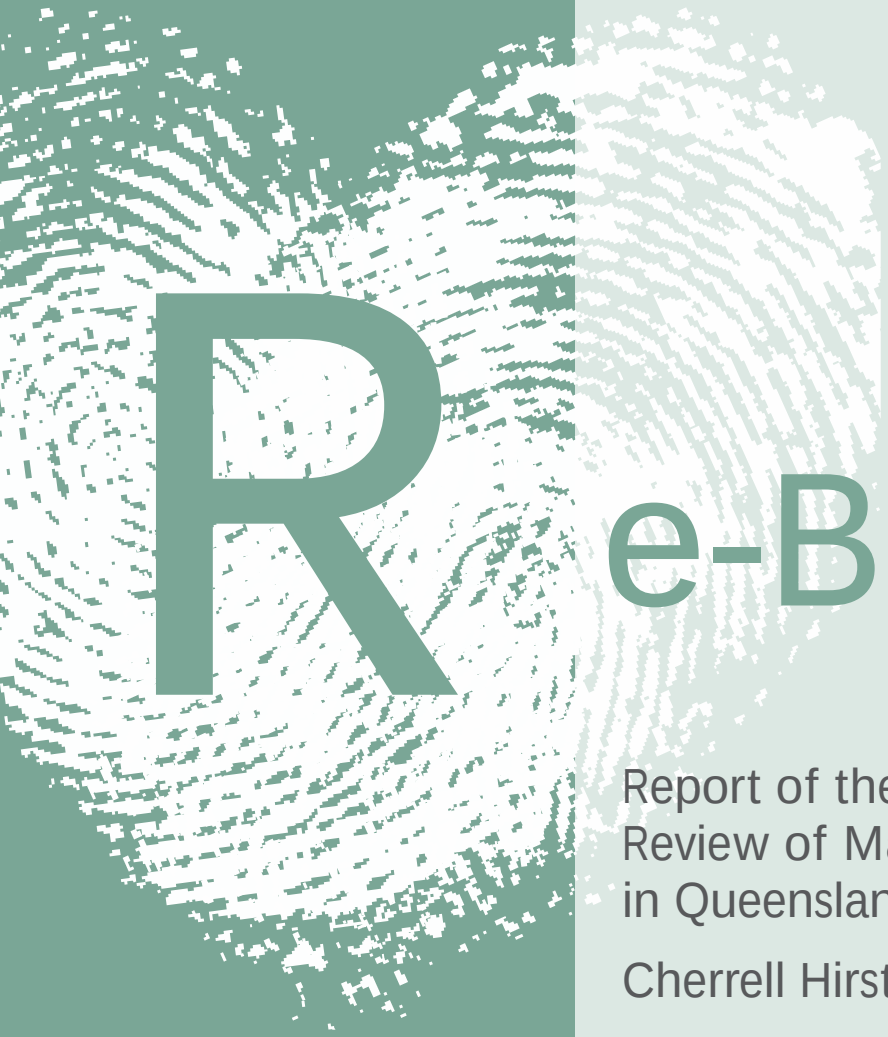
Correction Notice

Please note that the references to “Bub Hubs” on pages 4, 5, 24, 34, 43, 49, 50, 53, 54, 55 and 56 of this Report should be deleted and replaced with a reference to “family centres”.

“The Bub Hub” is an existing trade mark and domain name. Consequently, to avoid any confusion, the family centres recommended to be established in accordance with this Report will not be called “bub hubs” and will be named “family centres”.

This report represents the view of the Independent Reviewer and does not represent Queensland Government Policy



Re-Birthing

Report of the
Review of Maternity Services
in Queensland

Cherrell Hirst AO

March 2005

review of maternity SERVICES IN QUEENSLAND

Contents

Structure of the Report

This Report describes and makes recommendations about the people involved in maternity care. In order to provide a more complete picture of the views and experiences of people, narratives from consumer and carer submissions are included alongside reports of research and the findings of the Reviewer Cherrell Hirst.

The Review was asked to examine services for pregnancy, birth and post-birth care and recommend 'strategies to enhance choices for women.' This Report sets out

- the Review's major findings on current services for pregnancy, birth and post-birth care (including choices currently available to women, consumers' views about services and information on known outcomes)
- a sustainable strategy for developing and implementing evidence-based maternity care approaches and some specific principles on which existing and new approaches can be based.

Unless otherwise indicated, data included in the Report were provided by the Health Information Branch within Queensland Health.

Executive Summary

The Review of Maternity Services was set up in July 2004 by the Queensland Minister for Health to examine services for pregnancy, birth and post-birth care across Queensland and recommend evidence-based, sustainable strategies to enhance choices for women, wherever they live, without compromising safety. The Review's brief relates primarily to public sector maternity services, but the Review's recommendations incorporate private maternity care.

The ways in which we care for pregnant women and babies reveal a great deal about the kind of society we are and wish to be. Throughout the course of the Review, many people in Queensland have demonstrated their active interest in and passion about maternity care. An initial call elicited over 450 submissions, from carers, support organisations and especially the community, the many women and their families who have needed maternity care to help them on the journey from conception (and preconception) to early parenting.

In Queensland, maternity care is a large system that has developed over a long time without the benefit of a strategic framework for relating care to consumer needs or contemporary knowledge and ideas in any systematic way. There are few change champions and none in leadership roles. The Queensland Government has demonstrated its commitment to families and to maternity care in recent times, establishing this Review in order to improve the maternity care system. At the same time, Queensland Health, the largest provider of maternity services, has a strategic plan that scarcely mentions the care of pregnant women and new mothers and babies, and the Department's strategy for children and young people does not include strategies to improve the maternity care system. Despite views, priorities and plans at State or Zone level in the system, decision-making about specific approaches to maternity care and improvements in services appear to be devolved to Health Service Districts and to individual hospitals and providers.

In the private sector, maternity care approaches are left to individual hospitals that are influenced to a large extent by the priorities of health funds, the policies of the Health Insurance Commission and approaches of individual obstetricians whose patients are cared for in the hospital.

There are two distinct cultures in the milieu of maternity care, described by many of the individual carers and consumers who wrote to or met with the Review. They are crucial to the future of maternity care but currently in many care environments and decision-making groups they are unable to reconcile their differences which is a major obstacle to change. Some individuals place pregnancy and birth in a life context as a predominantly low-risk natural process requiring care and support and medical intervention only as needed. Others place pregnancy and birth in an intervention paradigm, a potentially high-risk situation that requires dedicated care and access to the best technology has to offer. These two cultures have different external influences, different ethical

considerations, different skills and knowledges and different values around risk and safety. In order for care to be effective, both cultures are needed. In Queensland and in many other places one culture dominates, with variable attention paid to the life context of pregnancy and birth in the care of most women across the State.

Despite differences of view, three concerns are shared by everyone involved in maternity care, be they consumers, midwives, obstetricians, general practitioners, other health professionals, hospital providers, local councils, Government Departments and universities. They are

- the unacceptable rates of death in newborn babies of Aboriginal and Torres Strait Islander women
- the situation of women in rural and remote areas who must travel and/or relocate for maternity care
- the impoverishment of post-birth care for new mothers and families throughout Queensland.

For the majority of women who have babies in Queensland, care from pregnancy to early parenthood is segmented, with different components provided by different agencies and carers, funded under different Commonwealth and State arrangements, and structured around these organisational and funding arrangements rather than around the woman's and family's needs. Women have few choices. They are not routinely informed of the choices they do have. Continuity is not available for the majority of women, most of whom, until they arrive at hospital in labour, will not even have met the person primarily responsible for helping them through the emotionally and physically demanding and unknown place that is the birth of a child.

In submissions to the Review, consumers highlight the need for choice in terms of care approaches and access to care in local communities, information about care approaches and outcomes, participation in care decisions, respect from carers, continuity in care with a known carer and safety in its broadest sense. Continuity of care with a known and trusted carer has been raised as an issue for women in most consumer studies.

Submissions also suggest that women feel they are not active participants in their own care. Some experience a lack of basic respect from carers. Aboriginal and Torres Strait Islander women, adolescent women and women in marginalised circumstances are less likely than other women to participate in pregnancy care. They are also most in need of appropriate pregnancy care. Submissions from support organisations suggest that women with special cultural needs are also not well accommodated in the current system. Similarly, the needs of women with disabilities are not well accommodated in care.

In its six months of consultations, the Review visited over a dozen hospitals in Queensland and heard from hundreds of carers. There are pockets of good practice throughout the State that partly respond to the kinds of best practice principles outlined in some of the 19 reviews and reports that have been written in the last decade. But the continued support for such models is invariably precarious. The Review found a number of examples where good practice came into being as a result of the work of a few individuals, and disappeared when the individuals became exhausted and/or left.

Inconsistencies in a range of clinical care areas across the State are a major concern. The use of water for pain relief or birth is in contention. Vaginal birth after caesarean is dealt with inconsistently in different hospitals. Controversy on both of these issues has recently been the subject of media interest. Pregnancy care practices, post-birth care and conventions in labour and birth vary from provider to provider and sector to sector. Inconsistency in advice about breastfeeding is the most mentioned care issue among consumers. Women report inconsistencies in advice and practice, even in the same post-birth ward of one maternity unit.

The profile of maternity carers is changing. GP obstetricians are leaving obstetric practice in rural and remote areas, but GPs across the State are increasingly involved in pregnancy and post-birth care in formal shared care arrangements with hospitals or otherwise.

