore a top priority for immediate action.

“The research concludes that it is time to stop maternity unit closures in rural New South Wales and to develop strategies and models of midwifery care that will enable the reopening of many that have been closed.” (Elaine Dietsch et al, 2008)

The Commonwealth and State/Territory governments should collaborate to maintain the services of hospitals in as many smaller centres as possible. They should require their Area/District Health Services to consult with the local community over such decisions, and provide information on the pros and cons involved and the potential trade-offs with other aspects of health service (eg domiciliary care). Part of the decision making process should include an analysis of the potential immediate and longer term risks that would be imposed on mothers and families if the hospital closure would result in the loss of local maternity services. A new National Maternity Services Plan should place an immediate moratorium on the closure of rural obstetrics units within rural and regional hospitals, and establish a framework for consideration of such decisions. This framework would include the impact of losing maternity services in the community and continuity of care for women throughout and after their pregnancy, especially in relation to the greater care and health needs of people from lower socio-economic groups. (Apart from anything else, babies sometimes do not wait and therefore cannot be transferred.)

If closures do proceed, action must be taken to implement alternative methods of providing local maternity services.

The need for quality and safety

Achieving quality and safety in maternity services is about discussing with women and their families their ideas and desires, providing good information and enabling them to make informed choices as to their maternity support, including healthy pregnancy, birthing options and needs, and post-natal support. Giving women the information necessary to make informed decision requires a good understanding of their needs and of the maternity services system and its associated strengths and risks.

The evaluation of risk in pregnancy, labour and childbirth can be a changing and complex issue. There is evidence that small hospitals have birthing outcomes that are just as safe as large tertiary units if they have appropriate selection of patients and effective escalation protocols.⁵ Many are

⁵ *Does size matter? A population-based study of birth in lower volume maternity hospitals for low risk women*, Sally K Tracy, Elizabeth Sullivan, Hannah Dahlen, Deborah Black, Yueping Alex Wang and Mark B Tracy, BJOG, 113(1), 2005.

of the view that the key determinant of quality and safety is not numbers, but the existence of, and adherence to, well-defined clinical protocols.

The Alliance understands that there are no current national guidelines, such as from the NHMRC, on clinical procedures and assessment of clinical risk in pregnancy. Different jurisdictions and professions have, or have had, their own set of safety protocols. Current moves to national registration and accreditation, and the maternity services review itself, will hopefully speed progress towards the agreement and adoption of national protocols and guidelines wherever possible. If we are to be serious about quality, wellness and efficiency, these guidelines should cover multidisciplinary maternity services.

The operational safety of birthing services can be assured through adherence to agreed guidelines for services and practice, and by maintaining competencies and infrastructure within a 'capability framework' relating to institutional and clinical risk. The development and maintenance of these guidelines will be informed by national and international evidence. (The capability framework is further discussed on pages 9-10 of the Alliance's 2006 Position Paper.)

Such guidelines need to have a clear understanding of the risk profile of women in pregnancy, and provide for optimum outcomes for the vast majority of women and their babies with low risk pregnancies as well as provide for appropriate escalation of assessed higher risk situations. Broadening of investment by the Safety and Quality Commission in the interdisciplinary aspects of maternity services would also be consistent with an overall policy of more holistic maternity services.

One aspect of quality and safety that is clear is that the closure of a local maternity unit due to the perceived risks that its continued operation may pose for a small proportion of deliveries will impose additional and escalating travel and distance-related risks on the vast majority of women and families in the area who will experience 'low-risk' pregnancies. The Alliance believes that a comprehensive focus on quality and safety should be informed by research on the maternity risks and physical and mental health outcomes of women and babies who do not receive continuity of care but are forced to travel long distances for birthing and/or pre- and post-natal support.

Achieving safe maternity care for rural women will also require re-investment in diagnostic and monitoring equipment and in the preservation of staff competencies for maternity care.

