

Maternity services networking – providing quality services in the face of a diminishing workforce

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ABSTRACT

The number of general practitioner obstetricians has fallen by about a third in the past 10 years. General practitioner anaesthetist numbers have fallen to the same degree over this time. There is equally a worsening workforce crisis in Australian midwifery with a national shortage of over 1800 midwives. The high average age of midwives (48 years) means the situation will continue to deteriorate. Over the last decade women in approximately twelve communities have lost the opportunity to give birth locally and these pressures continue.

The viability of maternity services in rural communities commonly depends on the commitment of a small number of general practitioner and specialist obstetricians and a small number of practicing midwives. These clinicians commonly work with the backing of general practitioner anaesthetists and operating theatre nursing staff for the management of obstetric emergencies. A reduction in the workforce, even the loss of one member of the team, can threaten the existence of the service.

We examine the workforce challenges facing maternity services in rural communities, and the policy responses that are being made to those challenges. These issues are then placed in context by describing the response to the threatened loss of maternity services in the Eurobodalla Local Government Area, on the far south coast of New South Wales. The imminent loss of general practitioner obstetricians and the resident specialist obstetrician threatened the existence of maternity services at both the Areas hospitals – at Batemans Bay and Moruya.

We describe how the creation of a maternity services network with birthing services at one site and antenatal and postnatal services provided in three communities has not just ensured the sustainability of maternity services, but has opened up the opportunity to contribute to the solution to rural workforce problems, by undertaking the local training of general practitioners in procedure obstetrics, and training registered nurses to become midwives. It is concluded that a collaborative rather than a competitive approach is needed to ensure the ongoing access to maternity services in rural communities. In addition local action is needed to create opportunities for training of the future workforce and that this local action needs to take place within a context of increasing state and Commonwealth support for rural training of rural procedural general practitioners and rural midwives.

BACKGROUND

There has been for many years concern about the ability to maintain access to birthing services in rural Australia. A contracting general practitioner proceduralist workforce threatens the viability of birthing services in small rural hospitals. In New South Wales the number of

general practitioners practicing advanced procedural skills in obstetrics and anaesthetics has fallen by a third in the last ten years and twelve communities have lost local birthing services.¹ There is a national shortage of midwives. Comparison of funded clinical midwifery positions in maternity units to actual numbers reveals a workforce shortfall of 1847.² The average age of midwives has been estimated at 48 years³ and this means that the situation will continue to deteriorate.

Eurobodalla Health Service provides hospital and community health services for a population of 33 000 in the Eurobodalla Local Government Area of the Far South Coast of New South Wales. The area is approximately two hours from Canberra and four hours from Sydney. It is a popular tourist destination and visitors outnumber residents over peak holiday periods.

Acute hospital services are provided at Batemans Bay and Moruya. The two hospitals are 25 minutes apart by road. Community health centres are located at Batemans Bay, Moruya and Narooma, with outreach to smaller towns.

Batemans Bay Hospital was in 2003 a 37-bed district acute rural hospital providing medical and surgical services (primarily day only), emergency services and maternity services. An after hours theatre roster was provided, primarily to support the maternity service. Medical cover for the maternity unit was provided by two general practitioner obstetricians. The GP obstetricians worked a one in two roster and attended all births. One of the GP obstetricians had advanced skills and could undertake caesarean sections. There were 137 births in the 2002/03 year.

Moruya Hospital was a 60-bed district acute rural hospital providing medical and surgical services (including overnight stay surgery) emergency services and maternity services. Medical cover for the maternity service was provided by a resident specialist obstetrician, supplemented with locum specialist cover. The specialist also provided support to the GP obstetricians at Batemans Bay Hospital. There were 158 deliveries in the 2002/03 year. Midwives attended all deliveries unless specialist medical intervention was required.

The provision of maternity services to the Eurobodalla community was threatened late in 2003 when one GP obstetrician left Batemans Bay to take up a position elsewhere. This created a 'domino effect' with the remaining GP obstetrician at Batemans Bay unable to provide a service on his own for more than a short time. It was clear that the one specialist could not support 300 deliveries over two hospitals if left with no GP obstetrician support. Intensive recruitment efforts failed to identify any candidates for the vacant position of GP obstetrician. A very real prospect appeared of the loss of maternity services from the Eurobodalla, and a two hour drive for alternative hospital birthing services.

In addition to the medical workforce issues there were difficulties recruiting midwives to the two maternity units. The part-time nature of the midwife role in each of the two small units was a barrier to recruitment. There was insufficient work in each maternity unit to fully occupy the one midwife employed on each shift and midwives spent much of their time in the management of general medical and surgical patients.

POLICY INITIATIVES

A number of policy initiatives have been implemented at federal and state level designed to address workforce and related problems. From the perspective of service providers in New South Wales these include:

- funding of the Rural GP Procedural Training Program, a \$3.5 million initiative to establish thirty training positions in New South Wales in general practice obstetrics, anaesthetics, surgery, mental health and emergency medicine
- reimbursement of continuing education costs for general practitioner obstetricians and other GP proceduralists up to \$15 000 per year
- provision of free medical indemnity cover for public and private hospital work in public hospitals in rural New South Wales
- financial subsidies and tort law reform designed to reduce the cost of indemnity insurance for medical practitioners, particularly procedural medical practitioners
- continued support for the recruitment of overseas trained doctors as a short term measure in areas of workforce shortage
- employment of nurses who have left the profession through the NSW “Reconnect” program
- improved wages for nurses and midwives in New South Wales
- overseas recruitment of nurses by NSW Health.

Although the list could go on, these are the policy initiatives that appeared to us as service providers to have the most practical impact.