In public sector hospitals, there are inconsistencies and unclear arrangements around responsibility and accountability for various aspects of care. There are shortages in the midwifery and obstetric workforces across the State, particularly affecting rural and remote areas, with predicted increased shortages in the coming decade. Midwives and obstetricians are aging and leaving professional practice for a variety of reasons. Both professions are somewhat bruised in the current climate where the two cultures of care seem unable to find a common ground for care provision

Individuals, whether they be obstetricians, GP obstetricians or midwives, feel they are not valued by Queensland Health, not listened to in terms of care provision and not understood in terms of requests to support enhanced care. Leaders in these fields who have been in Queensland have left and many of them have assumed positions as champions of change in different climates. National health workforce reports urge recruitment into maternity care professions to meet demand and steps to encourage retention. Education, professional development, skills in communication and incentives for professionals are needed, particularly in a climate of change.

Queensland's overall rates of newborn baby and mother death are low, consistent with national rates. Australia's

rates of newborn baby and mother death are comparable with many other developed countries and this is a commendable achievement. Rates of death are a crude measure of outcomes, and the Review has struggled with available data to draw a more complete picture especially one which provides information about health effects of maternity services on babies and mothers. Currently there is no proactive forum in the State through which issues such as the rising rate of caesarean births and changes to clinical practice can be considered and debated. Postnatal depression is also increasing and women relate their depression to care experiences although data are not systematically collected. Outcomes important to consumers are not measured in the current system of maternity care.

There is general agreement among interest groups that maternity care in Queensland must change. In fact it will change, even if Government does nothing. Small changes now – early discharge from hospital combined with pressures on community post-birth care, requiring country women to relocate for birth, increasing intervention for low-risk pregnancy – create enormous and potentially irrevocable changes for the outcomes of the future. Skills in vaginal birthing among midwives and obstetricians are on the way to being lost. Caesarean births create caesarean births. Technology creates the need for more technology. Even in the short term, workforce shortages are predicted to increase and dissatisfaction and stress among carers can only enhance the drift away. Shortages in some areas have already reached a chronic stage. But most importantly of all, the changes we are seeing now mean that birth is being removed piece by piece from community and family life. This may have wideranging but unknown consequences, on the scale of the transformation to the nuclear family, which impacted on our society and our individual lives in positive and negative ways even before we realised it was happening.

Change in maternity care in Queensland has proven difficult. There are concrete improvements people in the public health sector feel could be made tomorrow – improving financial support for the women in rural or remote areas who have to relocate, extending hospital stays for women who want or need more hospital support, strengthening community post-birth care and creating an information website. But even some of these are fraught in the current milieu. What information will be provided on the website? Who will decide the evidence base for issues like the safety of water in labour and birth? How will different approaches to care be described? Other changes are impossible without the will of work teams – continuity of care for women and families, flexibility of labour and birth choices, understanding and respect during labour and birth care, unbiased information for women and families at every stage and level of care and help with being new parents.

Changes such as these would be difficult in any devolved professional system, particularly one in which funding models are not used to facilitate strategic change. In maternity care as it stands, change is much more difficult. In many care environments the two cultures of care are in total opposition. Carers in the current care environments are fatigued, stressed and overworked. It may not be productive and may not even be possible to implement new approaches to care in those environments where there is vehement disagreement over managing risk and achieving safety for women and babies. Change must be agreed and acted on in individual care

'There will always be an element of risk in birth whatever the choice of birthplace. However, safety in childbirth is intrinsically related to the mother's emotional, psychological and physical well-being during labour. This, in turn, is influenced by the choices which are made during pregnancy, choices which should enable a woman to give birth at ease with her environment, her attendants and herself.'

The Townsville Aboriginal and Islander Health Service Mums and Babies program pulls together a range of health providers at the one mother and baby friendly centre, including a hospital midwife, a child health nurse, a GP, and health workers. Birth outcomes are improving as a result, with birthweights now comparable with the non-Indigenous population.

environments and to suit needs. At the same time, change must come and a process needs to be in place to ensure that it does.

In the medium to long term, pregnancy and post-birth care could leave hospital environments altogether and be provided in integrated, community-based centres. Local 'bub-hubs' in existing child health facilities or in other community facilities, in urban areas and in the bush, could bring together teams of hospital carers for pregnancy, birth and post-birth care of women and their families, with other carers who currently provide family and child health care (eg. Child Care Hubs). In cities, large hospitals could establish a number of community bub-hubs, with birth care provided in the hospital by the same care team that provides pregnancy and post-birth care in the bub-hub. Bush bub-hubs could be part of Rural Clusters of Care that include carers from different towns in a rural or remote community in a formal arrangement that can provide local pregnancy, birth and post-birth care. With positive outcomes from a carefully structured and evaluated demonstration project, birth at home might be considered for the few women who might choose it. These are long term goals the maternity system might well espouse. They are not achievable yet.

This Report sets out a sustainable strategy for developing and implementing evidence-based maternity care approaches that will work in the current context of Queensland maternity care, by recommending *Maternity Care 2010* as a set of guiding principles and actions that will lead to changes to approaches and new approaches to care. The principles are that

- Care is safe and feels safe (care must be provided within a framework of risk management, and families including those with special or different needs must feel safe in order to be safe which has implications for how care environments operate)
- Care is open and honest (families are provided with all the information they need to make all the decisions they have to make which has implications at State level and for care environments)
- Care is local or feels local (everyone should be working towards providing women with maternity care in their local communities and where this isn't possible, providing adequate support)
- Care is integrated (across a family's experience of new life rather than across funding systems and kinds of carers)
- Care belongs to consumers (women and families must decide how they birth and be involved in care decisions)
- Carers work together and communicate (carer teams need clear roles and responsibilities and individual carers need highly developed communication skills).

The Review's second recommendation deals with a process to achieve *Maternity Care 2010*, through the creation of a new independent body whose role will be to facilitate change and continuously monitor the appropriateness, effectiveness, quality, safety and evidence base of maternity services in the State. The Centre for Mothers and Families will operate across health sectors, government levels and portfolios, professional bodies and consumer groups to be a voice and agent of change for mothers, families and the beginning of new life. The Centre will be responsible to the Minister for Health (with links to and annual reporting to the Ministers for Aboriginal and Torres Strait Islander Policy, Child Safety, Communities and Disability Services, and Education and the Arts). It will be able to play a key role in the Queensland Government's policy commitment to families, operating as a protector and promoter of the most important stage in any family's life.

The Centre's interests will span private and public sector care in Queensland. The Centre's board will include

representation from relevant sections of government, the two health sectors, professional organisations, consumers and the wider community. Because of the nature of maternity care and the current environment the Centre's role will be facilitating rather than prescriptive. It will promote improvements to maternity care through a series of demonstration projects and other collaborative initiatives with carers and consumers and be and be seen to be an independent authority on the full range of issues that remain uncertain in maternity care, advising Government, the professions and the community. The key strength of the centre approach is its capacity for independence, independence from any of the professional bodies that are currently vying for maternity power, independence from consumer lobby groups with particular interests, and independence from Queensland Health which is a provider as well as the Government's voice on health care. As an independent body the Centre will be in the best possible position to bring relevant people or organisations together to solve problems and make sustainable improvements to care.

Demonstration projects will be one of the tools the Centre uses to implement change. By way of example, a demonstration project will be able to facilitate the gradual transition across Queensland to integrated care in local bub-hubs. While the bub-hub structure – with small carer teams operating in primary care models in the community – has wide support from many people in Queensland, differences emerge about almost every aspect of detail. Bub-hubs should not be set up until care teams are ready and carers are appropriately prepared and trained and talking to one another, at State level (through the Centre for Mothers and Families) and in individual care environments (with the help of Queensland Health's Clinical Practice Improvement Centre).

A third group of recommendations from the Review aims at caring for carers, enhancing the education and training of carers who can meet the needs identified in *Maternity Care 2010*. Responsibility for education and training programs rests with a number of different organisations and the Centre for Mothers and Families can play an important role in helping providers ensure that courses are aligned to the needs of consumers, that care across education and training sectors is appropriate, and that learners (future carers) learn to work together. In other workforce areas, Government support will be needed to negotiate change.

In the current climate of maternity services in Queensland, change imposed from above will not be sustained, as previous reviews and reports have demonstrated. Distrust and a lack of respect between carers and failing confidence in the system's capacity to change itself combine to make change difficult if not impossible without outside independent help. By setting up a Review of Maternity Services, Government has started the process of bringing together the many groups who have ownership of the care of women and new babies. The best way forward from here will be to continue that process of interaction among carers, consumers and the community. Using *Maternity 2010* as a guide, the people who can make change happen or not need to remain together through difference and agree a future. Families matter in Queensland. This is a unique opportunity for the State. Its time has come.

Introduction

Background to the Review

In July 2004, I was asked by the Minister for Health the Hon Gordon Nuttall MP to undertake a review of maternity services in Queensland. The Minister's brief asked me to:

- examine existing and future models of care, in particular midwifery models of care, and recommend strategies to enhance choices for women
- consider ongoing mechanisms to support the implementation, monitoring and evaluation of endorsed recommendations,

while being mindful of a number of issues, including

- the cultural and geographic diversity of Queensland
- safety and quality
- cultural security
- the specific needs of Aboriginal and Torres Strait Islander women
- the evidence base of any proposed changes
- the need to engage relevant stakeholders and consult the community.

The Review had been prompted by the Queensland Premier, the Hon Peter Beattie MP who, in response to a request from the Maternity Coalition, had committed a re-elected Government to a Statewide Review of birthing services to determine how midwifery models of delivery and care could be enhanced, without compromising the safety of women and babies.