Quality and safety will also be enhanced by critical event analysis and clinical audits to detect and assess less than optimal outcomes and to provide for mentoring and continuing professional development (CPD) and for review of organisational and infrastructure capacities. These processes should be integral to the evaluation of the National Maternity Services Plan.

Quality and safety are also dependent on high quality retrieval services and on access to timely, effective specialist obstetrician support. With good lines of communication, some of the care provided by the maternity services team can be delivered by telephone and telehealth. However, this depends on good ICT infrastructure being available in the community and this does not exist in all areas. In more remote areas where there is no maternity service, local health professionals will benefit considerably from having good communication skills and systems.

In all cases where obstetrician backup and support are provided through telehealth there must be properly resourced and fully reliable response times, with the service giving as much weight to the safety of the women being supported at a distance as tertiary hospitals do for their own in-patients.

Every rural health service where there is no birthing facility must have and/or train frontline staff who can deal with the occasional emergency birthing situation that will arise however effective a new national plan might be. These must have at their disposal appropriate clinical guidelines and support.

The need to identify and employ effective models of service

Part of the action agenda for development of the National Maternity Services Plan should be to collect detailed case studies from rural and regional areas of maternity services that are working well. The Alliance is aware of a number of specific local situations in which models are working effectively, as well as a number of specific locations in which there are ongoing difficulties. Providing rural women with options for accessing collaborative, team-based, flexible, safe, sustainable and well-funded maternity services will be assisted through more thorough collection, collation and dissemination of examples of working models from the field.

Once this detailed information from local sources becomes available, the issue becomes how such models may be applied more widely.

The Commonwealth should provide additional funding for the States and their Area Health Services and hospitals to meet particular targets for maternity services in rural areas.

As discussed above, a more widespread network of maternity services will be a key plank in both the sustainability of country hospitals and, more broadly, in the sustainability of rural, regional and remote communities. It has been suggested that the absence of birthing services is a disincentive for people of child-bearing age to move to or remain in rural communities, and is thus a drag on regional development, which has a consequent and long term negative impact on rural health outcomes generally.

Regional maternity services should be able to respond to the needs of the surrounding smaller communities and this will involve the commitment of regional funds. Priority should be given to establishing clinical support systems within Area or District Health services to co-ordinate planning, service provision, including on-call, clinical support, and retrieval services for their smaller or outlying maternity services.

The Alliance is also concerned that complementary primary care services support the health of women in pregnancy and postnatal outcomes, especially in relation to nutrition, mental health and oral health. These supports, including access to health professionals such as dentists and psychologists, should be imbedded in a maternity health program. Such services, if not locally available, could be provided through locum services, modelled along the lines of the Medical Specialist Outreach Assistance Program (MSOAP) or the Specialist Obstetrician Locum Service, or through such programs as Access to Allied Psychological Services. Rural and remote dental services must be expanded to provide essential care to women and infants.

Models of service also need to have regard for the needs of the health professionals. Models of good practice should provide for partnership and respect among health professions, integration of

their services, opportunity for peer support and for high quality continuing professional development, and especially for avoidance of sustained overwork. Models of service should also respect individual preference for fee-for-service, salaried or blended payment options. The Alliance recognises that, because of a poor supply of private practitioners, services that rely on access to the MBS are unlikely to result in the best outcomes for people in rural Australia.

The need for improved workforce planning and capacity

The attraction and retention of relevant maternity services professionals is crucial. Shortages in rural Australia of GPs who practise obstetrics and of midwives are serious. No amount of valuable work on policy and practice models will be of use without ensuring the supply of well-trained, well-supported and valued maternity health professionals.

There needs to be a strategic approach to planning of the maternity services workforce. This will cover training, education, curriculum and placements, recruitment and retention in particular geographic areas, ongoing support, indemnity issues and professional development for the whole of the maternity services team. Such an approach will help to address current and projected shortages and the current maldistribution of professionals which disadvantages patients in rural Australia.