There are many other initiatives not directly aimed at rural general practice obstetrics or midwifery that will nonetheless provide some workforce benefit in these areas. In particular we note the various initiatives to support rural training of medical practitioners, and perhaps to a lesser extent, rural nurses.

SERVICE NETWORKING

The challenge of maintaining accessible maternity services for the Eurobodalla population in our view required the networking of services across the sites. Although the three largest towns in the Eurobodalla – Batemans Bay, Moruya and Narooma – had historically competed for services, this competition had led to duplication of services. In the case of the maternity units in the two nearby hospitals, attempting to persist with this arrangement threatened the existence of both.

A consultation process was undertaken with staff and with the community, with a view to developing a sustainable model for service delivery. An independent review of physical facilities and services at Batemans Bay and Moruya Hospitals informed that process. The consultation process led to the development of a model of organisation of care with births all at one hospital, antenatal and postnatal care in the three population centres of Batemans Bay, Moruya and Narooma, and postnatal home visiting provided by a “Midcall” midwife.

The controversial question of which site should undertake births was left until last. An independent consultant mediated a final meeting of community, staff and management representatives that recommended that births all take place at Moruya Hospital. Although there were a number of matters considered in that final consultation meeting, the geographically central location of Moruya Hospital in the Eurobodalla local government area was decisive.

A separate consultation process was undertaken to determine the model of patient care to be provided. This culminated in a decision to provide:

- patient choice of antenatal care provider – midwife, general practitioner or shared care
- management of all normal labour and delivery by midwives, with no medical attendance at the birth
- medical backup – general practitioner or specialist as required – available at the request of the attending midwife.

OUTCOMES

The Eurobodalla Maternity Service came into being on 1 July 2004. The provision of antenatal and postnatal services in all three major population centres has improved access to these services, and extended the choice of provider to include not just the general practitioner obstetrician, but also the patient's own general practitioner, midwife care, or shared care.

The consolidation of births at the one central site has improved the attractiveness of the service for both medical staff and midwives. Indeed the service retained the specialist obstetrician and attracted its complement of two GP obstetricians within a short time (although unfortunately one appointed GP obstetrician recruited was unable to identify a suitable private general practice opportunity and ultimately did not take up the position).

Midwives have the opportunity to take a greater role in the provision of antenatal and postnatal care. They also have more independence in practice, managing normal labour and delivery without medical attendance. The greater workload in the one place also means that midwives spend nearly all of their time providing midwifery services, and significantly less time assisting with the management of general medical and surgical patients.

The consolidation of all births to the one site also opened up the opportunity to provide training for general practice registrars. Accreditation of one position for the Advanced Diploma in obstetrics means that each year one general practitioner will graduate with the skills to undertake rural obstetric practice. In this way the Eurobodalla Maternity Service is not only sustainable in its own right, but is making a contribution to the sustainability of maternity services in rural Australia.

Funding for the new position of GP Obstetric Registrar was readily obtained under the New South Wales Rural GP Procedural Training Program. There was no difficulty filling the position.

DISCUSSION

Networking of services across hospitals is just possible solution to the workforce problems that threaten the viability of maternity services in rural communities. There is however a commonly held view in rural areas that every public hospital should provide maternity services. This is the biggest barrier to such networking arrangements.

We have very deliberately referred to the process we undertook as networking and make a clear distinction between this and the centralisation of services or simply the closure of maternity services in one hospital. Indeed midwives in the newly formed Eurobodalla

Maternity Service travel more than they ever did to deliver services as close to home as possible.

We are also clear that the process must define a role for all facilities in a network. Although outside of the scope of this paper, a similar process of networking of elective surgery has been undertaken in the Eurobodalla, with Batemans Bay Hospital being developed as a centre for day surgery. Indeed in 2005 utilisation of the single operating theatre in that 37 bed hospital is expected to increase to five days a week. The Hospital has also been developed to provide orthopaedic day surgery as one of three hospitals in a wider network extending down the far south coast of New South Wales to Bega and inland to Cooma.

CONCLUSION

It is important to maintain access to maternity services for rural communities. In some cases however it can be useful to consider solutions other than trying to maintain birthing services in every public hospital. In appropriate situations the networking of services across hospitals and across towns should be considered. This requires a collaborative rather than a competitive approach.

Service networking can have additional benefits, beyond improving the sustainability of local services. Training of the general practitioner obstetricians and midwives of the future requires access to maternity units in rural areas with sufficient clinical throughput to support such training. Local action is needed to create these opportunities for training of the future workforce and that this local action needs to take place within a context of increasing state and Commonwealth support for rural training.

RECOMMENDATIONS

- 1 Creation of maternity service networks across hospitals, with outpatient services at more than one site but birthing services at one site, should be considered in appropriate circumstances in order to maintain service access in the face of workforce shortages.
- 2 Opportunities should be explored to increase the number of rural training positions for general practitioner obstetricians and for midwives.

REFERENCES

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PRESENTERS

Jon Mortimer lives and works on the far south coast of New South Wales, providing medical management support for health services in coastal towns from Batemans Bay to the Victorian border. He spent 15 years in clinical and management positions in the Illawarra, Western and South Western Sydney before moving to the coast. Jon Holds the position of Deputy Director of Medical Services with Southern Area Health Service. He lives with his wife, Elizabeth, their three children, and a menagerie of farm animals on a property outside the town of Mogo.

Helen Davis is a registered nurse and midwife with 30 years' experience, and has worked in rural maternity services for the past 15 years. In her role as Nurse Unit Manager of the newly formed Eurobodalla Maternity Service she is working to develop a new model of service delivery to birthing women within a rural health setting. With the networking of maternity services in the Eurobodalla she is hoping to increase birthing numbers and therefore enable the attraction of midwives and medical staff to a rural health setting on a more sustainable basis.