The full terms of reference of the Review are included as Appendix 1.

At the time I agreed to undertake the Review, I knew a little about maternity care and its systems, as a health professional of more than 30 years' experience who many years ago had been a maternity care consumer. The predominant part of my professional life has been spent in Women's Health in the area of breast cancer screening and diagnosis. Like many people, I have a fundamental belief that the birth of children is crucial to the physical and emotional health of a society. For me personally, pregnancy, childbirth and early parenting were unique and life-changing experiences.

During the months of the Review, I have been fortunate to meet many outstanding individuals who have dedicated their lives to the improvement of the care of women and babies. I hope this report is faithful to their vision and honours in some small way their selfless dedication. I hope they will continue to work towards a future where all the dimensions of a woman's life are considered and accommodated in her maternity care experience.

Acknowledgements

Many people have contributed to the Review of Maternity Services and I want to thank first and foremost the women with babies or young children who took the time to write or talk about what were invariably important and at times difficult things to write or talk of. I hope I have reported faithfully your concerns, shared your joy with the wider world and honoured your stories.

Many people who work in maternity care all over Queensland and in other parts of Australia took time to meet with me and talk about their care environments, research, aspirations and challenges. Many of them are named in the Appendices listing Advisory Panels and Consultations. Their input to the Review has been invaluable, and I appreciate their efforts and dedication to serving women.

While the Review's consultation process was extensive, it was by no means exhaustive and I am sorry that time and resources meant that I was not able to travel to all of the many places and communities that had an interest in sharing their experience of maternity care. I apologise to those people who would have met with me. I hope the changes recommended in this Report will be of benefit to those who experience and as a result those who work in maternity care.

The eagerness of many individuals to serve on panels advising the Review was encouraging and it was disappointing that some who would have made valuable contributions had to be omitted in the interests of practicality. The people who were asked to commit to a regular meeting of an Advisory Panel for the Review did so enthusiastically and willingly. It is never easy for anyone with knowledge or expertise or experience of a particular kind to be large enough of nature to accept views different from or even opposed to one's own and to travel together towards a workable future, but the Panels advising the Review have managed to achieve this goal and remain together at the tables at which we met. The Review would be poorer without the work of the individuals who served on the Advisory Panels and I thank them for their advice and assistance.

A review of any kind invariably wants data – information about populations, workforce, trends, outcomes – and the data available invariably fail to meet the need. I am indebted to the staff of the Health Information Branch of Queensland Health who met with me regularly throughout the period of the Review, answered simple and difficult questions with the same equanimity and good-naturedness, and did whatever they could to turn my need for information into the bricks and mortar of tables and graphs.

Many other individuals in both the central office of Queensland Health and throughout the State have contributed to the Review's work, providing background advice, arranging visits, producing documents, assisting with media and generally making themselves available and open to suggestions, and their efforts have been appreciated.

Lastly I want to acknowledge the small project team that assisted me through the Review, organising a complex schedule of consultations, pulling together at short notice a forum on maternity care for consumers and carers, researching issues and assisting in the preparation of documents. Thanks to the Team and to the readers of various drafts of the *Interim Report to the Minister for Health* (November 2004), a public *Issues Paper* (January 2005) and this *Final Report* of the Review. Team members and readers are listed in Appendix 2.

Change must come in maternity services in Queensland. Many consumers want change, most carers want change and the community wants change. But change will not come because of this Report or any other. While the Review can summarise views and collect them into an acceptable framework and suggest directions and ways change might be facilitated, the only people who will make change happen are the people within the system itself, the carers, consumers and administrators who together create and maintain maternity care experiences. The strength of submissions from women who have birthed in Queensland, the work of the Review's Advisory Panels and the wider community of people in Queensland and elsewhere the Review has consulted indicates to me that change can and will happen in maternity services in this State. I intend that this Report will help to pave its way.

Review Process

The terms of reference for the Review asked that

- stakeholders be engaged in the Review process
- views from consumers be sought on the accessibility and choice of maternity services available to them
- existing State, national and international literature and reports as well as evidence and the evidence base of practice be considered.

Community Views and Engagement

As its first task, the Review called for community submissions widely and non-specifically, through advertisement in local and national print media and direct mail to known stakeholders. Posters and postcards were circulated to hospital maternity service units, general practitioners and other community health providers. A media release invited submissions from all interested groups and individuals. Letters were sent to professional bodies, organisations,

the Private Hospitals' Association of Queensland, Queensland Health, other Government Departments and education providers. Advertising and media for submissions are included as Appendix 3.

Over a four-month period, a total 447 submissions were received, with over half (229) of these from maternity services consumers, almost all women. The remaining submissions were from carers, some of whom also wrote as consumers, maternity care organisations, support organisations and universities/research groups. A list of submissions received is included as Appendix 4.

Consumer submissions differ from systematic studies of consumer opinion in that the views expressed do not necessarily represent those of the whole community but they do provide valuable feedback from people motivated to write.

In its first few weeks and in the absence of a regular Statewide survey of maternity services experiences, the Review also considered commissioning a comprehensive consumer survey along the lines of the surveys regularly conducted in Victoria (Bruinsma et al 2000, Darcy et al 2000, Brown et al 2000) but limitations in time and resources made this impractical.

Advisory Panels

The following panels were established to assist the Review:

- an Expert Advisory Panel whose members were drawn from among consumers, professionals, educators and the broader community which met on six occasions, to provide advice, to act as a link to groups and organisations interested and involved in maternity care, and to consider obstacles and work on proposals for change.
- an Indigenous Advisory Panel whose members were drawn from among professionals, educators and policy makers in Indigenous health care which has met on four occasions, to provide advice, particularly on cultural issues, and to consider obstacles and work on proposals for change.
- a Rural and Remote Care Advisory Panel whose members were drawn from Rural Doctors Association of Queensland and the Australian College of Rural and Remote Medicine which met twice to provide advice on care issues facing women in rural and remote communities and to consider proposals for change.
- a Quality and Safety Advisory Panel which provided expert advice on risk management and safety pertaining to the recommendations (the panel could not meet because of time constraints and provided written comments on issues).

The four panels advising the Review together include representation from many of the groups which will be key to the future of maternity care in Queensland. The Review has also consulted individual professionals and experts about particular issues in care.

Terms of reference and memberships of panels are listed in Appendix 5.

Consultations

Given the relatively short timeframe for the Review, an extensive process of consultations overlapped in time with the call for written submissions. Over a seven-month period, the Review met with women, carers and researchers, in the community and in hospital and other health care settings, in urban, rural/remote and Aboriginal and Torres Strait Islander communities. Meetings were also held with health policy makers and researchers from Queensland, Victoria, New South Wales and New Zealand. Consultations included

- visits to 14 of Queensland's public and private hospitals in different parts of the State (Brisbane, Cairns, the Gold Coast, Maleny, Mareeba, Nambour, Rockhampton, Thursday Island, Toowoomba and Townsville) and discussions with carers and administrators in these hospitals
- visits to Aboriginal and Torres Strait Islander Health Services in Brisbane, Cairns, the Torres Strait, Townsville and Woorabinda
- visits to a number of non-hospital providers of maternity care or support services including the Alukura Women's Health and Birthing Unit in Alice Springs, Mookai Rosie-Bi-Bayan in Cairns, the Royal Flying Doctor Service in Cairns, the Townsville Mums and Babies Program of the Townsville Aboriginal and Islander Health Service, and the Young Women's Place in Toowoomba
- individual consultations with officers of professional and community groups, including the Australian College of Rural and Remote Medicine, the Australian College of Midwives Inc., the Australian Medical Association, the Australian Physiotherapy Association, Doula groups, the Ethnic Communities Council of Queensland, the Home Midwifery Association, the Private Hospitals' Association of Queensland, the Queensland Nursing Council, the Queensland Nurses Union, the Rural Doctors Association of Queensland, United Medical Protection Ltd and the Women's Health Network
- community forums requested by groups in Rockhampton and Townsville (linked to other centres) and consumer meetings requested by women in Brisbane (Home Midwifery Association), Maleny and Toowoomba
- discussions with carers and policy makers from other States of Australia and from New Zealand, on major reforms and current models of care, including the Department of Human Services in Victoria, the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity, the New South Wales Health Aboriginal Maternal and Infant Health Strategy Project, and the New Zealand College of Midwives

- attendance at the December 2004 National Rural Health Alliance Public Forum on Maternity Services, and at the Rural Doctors Association of Australia/Australian College of Rural and Remote Medicine National Symposium on Obstetric Services in Small Rural Hospitals in Alice Springs in March 2005
- visits to maternity care units in other States, including the Mercy Hospital in Melbourne and the Royal North Shore and St George Hospitals in Sydney
- discussions with staff in a number of research and improvement centres including the Australian Institute of Health and Welfare National Perinatal Statistics Unit in New South Wales, the Centre for Midwifery and Family Health at the University of Technology in Sydney, the Centre for Mother and Child Research at La Trobe University in Melbourne, the Clinical Practice Improvement Centre and the Innovation and Workforce Reform Directorate within Queensland Health, and the Perinatal Data Unit of the Department of Human Services in Victoria
- discussions with Government officers including the Directors-General of Health, Aboriginal and Torres Strait Islander Policy, Child Safety, and Communities and Disability Services, the Acting Commissioner for Children and Young People, and the Minister for Education and the Arts.

A full list of consultations is included as Appendix 6.