The importance of all members of the team - obstetricians, GPs, midwives, anaesthetists, paediatricians, Aboriginal health workers, psychologists, physiotherapists, paramedics and health service managers - must be acknowledged.

In the view of the Alliance, there are at least five key areas relating to workforce supply, distribution and capacity that warrant attention:

- financial incentives and support for nurses, midwives and allied health professionals to attract and retain them in rural areas;
- financial support for health services (public and private sector) to provide, and for health professional graduates to undertake, high quality clinical practice in rural areas; (this would ensure that emerging graduates have attractive options in rural Australia; given the lack of obstetrics training in undergraduate training, placements with rural GP generalists and proceduralists are especially critical, as long as the practitioners are protected from the burnout that could result from their teaching responsibilities);
- clinical placement and CPD opportunities that are interdisciplinary in nature;
- interdisciplinary training; (while time and content pressures on courses make this a challenge even in universities offering a range of health profession courses, the professions recognise that interdisciplinary training is an effective building block for team service provision); and
- targeted upskilling for medical graduates serving in rural and remote areas who may have relatively undeveloped procedural skills.

In rural and remote areas it is particularly important to provide care for staff involved in an adverse event (eg through debriefing and counselling). The Bush Crisis Line provides a model of

service in this area. The need to provide professional and emotional support is even greater where staff experience such things in a very close and personal fashion.

There are a range of issues pertaining to the attraction, retention and effective use of midwives in rural areas. They include requirements that they be employed by hospitals rather than primary health care providers; that they are often required to undertake other nursing duties; that their skills may be narrowly used in birthing rather than in the broader spectrum of maternal and infant primary care; that there is a lack of access to affordable insurance, a lack of connection to GPs, and a lack of funding for private midwives to provide services. These issues must be addressed quickly if Australia is to develop a framework of maternity services that enables a comprehensive and collaborative model rather than competitive and partial arrangements.

The need to improve indemnity arrangements

The Alliance is on the record as supporting the establishment of a no-fault insurance scheme which would substantially reduce the costs, to both clinicians and taxpayers, of adverse outcomes. Such a scheme would help the further development of the maternity services workforce.

While there are a small number of children who are harmed by negligence in birth, it is often very difficult to work out which they are. For example, the great majority of cases of cerebral palsy arise where there is no evidence of birth asphyxia. Many of the resources of the legal system go into arguing about this, to the cost of taxpayers and to the benefit of no-one except the legal profession.

The indemnity premiums payable by those who provide services where there are higher risks of long-term harm often result in those providers withdrawing their services altogether.

The impact of a small number of cases involving high levels of disability is very great and the care costs component is the single main contributor. In the absence of a 'no-fault' scheme the tort system provides the only means of meeting these costs (beyond the social security system). Under the tort system, such costs are usually paid as a single lump sum payment.

The Commonwealth Government already provides a significant contribution to the costs of the present tort system relating to medically-related catastrophic disabilities, through its various medical indemnity support arrangements for doctors. The Government should consider extending these arrangements to midwives (see Attachment B). At present the inability of midwives to secure professional indemnity insurance in Australia is preventing the expansion of services by this key group of maternity service providers.

However it would be more equitable to have such support going directly to meet the needs of people who suffer catastrophic disabilities. With the level of legal and administrative costs associated with the tort system, it is likely that a move to a no-fault system for these costs could not only be more equitable but be provided more cost effectively.

Unpublished work undertaken for the previous Government by PriceWaterhouse Coopers to look at the likely costs of a national no-fault system for long-term care costs apparently showed that it would be both feasible and economically possible.

To have a major beneficial impact in rural and remote areas, a first priority would be for the new scheme to cover those people who are injured in medical misadventures and children born with cerebral palsy. (More details of the case for a no-fault insurance scheme, particularly as they relate to maternity services, are at Attachment B.)