Literature and Reports

An initial literature scan showed that there have been many reviews and reports on maternity services in Queensland, other States and nationally over the last 15 years, including the 1999 Senate Community Affairs References Committee *Rocking the Cradle - A Report into Childbirth Procedures* and the 1996 National Health and Medical Research Council *Options for Effective Care in Childbirth*, both of which made a number of key recommendations for changes in maternity care which are reiterated in several subsequent Queensland reviews. In Queensland, in addition to a number of reviews recommending change in the maternity care system, there have been several studies and reports on Aboriginal and Torres Strait Islander maternity services, most of which recommend that birthing services be reintroduced into communities. To date, this has not happened.

Detailed summaries of national and Queensland reviews and reports are included as Appendix 7.

The Review sought specific advice from Queensland Health and the Private Hospitals' Association of Queensland on models of care and their costs. A broad picture was developed of the current situation in Queensland, although advice about many issues including the costs of various models of care proved impossible to obtain. This has made the Review's own costing exercise difficult.

The Review sought advice from health authorities in other States about approaches to care. Approaches to care in other countries (New Zealand, The Netherlands and Canada) have also been considered.

The Review's research has included specific questions about women and their experiences whose answers have not been easily available from the existing Perinatal Data Collection. Responsibility for data is dealt with later in the Report.

Clarifying Issues

The Review's initial timetable provided for circulation of an *Issues Paper* in November 2004 and a second round of community submissions responding to the issues raised. First round submissions from key groups were still being received in December 2004 when an initial draft of the *Issues Paper* was circulated to Advisory Panel members. A series of revised drafts were read by members and other key individuals. The final *Issues Paper* was circulated in January 2005. This iterative process of developing the *Issues Paper*, responding to comments and using the paper in community consultations provided valuable feedback to the Review and informed this final Report.

In order to allow more time for consultation following the release of the *Issues Paper* and to encourage the meeting of different views and gauge responses among stakeholders, the Review organised a Forum on Maternity Care which was held on Saturday 26 February 2005. The forum drew together by invitation a range of consumers, carers and researchers for a full day of presentations and discussion around directions for change in Queensland. It was an overall positive experience and a rare opportunity for consumers, carers and others to come together and consider the future for maternity care in the State.

While the Forum provided some opportunity for discussion and debate, targeted consultations have also been undertaken since the release of the *Issues Paper* and particularly on the recommendations which might be made in this Final Report.

Moving to Recommendations

This Report and its recommendations represent the work of several months of hearing, reading and seeing maternity care. They are the result of a collaborative process but are the final conclusions of an individual reviewer.

The consultation process for the Review has been extensive but consultation is never extensive enough, and compression of an original timetable because of the number and lateness of submissions and the Review's limited resources has meant compression of a final discussion of recommendations to the last few weeks. As late as February, people who had written to or met with the Review

'I sense an almost complete acceptance by trainees that high-level evidence should be the principle guiding practice. This gives me great confidence in the future of obstetrics, which is a wonderful thing to be able to say with conviction as I leave it to the next generation.'

(King 2005).

previously wanted to meet again to talk through proposals for change but the time had come when we had to stop talking and finish writing.

I believe this Report gives Government a way forward. It is not the only way forward but it is a sensible way forward which will generate enhanced and sustainable maternity care in the short, medium and long term. It has the support of all advisory panels – the Expert Advisory Panel which assisted throughout the period of the Review, the Indigenous Advisory Panel which was set up to consider maternity care for Aboriginal and Torres Strait Islander women, the Rural Advisory Panel which advised the Review on rural and remote services and members of the Quality and Safety Advisory Panel who considered issues relating to risk management and safety. From discussions I have had, I believe all those who have been involved in the Review process will accept these recommendations as a means of negotiating the challenges that have stymied change in maternity services in the past and a way ahead that assures a future that understands consumer needs.

Limiting and Expanding Scope

The Review has visited a number of maternity care providers and discussed approaches to care in Queensland and elsewhere. Basic information has been collected but this has not extended to an audit or systematic review of maternity care providers across the State. It became clear in the first few weeks of the Review's life that earlier reviews had pointed the way to change in maternity services in Queensland and that despite considerable consistency in recommendations they had overall failed to change practice in any system-wide sense. This was the issue this Review determined to focus on.

Maternity care touches many areas of life and the health system and the Review has had to limit its scope to care during pregnancy, birth and post-birth for mothers and babies. At the same time, while the original brief from the Minister suggested the post-birth period be limited to one month, this was always an artificial end point and the Review's consideration and recommendations reach beyond one month to the early parenting experience and ongoing health of the child so important for mothers, families and society.

While the Review sought the advice of paediatricians, neonatologists and anaesthetists who are involved in the care of mothers or babies, this Report and its recommendations do not directly relate to these services.

The Limits of Evidence

The Review has been asked to base its recommendations on evidence and to consider the evidence base of practice. There are a number of issues relating to evidence in maternity care which should be understood in order to make sense of this Report and its recommendations. They relate partly to the two cultures that operate in maternity care at the present time which are discussed later in the Report and they relate to the nature of evidence and its application in care.

Knowledge about various aspects of maternity care remains contested, which means different experts have different opinions, often supported by different elements of available research. Sometimes this is because the lack of scientific evidence means there are not conclusive answers. Often, other factors come into play.

Knowledge is socially as well as scientifically based. Our beliefs, convictions and philosophies influence what knowledge we accept or rely on, even when we are the kind of people who rely on evidence to do our work. In some instances strong beliefs around practice generated and reinforced over time may tend to influence or maybe even dominate rational analysis.

Maternity care is an area of life characterised by strong beliefs and convictions. I, for example, believe in a woman's right to have control over what happens to her body. I probably have an underlying belief that a human, naturally-driven process is preferable to a technologically driven one where perceived outcomes do not differ. These beliefs and principles cannot help but influence what I consider to be important.

In addition, in many areas, clinical practice takes a long time to change in response to evidence. Research suggests that practitioners are more likely to rely on senior colleagues for change leadership than on systematic reviews per se (Jordens et al 1998). In places where senior colleagues rely on their own experience rather than evidence, change will be slow indeed.

The last several decades have seen a gradual shift towards evidence-based practice in obstetrics. University medical courses give students the tools for assessing evidence. Clinicians are more likely to turn to systematic reviews than they once were. This gradual paradigm shift in practice since the 1970s is rendered elegantly by obstetric epidemiologist James King in a recent journal article that traces the writer's own career with the development of evidence-based medicine. King finishes where he began, at the Royal Women's Hospital in Melbourne, many years after he trained there as a medical student when opinion-based practice was standard. King writes, 'I can remember watching in horror as women's wrists were strapped to the side of the metal delivery frame, so that "the patient would not contaminate the sterile field", prior to an operative vaginal delivery, which we were summoned to observe. Forceps rotations and other manipulations were the hallmark of the skilful obstetrician, the highest compliment for whom was "he is great with his hands".' (King 2005). King's experience of the same hospital in 2005 is much changed.

It is in this environment that the Review's recommendations for change must be made. No authoritative statement from this Review of Maternity Services or any other can provide an unequivocal ruling on issues to which much more than scientific evidence contributes. Different ways of negotiating change must be found, especially if change is to be sustained, and they must involve carers from across the maternity care spectrum who can together contribute to decisions about clinical care based on evidence and what to do when evidence is inconclusive. The tensions at work in maternity care that are preventing healthy decision-making based on evidence are discussed in the following section.

Maternity Care in Queensland

'The real reasons for our passion about birth are hard to describe. They are to do with how we feel. Not only is it hard to find the right words, we have adapted to a maternity system which devalues how people feel.'

Pregnancy and the birth of a child are transforming life experiences for women and their families. Throughout the Review's short life, submissions from and consultations with women and families have focused on stories, vivid stories, charged with emotion, remembered for years, about how children are born; who was there, what was done, how they felt. These stories are powerful enough to change thinking, and the submissions to the Review might usefully be read by anyone who has the responsibility of caring for a woman in labour.

Maternity care is perhaps the most whole-of-government of the whole-of-government issues, as important and wide-reaching as child safety. It profoundly affects hundreds of thousands of Queenslanders every year. It can be influenced to a large extent by policy. It directly involves many Departments in addition to Queensland Health, including Aboriginal and Torres Strait Islander Policy, Child Safety, Communities, Disability Services, Education and the Arts, Emergency Services, Employment and Training, and Queensland Transport. Local governments also invest time and interest in maternity care.

In short, maternity care tells the truth about the kind of society we are and wish to be.

Maternity Care in a Historical Context

Nowadays in Queensland and Australia, most maternity care is provided in hospitals but up until the 1940s care was mostly provided in homes. During pregnancy, women were likely to see a family doctor. Births were attended by midwives, in the presence of older women with expertise and those of significance to the individual mother-to-be for support.

During the late 1940s and 1950s responsibility for pregnancy, birth and post-birth care gradually shifted to hospitals with increasing involvement of obstetricians. During the 1950s and 1960s, pregnancy education became a feature of the experience, stemming initially from the natural childbirth movement but later mainstreamed. This overall framework for care has continued in Queensland and Australia to the present time.

The Maternity Care System

Maternity care in Queensland now is a large complex system of environments and people that interacts with almost 50,000 women each year and with each woman for many months. Through immediate and extended families and communities, the system reaches most Queenslanders. Maternity care is the third most common reason for hospital admissions in Queensland, and its total cost is borne directly or indirectly by the community, through the Commonwealth with its Medicare and other funding schemes, Queensland Health and its hospital and community providers, and consumers and their private health funds who pay for private care.

Queensland Health

The Queensland Government's policy priorities include strengthening Queensland's communities, *inter alia,* through improving health care to the community and protecting children. Queensland Health, which is partly or

fully responsible for the care of two thirds of the women who have babies in the State, operates within a comprehensive strategic planning framework, although the extent to which resources follow plans is not immediately clear. It appears to the Review that resourcing of Health Service Districts is based on historical factors and a complex formula that encourages throughput rather than on strategic plans and community aspirations.

The current *Queensland Health Strategic Plan to 2010* identifies current challenges including the health of Aboriginal and Torres Strait Islanders, the cultural diversity of Queensland and the health needs of people living in rural and remote areas of the State. Queensland Health is committed to providing information and skills to people to improve and manage their own health, to building a stronger and more responsive primary health care sector and to investing in health prevention strategies.

The Strategic Plan includes five strategic intents, but few of the initiatives under the strategic intents relate directly to maternity services. *Healthier Partnerships* commits the Department to improving community participation in the planning and delivery of health services. *Healthier People and Communities* commits the Department to providing better health-related information to people. *Healthier Hospitals* includes commitment to increased use of clinical evidence-based decision-making, care which focuses on patients, and improved continuity of care at the interface between community and hospital care. The Strategic Plan also includes an undertaking to 'inform and contribute to the Ministerial review of maternity services in Queensland.' Queensland Health's submission to the Review does suggest ways in which the five strategic intents could apply to maternity services but these have not been promulgated in the context of the current strategic plan.

Queensland Health also has a *Strategic Policy Framework for Children's and Young People's Health* (2002 – 2007) which recognises the key role played by pre-birth and early experiences in determining health. The Strategy does little to place the health of a yet-to-be-born child or baby in the context of the health of a mother or family.

Queensland Health has a patient charter which sets out the legitimate rights, expectations and responsibilities of health consumers in the State. The charter was developed as part of Medicare Agreements in the 1990s and reviewed in 2002. The charter has been widely promulgated in care environments, but advice from Queensland Health suggests it was not developed or reviewed in consultation with consumers.

The Private Sector

The private sector in Queensland cares for a third of the women who have babies in the State. It has been difficult for the Review to ascertain patterns of care and particularly the drivers of changing patterns of care within the private sector. Decisions about care are made within the context of each individual hospital's strategic plans and direction and are influenced by policies and practices of private health funds. Each obstetrician determines how care is provided to his or her patients within the broad hospital clinical framework.

Some data which would have assisted the Review in its consideration of private sector care were considered 'commercial in confidence'.

Compounding the difficulties around any future integration of care in the private sector is the arbitrary and system-oriented (as opposed to patient-oriented) absolute division into inpatient hospital care which is the domain of the private health funds and private hospitals and non-hospital care which is the domain of Medicare and the Health Insurance Commission. Providers are obliged to work within these rigid silos which act against the integration of care and the provision of continuity of care in maternity services.

Best Practice Principles

While there is no Statewide strategy for the provision of maternity services, work within Queensland Health over the last ten years has attempted more than once to identify best practice principles for maternity care. These were summarised in papers of 2002 and 2003 and reiterated in Queensland Health's submission to the Review:

- Safety is paramount for all women during all phases of pregnancy and childbirth.
- Maternity services should be culturally appropriate and responsive to the individual needs of each woman.
- Maternity care should be woman and family centred.
- Maternity care should be provided by multidisciplinary teams with an emphasis on coordination and integration of services.
- Maternity services should have available the necessary levels of intervention and technology.

- It is important to ensure continuity of care, and wherever possible, continuity of carer, throughout pregnancy and post-birth care.
- Women should be informed of the full range of choices in maternity care.
- Women should have, and feel, autonomy and control over the birthing process.
- For pregnancy and post-birth care it is important to provide care locally to enable a high level of access to services (Queensland Health 2002, Queensland Health 2003).

These principles may or may not have been adopted by Queensland Health but whether they have or not, there is no leadership of change in maternity care, and no champions in senior roles in the State who are willing and able to drive change. There is no strategic framework through which change can be addressed systematically. There are no incentives, financial or other, across public and private sector care that might encourage or foster these or any other aspects or qualities of good practice in maternity care.

Approaches to care appear to develop in an *ad hoc* fashion, with good practice the result of the efforts of individuals in care environments who have good ideas and are able to implement them. Personal commitment is the driving force behind quality rather than any system-generated motivation. Consultations suggest the continued existence of these practice exemplars is invariably precarious. Individuals burn out and leave. Funding is cut. At the program level, the Review has been told of at least half a dozen individual schemes which have been implemented and later discontinued or dismantled, with lack of human and other resources or the lack of support from management as the reason.

Evaluating Care in the System

There is a Statewide perinatal data collection for maternity care experiences that feeds into a national collection which is published annually (Australian Institute of Health and Welfare, "Australia's Mothers and Babies" report). Providers and professional bodies claim that data are not provided in a timeframe which can engender action in response.

Within Queensland Health, there is a Statewide Maternal and Perinatal Quality Council whose membership provisions include 'clinicians, consumers, academics, government officials and the wider community'. Appointments to the Council are made by the Chief Health Officer and a new membership has recently been appointed.

The Maternal and Perinatal Quality Council meets quarterly and is supported by working parties. The Council's terms of reference include quality measurement (developing clinical indicators, monitoring and analysing data, providing annual reports, conducting ongoing evaluation), sentinel event monitoring (analysing, assessing trends and patterns and making recommendations to the Chief Health Officer), and clinical audit (in an expert reference group role). The Council has experienced difficulty in developing indicators, particularly around the health effects of aspects of maternity care on women.

The Clinical Audit Program within Queensland Health included a clinical care review of nine maternity hospitals in the State in 2003, the Report of which has been provided to the Review. This is an excellent resource and a thorough review of clinical care, incorporating consumer feedback and clinical audit.

The Review understands that at time of writing the Nine Hospitals Report has been approved for release to managers of Queensland Health Zones who will refer it to District Managers.

While there is no comprehensive set of performance indicators through which care providers and sectors might be able to monitor outcomes, the Perinatal Data Collection provides quarterly reports to hospitals. In addition, the measured Quality Program in Queensland Health has developed indicators which are circulated to hospitals annually. The indicators include caesarean birth rates and rates of intervention. They were developed within Queensland Health, with input from clinicians. They were not considered by the Maternal and Perinatal Quality Council and their further development will provide a good basis for better measurement of quality and safety in maternity care in the State.

The Maternal and Perinatal Quality Council has a potential key role in monitoring and evaluating the quality of maternity services, but it cannot do this unless there is a framework for measuring performance which reflects a range of desired outcomes. National performance indicators in the areas of access, appropriateness, quality (safety, responsiveness, capability, continuity) and sustainability are in the process of development and reflect the difficulties of deciding what ought to be measured to inform change.

During the 1990s, a community midwifery scheme offered from the Mater Hospital in Brisbane involved teams of midwives working in community centres to provide most pregnancy care for women, accompanying them to hospital for birth and providing home or community based post-birth care. This scheme was funded by the Commonwealth for 8 years to 1997, after which it was discontinued.

Previous Reviews of Care

At least 19 documents reporting on general and specific clinical and structural reviews for maternity services have been undertaken by Queensland Health committees and officers in the last ten years, with recommended changes that have been reiterated by consumers and carers to the current Review of Maternity Services. These earlier reviews are summarised in Appendix 7. One of the most recent, in 2003, like many before it, concluded that more options were needed for women. It stressed that improving post-birth care in the community should be a priority (Queensland Health 2003).

The Review has been advised by individual carers, administrators and policy makers that none of the system-wide reports has been widely welcomed or implemented in public or private care environments. It's as if while much good work has been done by individuals and groups within the health system, change has not been sustained. This may be partly the inertia of a large, devolved system, but it seems to the Review that another more fundamental set of tensions is at work, making lasting change almost impossible.

Cultures in Conflict

Many maternity care environments in the current system are characterised by conflict. This conflict has its roots in differences among individual carers in beliefs about care and more fundamentally about the nature of pregnancy and birth. With the potential for change in maternity services, these two cultures of care are vying for prominence.

Some individuals who have met with or written to the Review have a strong conviction that pregnancy and birth are normal life events that do not sit well in a medical situation. They characterise an 'organic' culture that stresses normality and espouses care that respects and involves a woman as the person in control of care. They are concerned at the levels of intervention in birth and particularly caesarean births. They are championed internationally by midwives, obstetricians and neonatologists who are calling for humanistic changes to the ways care is provided. 'By medicalising birth, i.e. separating a woman from her own environment and surrounding her with strange people using strange machines to do strange things to her in an effort to assist her, the woman's state of mind and body is so altered that her way of carrying through this intimate act must also be altered and the state of the baby born must equally be altered.' (WHO 1985)

Other individuals who have met with or written to the Review point to the physical safety of mother and child as the first priority for care. They characterise a 'mechanic' culture that stresses the need for access to the best facilities, equipment and carers modern medicine can provide in order to deal with the unforeseeable risks of pregnancy and birth. They applaud the achievements of the maternity care system and warn against changes that might jeopardise safety. They are championed by obstetricians and other medical specialists, in Australia and elsewhere. 'We now have 50 years of experience with "medicalised" birth, and the objective record of safety is good. In comparison, there is scant evidence on even short-term outcomes of less "interventionist" models of intrapartum care, and virtually no long term information.' (De Costa and Robson 2004).