The need for locum and fly in/fly out support

The current Specialist Obstetrician Locum Service is highly regarded in rural Australia and has been extended to cover procedural GP obstetricians and anaesthetists and would be a good model for midwives. There is scope to enrich this service through extension to other professions such as paediatricians and to support more Continuing Professional Development and peer support. It should also be examined as an option to maintain maternity units in rural hospitals at risk of closure for capacity reasons while more ongoing arrangements are put in place.

The need for patient travel assistance

While patient travel is not the preferred outcome, the Alliance is a strong supporter of improved and more uniform patients' assisted travel schemes. There needs to be more comprehensive eligibility, increasing funding and better promotion of such schemes.

The travel schemes should provide more uniform and universal cover for women and their carers who have to travel to access maternity services that are not available to them locally. There need to be appropriate accommodation facilities available, including 'step down' centres and places for fathers and children to stay. Priority should be given to families with low income.

The schemes should provide equivalent compensation for equivalent travel and accommodation, regardless of which jurisdiction the person lives in. The scope of the schemes should be revised to include a wider range of effective health interventions not available locally, including those related to antenatal care and should not only cover travel and accommodation for the mother who needs to travel to give birth, but should also provide for her partner or carer, as well as assisting other members of the family to cope while patient and carer are away from home.

With patients' assisted travel and accommodation, as for other strategies, provision needs to be made for Aboriginal and Torres Strait Islander people and their cultural security.

There also needs to be provision for support persons during transportation in an ambulance or air ambulance.

The needs of Aboriginal and Torres Strait Islander women

An understanding of the system and systemic risks is especially challenging for Aboriginal and Torres Strait Islander families and those providing maternity services for them. There is less evidence available and it is mediated by the need for cultural insight. The demographics of Aboriginal and Torres Strait Islander women are distinct. Attachment to land and birthing are intimately related and if there is a need to travel to give birth, mothers are away from both family and country. Requirements for a happy and fulfilling birth experience in a local and culturally suitable setting are even more critical for Aboriginal and Torres Strait Islander women.

Nevertheless, given that a significant proportion of services for Aboriginal mothers and children will continue to be delivered in a cross-cultural environment for some time, there is a need for significant investment in cultural security training of the kind developed by the Aboriginal Health Council of Western Australia.

The need for improved data, research and evidence base

As in other areas, evidence and monitoring are keys to the effective management of services related to antenatal care, birthing and early childhood development.

All routinely collected data during pregnancy, birth and for at least the first year of life should be available as one electronic record, allowing easier and more effective management of the childbirth continuum.

Special attention should be given to close monitoring of current practices, and of new practices that might be introduced as a result of the review, so that best practices are encouraged and sustained, and less effective practices are modified or discontinued.

Data collection is expensive in terms of both time and money. Collection of data should be realistically funded as a critical part of the management of pregnancy and birth.

Data collection should be relevant for the individual recording the information and the organisation coordinating the antenatal/birthing/early childhood service. Consequently, all individual maternity services should report publicly, with their results compared with their peers, and with the opportunity to justify different levels of reported performance.

A national archive of proven successful antenatal/maternity/early childhood services should be maintained as templates for best practice.

Key understandings should be consolidated, and where lacking, augmented through research facilitated and fed by well collected data. Such evidence could include data on the relationship between the holistic experience of birth (including location of the birth relative to maternal residence, antenatal care, the birthing experience, and the care and environment after birth) and the physical and mental development of the child and their future prospects for healthy life. Such information is critical so that practice is informed by all the evidence, rather than by convenience.

As birthing close to home has been identified by the review as important, thought should be given to how to assess whether road distance between maternal residence and birthing place is declining, unchanged or increasing in rural and remote Australia, especially for key groups (eg Aboriginal women).

Evidence obtained may demonstrate that new technology to make labour safer by predicting complications earlier should be made available first in tertiary institutions and then immediately in small birthing centres, rather than through the process by which it ‘trickles down’ to all destinations in-between before finally reaching small hospitals. Having said that, there should be no rush to adopt new technologies unless and until they have been proved. Low cost innovations based on sound clinical assessment may be more effective.