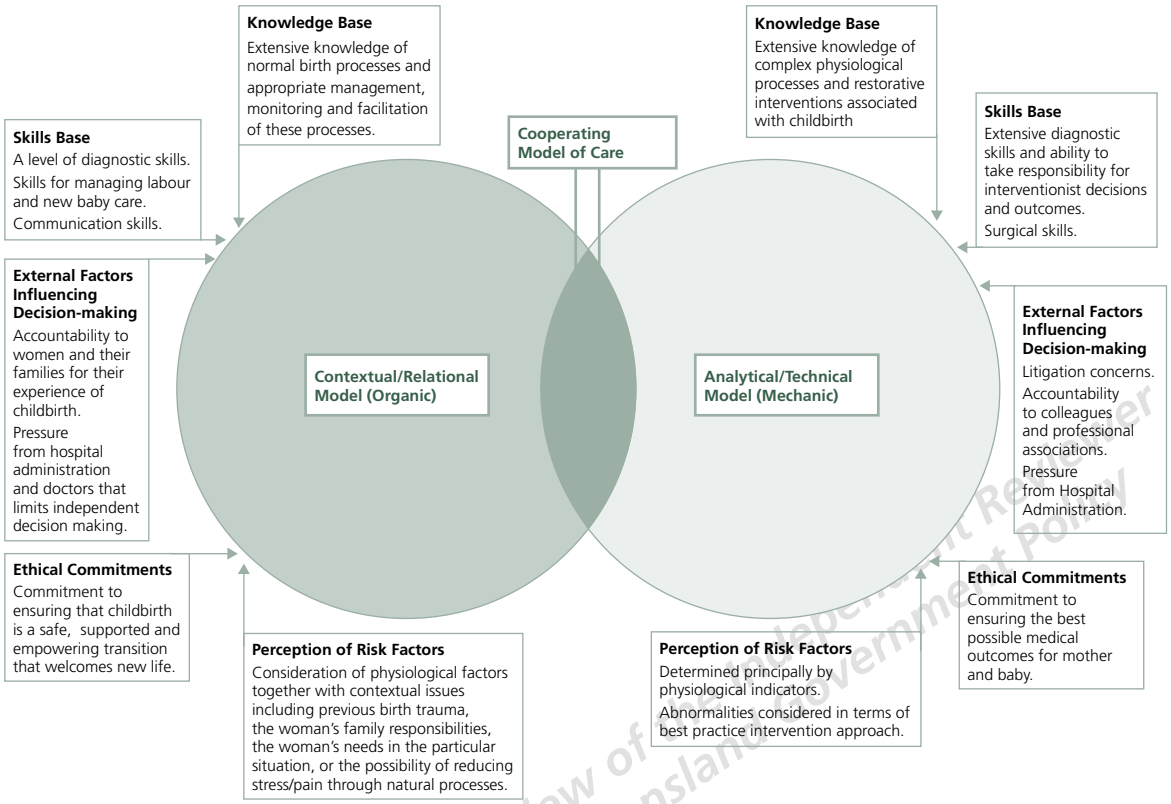
These two cultures of care are influenced by different environmental factors. Their skills and knowledge base are also different. Their ethical commitments are quite different. Most importantly, they have different frameworks for risk and safety. These differences are presented graphically in Figure 1 (page 16).

In some care environments in Queensland carers who may have differences in

Organic: 1. occurring or developing gradually and naturally, without being forced or contrived. 2. consisting of elements that exist together in a seemingly natural relationship that makes for organised efficiency.

Mechanic: 1. Pertaining to or involving manual labour or skill. 2. Pertaining to or of the nature of a machine or machines.

Figure 1.Cultures of Maternity Care



This is an abstract representation of the cultures of care. Many practitioners, for example, share skills and perceptions from both models. The models are intended to demonstrate that both cultures of care bring a rich complexity of knowledge, skills and commitments. The models are differently oriented in the way that they perceive risk and seek to actualise their professional commitments to birthing women.

The overlap of models is labelled 'cooperating care'. This does not simply represent the common ground, though the two models do have many things in common. Rather, it is the bringing together of the strengths of both models. By developing models of care for Queensland maternity services which are actively 'cooperating models', consumers would have the benefit of their care being coordinated by professionals who bring a rich tapestry of skills and understanding to the process of birth which is at once natural, yet unpredictable in its unfolding.

their philosophy of care, who may be mechanics or organics, have learned to work together respecting and trusting each other's practice. Perhaps their philosophical positions are less strongly held, or perhaps they can work with difference. But this is far from the norm. The Review has been advised of many situations in which a lack of interprofessional cooperation is contributing to negative outcomes for everyone involved in maternity care, including the carers who are experiencing the stress of change and the individual consumer and her family who are experiencing the consequences of conflict as it plays itself out at the birth of their child.

It is in this framework that maternity care is provided in Queensland and in which the Review's recommendations for change must be situated.

Priorities for Change

There are many issues which have been raised during the Review that suggest the need for change in the way in which maternity care approaches are developed and delivered. Some of these are discussed in later sections of the Report. The three issues identified by the Review as priorities also have the support of every interest group the Review has been in contact with – consumers, carers, Government at State and local level, care organisations, support organisations and policy makers.

- poor outcomes among babies of Aboriginal and Torres Strait Islander women and the need to make this the first priority for change
- care for women in rural and remote areas
- the dearth of post-birth care in the community and the transition from hospital to community care.

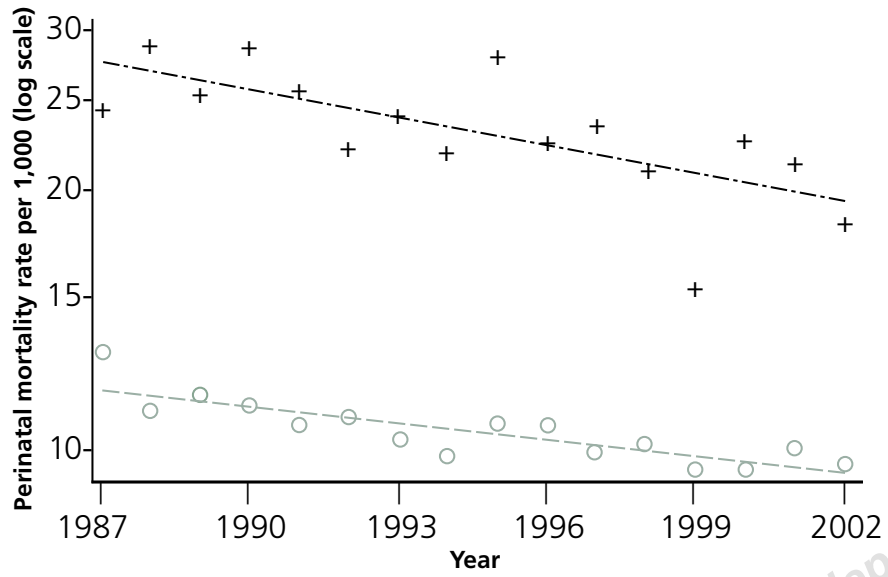
Poor Outcomes for Aboriginal and Torres Strait Islanders

The death rate among newborn babies[1] of Aboriginal and Torres Strait Islander women is twice that of babies of non-Indigenous women in Queensland. Figure 2 (page 17) shows that while newborn baby death rates have been decreasing across Queensland, the gap between Indigenous and non-Indigenous populations has not decreased at all in at least 15 years.

Birth outcomes are poorest of all for babies of Aboriginal women. The newborn baby death rate for babies of Aboriginal women was 21.5 per 1000 births in 2000 – 2002, compared with 17.2 per 1000 births for babies of Torres Strait Islander women and 9.7 per 1000 births for babies of non-Indigenous women.

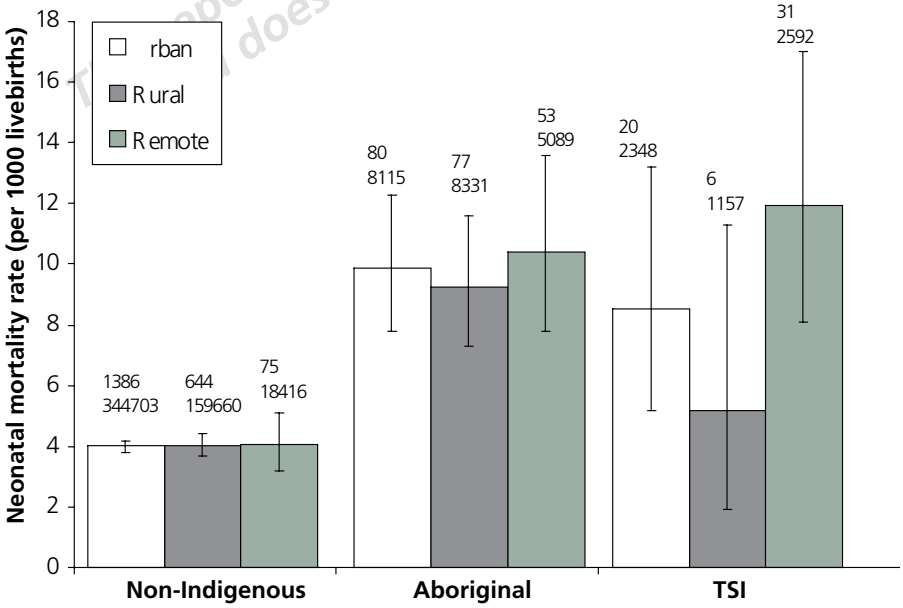
[1] Based on perinatal mortality rate which includes stillbirths of >400g/20 weeks gestation and liveborn babies who die in the first 28 days of life, expressed as deaths per 1000 births.

Figure 2. Newborn Baby Deaths in Queensland by Indigenous Status 1987–2002



Based on perinatal mortality rate. Aboriginal and TSI data were combined for calculation of trends due to small numbers.

Figure 3. Newborn Baby Deaths in Queensland by Remoteness and Indigenous Status 1988–1999



Based on neonatal mortality rate (which includes liveborn babies who die in the first 28 days of life).
The vertical lines represent 95% confidence intervals.
The top number above the bars is the number of neonatal deaths; the second number is the number of livebirths (1988-1999).

Outcomes are poor for Aboriginal and Torres Strait Islander women whether they live in cities or remote areas. Figure 3 shows the relative differences (Coory 2003)

Birth outcomes for Indigenous people were the subject of a 2004 study by Michael Coory and Trisha Johnston of Queensland Health's Health Information Branch which showed that babies of Aboriginal and Torres Strait Islander women were more likely to be low birthweight[2] than babies of non-Indigenous women (Queensland Health 2004). Babies of Aboriginal and Torres Strait Islander women were also more likely to be born preterm[3]. More low birthweight babies and preterm babies die or are sick. In 2000 – 2002, 6.58 per cent of babies of non-Indigenous women were low birthweight, compared with 13.04 per cent of babies of Aboriginal women and 9.97 per cent of babies of Torres Strait Islander women. Birthweight among babies of Aboriginal and Torres Strait Islander women has shown no improvement in at least 15 years.

Birthweight and prematurity contribute directly to the higher death rate among babies of Aboriginal and Torres Strait Islander women. When death rates among newborn babies of Aboriginal, Torres Strait Islander and non-Indigenous women are compared within each birthweight and stage of pregnancy, babies born of Aboriginal and Torres Strait Islander mothers are no more likely to die than babies of non-Indigenous mothers.

Contributors to low birthweight include a number of risk factors present in Aboriginal and Torres Strait Islander communities (cigarette smoking, poor nutrition, genito-urinary tract infection and psychosocial stress related to economic disadvantage).

Relocation in late pregnancy for rural and remote women is discussed in the next section. Relocation is much more likely

[2] born weighing <2500 grams.
[3] born before 37 weeks.

Pregnant women who live in Torres Strait communities must travel at 36 weeks to Thursday Island where there is a hospital and wait in a hostel for birth. Children are not able to stay in the hostel, and these women leave young families behind. One woman who met with the Review had to relocate at 32 weeks because the single midwife in her mainland community was on leave. The woman had not seen her two-year-old son for the whole two months.

to affect pregnant Aboriginal and Torres Strait Islanders women. More than half of the Aboriginal and Torres Strait Islander women who have babies live in rural and remote areas, whereas less than a fifth of the non-Indigenous women who have babies live in rural and remote areas. Aboriginal and Torres Strait Islander women may experience particular hardship given the cultural links between the process of birth and the meaning of lands in some cultural groups. These communities already face extreme disadvantage.

Aboriginal and Torres Strait Islander women face disempowerment stemming from historical cultural and social factors. Disharmony in some communities can mean that women and children are victims of abuse and violence. Forcing women who already face such a burden to birth far from home and family, disrupting families who are already facing social problems and removing women from their homes are unsustainable if Indigenous people are to be strong.

The New South Wales Aboriginal Perinatal Health Report identified four risk factors associated with low birthweight in newborn babies of Aboriginal and Torres Strait Islander women in that State: Underutilisation of antenatal services, young adolescent birth rate, lack of empowerment (lack of control over life events), and social, economic and political factors affecting women (and families) (NSW Health 2003).

It would be naïve for this Review or any other to assume that maternity care could address in total all of the factors that contribute to poor outcomes for Aboriginal and Torres Strait Islander families. At the same time, pregnancy is a unique stage where a cycle of disadvantage has an opportunity to start again or not and a moment where women, families and communities are open to change.

There is evidence from a number of studies that appropriate pregnancy care can contribute to improved birth outcomes. The Review has been advised in consultations that Aboriginal and Torres Strait Islander women may find mainstream pregnancy care culturally inappropriate and unwelcoming. The Review's consultations with Aboriginal and Torres Strait Islander women and carers support the findings of many previous reviews of maternity care for Aboriginal and Torres Strait Islander communities that women feel uncomfortable in maternity care environments, from hospital clinics to birth suites and wards. Aboriginal and Torres Strait Islander women will be more likely to engage in pregnancy care they see as relevant for themselves and their families.

The Townsville Aboriginal and Islander Health Service Mums and Babies program pulls together a range of health providers at the one mother and baby friendly centre, including a hospital midwife, a child health nurse, a GP, and health workers. Birth outcomes are improving as a result, with birthweights now comparable with the non-Indigenous population.

The Queensland Government's recent focus on child safety and contemporary policy development stress the key role played by the first year of life in physical, social and emotional wellbeing throughout life. The Department of Aboriginal and Torres Strait Islander Policy is focused on the unique stage of pregnancy and the first three years of life as its key priority area. Approaches which improve health and wellbeing of women and families during this critical period are crucial. The role that can be played by maternity services in this regard is immediately obvious and the potential for synergy needs to be exploited with a whole-of-government approach.

For several decades, national Aboriginal and Torres Strait Islander health strategies have been moving in the direction of

a primary health care approach that emphasises community participation and control as key factors. Community-determined primary care approaches invest not only in the physical health of communities but also in their economic and social health, building confidence, valuing community life and promoting self-determination for Indigenous people.

Maternity care has more potential to contribute to the health of Aboriginal and Torres Strait Islander mothers and families than almost any other area of health care.

A way ahead for Aboriginal and Torres Strait Islander care

The principle of returning birth to Aboriginal and Torres Strait Islander communities must be affirmed by Government, with steps taken to empower women and educate more Aboriginal and Torres Strait Islander carers so that this can happen safely. This will require the will of policy makers, administrators, carers and other people, within and outside Indigenous communities. An initial demonstration project might be put in place in 2006, to return birthing to one of the communities, in line with recommendations of previous reviews of Indigenous maternity care.

Increasing participation of Aboriginal and Torres Strait Islander women in culturally and socially appropriate prepregnancy and pregnancy care and education must be a priority. There are a number of places in Queensland, including the Townsville Mums and Babies Program, that are increasing participation in care and showing improvements in birthweights. These exemplars of pregnancy care that is sympathetic and responsive to Aboriginal and Torres Strait Islander women and families need to be recognised and more widely provided throughout Queensland. The Review's recommendations include development and implementation of programs that meet the needs of Aboriginal and Torres Strait Islander women.

Care for Women Who Live in Rural or Remote Areas

'The most asked question was not "how is it all going?" or "how are you feeling?" but "when are you going away?".'

Many women from rural and remote areas of Queensland are routinely required to travel for some or all of their pregnancy, birth or post-birth care as facilities and/or carers are not available in the local community. Access to care was raised by every woman from a rural or remote community who met with or wrote to the Review. 'I'm pretty lucky really – I'm only 150 km from a GP. I did find though that with antenatal classes they are really geared for town families. They always hold the classes at night, when the roos are really bad.'

Access to care is also raised in submissions from many support organisations, professional bodies, individual carers and local government authorities.

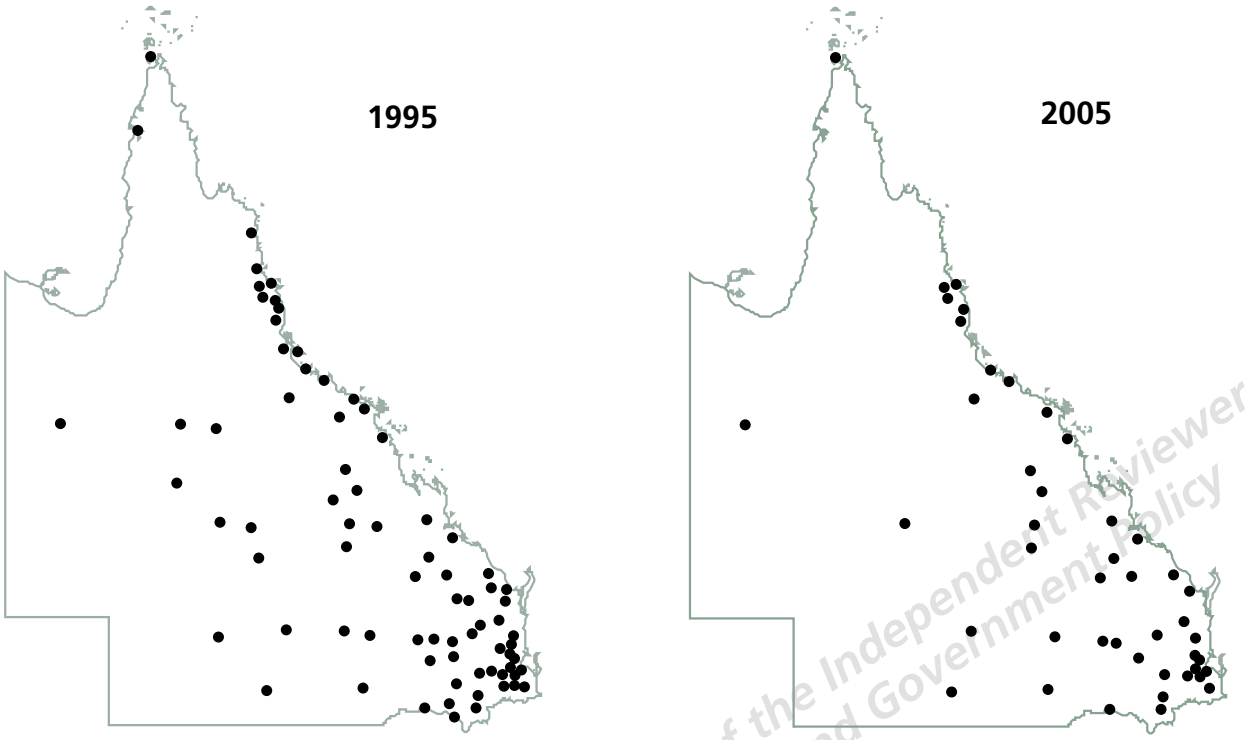
Women report having to travel long distances for pregnancy and post-birth care, but relocation to birth is by far the most difficult issue for women and their families.