Overall there needs to be further high quality research on safety and quality, including on how they are affected by the closure of rural units and the attendant risks of travel outside the local community and the lack of continuity of care. Rural hospitals nationwide need to look at the outcomes for uncomplicated pregnancies and exclude the confounders such as numbers who are referred away due to staffing issues rather than for medical reasons.

Fast tracking of a national eHealth capacity would greatly assist in the efficient recording of appropriate data, its use in enhancing the quality and coordination of services, and should lead to a better-focussed and more cost-effective service and better outcomes for mothers and babies.

Conclusion and Recommendations

There has been much discussion and deliberation on the shape and adequacy of maternity services in Australia. The Alliance considers that the imperative is now for urgent agreement and properly funded action at a national level. In rural Australia, the existing pressures across the board leave no scope for additional action or systemic change without targeted additional resources.

1. In the case of women and their families in rural and remote Australia in particular, it is time for all Governments to agree to the proposed National Maternity Services Plan. Specifically, governments should agree that:
 - women have the fundamental right to maternity services that maximise health and wellbeing outcomes for themselves, their babies and their families;
 - maximum health and wellbeing for all will be achieved by allowing for women to give birth in or as close as practicable to their own communities, supported by their families and to have continuity of care, as far as is practicable, by their own local health care professionals;
 - women's choice as to their options for giving birth in a safe and healthy environment should be supported by person-centred care and good information on the risks and benefits of various models of care;
 - the large majority of women for whom childbirth is a safe and clinically uncomplicated experience should not have their options reduced or have to incur additional risks and costs themselves through extensive travel and dislocation in order to maximise the safety of those who experience substantial risks;
 - the Plan should provide for accounting annually for any diminution in the provision of local maternity services;
 - the Plan should identify and share at a national level the examples of good practice and enhancement of services; and
 - the Plan should provide for national workforce planning as well as immediate measures to boost an interdisciplinary maternity services workforce in rural Australia.
2. Such governmental agreement would be consistent with the general principles espoused by the National Health and Hospitals Reform Commission, especially those related to people- and family-centredness, equity, strengthening wellness and providing for future generations.
3. The Australian Government should back the efforts of the States and Territories on maternity services and provide additional funding to build and rebuild maternity services in rural Australia.
4. There should be a moratorium on further closures of maternity services in rural hospitals. Maternity services should not be treated as a commodity, subject to provision at lowest possible short-term transaction cost. Nor should the focus on safety and risk for the small proportion of pregnancies that require higher level care result in higher risks for the majority of local women for whom birthing is relatively uncomplicated.

5. In view of the poorer access to the broad range of health services available to them, women in rural Australia should be offered continuity of care services, to provide for prevention and early intervention of both prenatal and postnatal health issues.
6. Information kits should be provided to expectant women on the nature, scope and availability of various models of care available to them both locally and wider afield.
7. Funding should be made available to support:
 - clinical placements for GPs and midwives in rural services providing quality maternity services at both primary practice and rural hospital levels;
 - a range of education, training and support initiatives to build the supply of midwives where there is demand by individuals for their services; and
 - clinical placements for all professions involved in the maternity services team in an interdisciplinary environment.

Attachment A

Member Bodies of the National Rural Health Alliance

ACHSE	Australian College of Health Service Executives
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA (RPG)	Australian Healthcare and Hospitals Association – Rural Policy Group
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors’ Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
ARHEN	Australian Rural Health Education Network Limited
ARNM	Australian Rural Nurses and Midwives
CAA (RRG)	Council of Ambulance Authorities - Rural and Remote Group
CRANA	Council of Remote Area Nurses of Australia Inc
CRHF	Catholic Rural Hospitals Forum of Catholic Health of Australia
CWAA	Country Women’s Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children’s Parents’ Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students’ Network
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors’ Association of Australia
RDN of the ADA	Rural Dentists Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service of Australia
RHWA	Rural Health Workforce Australia
RIHG	Rural Indigenous and Health-interest Group of the Chiropractors’ Association of Australia
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health

Attachment B

No-fault insurance and maternity services¹

The Professional Indemnity Review undertaken by the Commonwealth Government between 1991-1995, chaired by Fiona Tito, identified the costs of future care where someone had a catastrophic disability as being one of the main drivers of premium for medical indemnity, particularly among doctors who delivered babies. While there are a small number of children who are harmed by negligence in birth, it is often very difficult to work out which children they are. The Final Report of the Professional Indemnity Review stated, in paragraph 10.36:

Epidemiological and other research published in the late 1980s indicated that the great majority of cases of cerebral palsy arose in cases where there was no evidence of birth asphyxia - with only around 6%ⁱ- 9%ⁱⁱ being associated with birth asphyxia where there were no other complications such as congenital abnormalities. The Western Australian data has indicated a similar figure of around 8%ⁱⁱⁱ. Data have also showed that birth asphyxia was much more strongly associated with death of a baby, rather than survival with cerebral palsy^{iv}. Data also indicates that the signs of fetal distress or asphyxia may, in some cases, merely indicate the existing presence of cerebral palsy rather than result in it.^v

Many of the resources of the legal system go into arguing about this, to the cost of us all and to the benefit of no-one except the legal profession.

There are also other cases, where adults and children at different times suffer injuries in health care that give rise to profound disabilities, sometimes through health care services that are necessary to save their lives. In our vast country, with rural services stretched to breaking point, the additional medical indemnity premium costs payable for those who provide services where there are higher risks of long-term harm often result in doctors withdrawing from the provision of these services altogether.

The impact of this small number of cases involving high levels of disability is very great and the care costs component is the single main contributor. For example, during the last medical indemnity 'crisis' in the first half of this decade, the Report of the AHMAC Legal Reform Working Group, chaired by Professor (now Justice) Marcia Neave, stated:

[7.39] ... The number of large medical indemnity claims incurred in any one year is small, but the financial impact of these cases is significant. Some of this data was summarised in Chapter 3. The ACT public sector data shows that in the past 10 years, only three cases commenced over that time have been paid or estimated at over \$1M, but the costs associated with the cases exceeds 45% of the total cost.^{vi}

7.40 The contribution of care costs to this total is also very significant. Results of the NSW survey of its Treasury Managed Fund (TMF) cases set out in Table 6.1 show that 45.5% of costs of cases over \$1M were related to care costs. In the recent *Simpson* judgment in NSW, \$6.5 million was awarded for future attendant care costs. If all past

¹ Thanks to Fiona Tito and Barbara Vernon for inputs to this Attachment.

and future care and rehabilitation-related expenses were included, the proportion of damages payable in this case for these costs exceeded 80%. It has been estimated by Trowbridges that care costs comprise around 25% of MDO premium costs.^{vii}

7.41 NSW TMF data showed settlements for severe brain damage of neonates or infants increased from around \$2 million in 1992 to \$7 million in 1999, which is broadly consistent with the pattern of award increases. The single biggest component in these increases is ever growing amounts awarded for care costs, including home, vehicle and other modifications, rehabilitation expenses and the traditional ‘personal and attendant care’ costs. These have been increasing for a range of reasons.

The long-term care costs of all those who require it are, in one way or other, borne by our society. The tort system provides the only means of meeting these costs (beyond the social security system) where there is no specific ‘no-fault’ provision. Under the tort system, in the vast majority of cases such costs are paid as a single lump sum payment. The problems for disabled consumers, their carers and the community with lump sum provision for this care have been well-documented over several decades by various enquiries.

In the motor vehicle accident arena, these problems have resulted in a number of States taking these costs out of the tort system and providing long-term care and rehabilitation costs for catastrophic injuries on an on-going basis for the duration of the person’s need. These models of care have allowed much better assistance to be provided to all people who suffer these terrible disabilities without the costs associated with the legal system. It reduces the variability and size of costs for insurers and makes premium costs more predictable and hopefully lower.

The Commonwealth Government already provides a significant contribution to the costs of the present tort system relating to medically-related catastrophic disabilities, through its various medical indemnity support arrangements for doctors. The High Cost Claims Scheme and the Premium Support Scheme are both essentially industry support provided by the Commonwealth Government (and thus Australian taxpayers) to the medical defence industry to remove the financial risk of large claims from them and onto tax payers. It would seem more equitable to have such support going directly to meet the needs of people who suffer catastrophic disabilities. With the level of legal and administrative costs associated with the tort system, it is likely that a move to a no-fault system for these costs could not only be more equitable but provided more cost effectively.

It is understood that work was undertaken for the previous Government by PriceWaterhouse Coopers, to look at the likely costs of a national no-fault system for long-term care costs, and that this showed that it was both feasible and economically possible.

In New Zealand, in addition to no-fault compensation, a comprehensive consumer complaints process in maternity has been introduced, which involves face-to-face mediated consultation between affected consumers and the relevant clinicians. This is said to be highly successful in meeting consumer needs to understand what happened to them and why. This in turn means that few cases proceed to litigation.

The fact that indemnity support has not been provided to midwives has had at least three effects.

Firstly, the relatively small number of private midwives in practice has fallen since 2001 - and there has been an increase in unassisted births by women who refuse to access mainstream maternity care and who previously accessed a private midwife.

Agencies which used to fill temporary vacancies in hospital rosters with qualified and current midwives have been unable to buy indemnity for any midwifery care – with the result that hospitals are now routinely substituting midwives with non-midwives (RNS and ENS) in order to keep wards open. The midwives on duty are then responsible for ‘supervising’ the non-midwives and are legally accountable if anything goes wrong. This is adding to workplace stress (and absenteeism) as well as compromising care to women.

Third, universities are finding it very costly to purchase indemnity to cover the clinical education of students of midwifery. This is resulting in limited places despite high demand to join the profession and a national workforce shortage, estimated to be 1,850 in 2002 by AHWAC and likely to have worsened since then.

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- i. Naeye R, Peters E, Bartholomew M, Landis R. Origins of Cerebral Palsy. 1989 *AJDC* 143: 1154-1160.
 - ii. Nelson K, Ellenberg J: Antecedents of Cerebral Palsy - multivariate analysis of risk. 1986 *New England Journal of Medicine* 315 (2): 81 - 86.
 - iii. Blair E, Stanley F. Intrapartum asphyxia: a rare cause of cerebral palsy. 1988 *Journal of Paediatrics* 112: 515-519. See also Stanley F et al - note 3.
 - iv. Naeye R et al - see note i: 1159. Gaffney G, Susan Sellers, Flavell V, Squier, Johnson A. Case-control study of intrapartum care, cerebral palsy and perinatal death. 1994 *British Medical Journal* 308: 743-750.
 - v. Richmond S, Niswander K, Snodgrass C, Wagstaff I. The obstetric management of fetal distress and its association with cerebral palsy. 1994 *Obstetrics and Gynaecology* 83(5): 643-646 at 646. See also Lipson T. - see note 202, where he states that "Many dysmorphological syndromes such as the Prader-Willi Syndrome are often not diagnosed until beyond the age of 1 year and associated with significant perinatal asphyxia. This type of situation is an indication that lower apgar scores and birth asphyxia may be an early sign of cerebral palsy itself, decreasing the ability of these babies to respond to intrapartum stress. The baby's brain is not damaged by the birth process but abnormal in its development."
 - vi. Estimated from data supplied by the ACT Insurance Authority to ACT Department of Health and quoted in the AHMAC Legal Profess Working Group Final Report – see page 81.
 - vii. Estimate provided to the AHMAC Working Group on Medical Indemnity and quoted in the AHMAC Legal Profess Working Group Final Report – see page 81.