Contact with individual hospitals shows that in the last ten years, 36 of the 84 services in the public sector that were providing maternity care in 1995 have now closed. Reasons for closure have included concerns about safety arising from workforce shortages and the inability to recruit and retain midwives, GP obstetricians and/or anaesthetists to work in these communities. The effects of closures are shown in the maps of the State that make up Figure 4 (page 20).

It is difficult to determine accurately the total number of women in Queensland who are currently required to relocate ahead of birth as Queensland Health does not routinely collect data in this way. Of the 48,960 women who gave birth in Queensland in 2003, 18 per cent

'So it was at 1 am in the throes of my first labour we were flown to Rockhampton with little more than our wallets and my one change of clothes… We were both thrilled when I called my husband to come and pick us up – a 9 hour trip one way. I got the feeling that when I told the doctor this he thought I was exaggerating as he then asked me to come back next Monday for a check-up. I'm sure if he had known that getting home involved me walking across two swollen creeks with bub in arms in case the car was washed away he may not have been so keen for us to depart.'

Figure 4. Public Sector Birthing Places in Queensland 1995 and 2005.



(8,905 women) lived in rural and remote communities,[4] and more than half (62 per cent) of these travelled away from home to give birth.

Of the total 8,905 women living in rural and remote communities who had babies in 2003, 25 per cent (2,250 women) accessed private care and most of these (77 per cent, 1741 women) travelled away from their home before birth, either by choice or because no local facilities were available.

Of the 6,655 women in rural and remote communities who accessed public care in 2003, 57 per cent (3,765 women) travelled prior to birth and birthed outside their local government area. For 46 per cent (1,585 women), births were retrospectively considered low-risk.[5]

In order to investigate further the degree of choice women in rural and remote areas have, the Review looked at whether there were birthing services in the communities where women who had babies lived. A retrospective analysis showed that of the 1,585 women whose births were low-risk who went to a public hospital outside their local government area in 2003, 82 per cent (1,302) did not have a choice as there were no public sector maternity services in their local area. Most (83 per cent) of the 1,708 women with low-risk pregnancies who had a maternity service in their local area birthed in their local area.

Hospitals have closed their maternity services because of concerns about safety which arise from the departure of a critical mass of qualified carers. The Queensland Health *Clinical Services Capability Framework for Public and Licensed Private Health Care Facilities* suggests a Level 1 maternity services unit (which can manage low-risk pregnancices) needs, among other things, 24-hour access to obstetric anaesthesia, the capacity to provide care for elective and emergency vaginal and assisted births and selected low-risk elective caesarean births, and the ability of cope with sudden unexpected complications until transfer. Advice to the Review from the Australian College of Rural and Remote Medicine and the Rural Doctors Association of Queensland is that there is no evidence base to support the level of care suggested as necessary for low-risk labour and birth care in the *Clinical Services Framework*.

Assessment of the safety of birthing in smaller hospitals has been the subject of a recent study by Mark and Sally Tracy which found that over three years in New South Wales the likelihood of newborn baby death was significantly less in maternity hospitals outside tertiary centres regardless of risk status, and that after adjusting for risk, the death rate among newborn babies of women with low-risk[6] pregnancies was not significantly different (Tracy 2005, in press). The study also found that after adjusting for maternal age, health insurance cover, aboriginality and residential area, women with low-risk pregnancies in the smallest (<100 births a year) hospitals were less likely to have their labour induced/augmented or require epidural/spinal analgesia/ anaesthesia, or assisted or caesarean birth after labour. The babies were less likely to be admitted to a neonatal or special care unit.

[4] The definition of rural and remote communities for this purpose excludes the Southeast corner and the seven regional centres (Cairns, Townsville, Mackay, Rockhampton, Gladstone, Bundaberg and Toowoomba).

[5] Births of full-term mothers who had no medical complications in pregnancy and no previous caesarean births with a single baby who presented normally (vertex) and birthed vaginally.

[6] Low-risk criteria included age 20 – 34 years, no medical or obstetric complications, live single baby, head-first, at term, 10 to 90th birthweight percentile for gestational age.

Queensland perinatal data show similar results. After risk adjustment to take account of facility differences,[7] rates of deaths among babies born in small (<100 births a year) maternity hospitals between 1998 and 2003 in Queensland were not significantly different from rates of death among babies born in larger maternity hospitals.

An issue raised repeatedly in submissions and consultations is travel assistance for women forced to relocate for birth. There are inconsistencies among Queensland Health Service Districts in the implementation of the Patient Travel Subsidy Scheme rules, in terms of travel and accommodation support for women, which, if provided at all, is minimal. The Review understands that women in private care mostly have no support if they relocate to wait for birth. Closing maternity facilities must create savings for the health system but these are not being redeployed to support the women who have to relocate.

While maternity services in rural and remote areas have closed on the basis of safety (invariably due to a lack of appropriately qualified staff), there are aspects of risk the closures ignore. Closure of maternity services units creates less safe communities. Women will continue to go into labour unexpectedly, and there are now 36 fewer communities in Queensland with the expertise and capacity to accommodate unexpected labour, despite the *Clinical Services Framework* view that non-maternity facilities can manage emergencies. In 2003, 81 (6 per cent) of 1,387 women with low-risk pregnancies who did not have a maternity service in their local area delivered in a hospital in their local area. Women who travel in labour are at risk of birthing in transit or having an accident on the road. There is the high social and emotional cost relocation is levying on women and families, creating its own unsafe family environments when mothers are removed. Another aspect of safety is the situation of women alone for late pregnancy which has been raised by consumers and carers with particular reference to Indigenous women in Cairns and their fears for their safety.

Decisions to close maternity services units are based on a narrow view of risk which really only considers exposure to litigation and works to transfer risk from the carer to the cared for. Because they relocate women face new risks which the health system has no way of mitigating and takes no responsibility for.

Pregnancy and birthing are key aspects of community life. The consequences of removing mothers from families for late pregnancy and birth and of removing birth from communities may have unexpected negative consequences. Anecdotal evidence from changes in maternity services among the Inuit communities in Canada where birthing has been re-established in a framework of quality and safety suggests community life more generally has improved, with less domestic violence and alcohol abuse reported (JAG Films/SBS Independent 2002).

A key issue for provision of maternity services in rural and remote areas is the ability to transfer quickly to higher levels of care when this becomes necessary. The Royal Flying Doctor Service (RFDS), which for many years has been bringing doctors, midwives and other professionals to people in rural and remote communities, joins with other services including the Flying Rural Obstetrician and Gynaecologist Service in providing emergency care and/or retrieval transport when needed.

Consultations suggest that more could be done at a State level between the RFDS and Queensland Health to ensure timely responses in emergencies and to coordinate services, with reduced duplication on the part of various providers. This is a complex issue which appears to have more to do with the need for service coordination than the services themselves.

'When I go into labour I must immediately get in the car and drive to Theodore and hope I make it before the baby is born. If the doctor is not available in Theodore the day I am having the baby, it appears the hospital must ring around and find another hospital which will deliver. As far as the dash to the hospital is concerned, there are two women I know of, who, in the last twelve months, have delivered their babies on the side of the highway between Miles and Wandoan.'

[7] A birthweight-based correction to take account of the fact that high-risk pregnancy will be cared for in specialist care environments.

'I had to travel just over 1000 km one way for my scan. I will deliver hopefully about 700 km from the station where we live. If anything complicated happens, they will probably send me on further. For us, a single wage family, this is the only option – here we have my aunt to leave the children with when I am in hospital as accommodation costs during the lengthy wait in town (which the doctors insist on) would otherwise be huge.'

A way ahead for care of rural and remote women

The reopening of maternity services in some or all of the 36 rural and remote communities where birthing has closed needs to be a priority. This has obvious implications for the numbers and kinds of carers that work in rural and remote communities. The issues of recruitment and retention of staff are dealt with later in the Report.

At the present time, everything is working against maternity care in the bush, and a dedicated effort is needed to reverse the trend. Even with incentives, this is not something which can be left to individual carers or Health Service Districts to organise and develop. The reopening of maternity services will require the will and commitment of Government and the active involvement of Queensland Health.

Sustainable Rural Clusters of Care that recognise local community needs and respond accordingly could do much to alleviate the drain of carers from communities. These clusters would be made up of groups of carers from linked small communities who agree to form multidisciplinary teams that offer safe, quality care to women across the whole community. A process for establishing clusters would need to be put in place, flexible enough to respond to local needs but formalised enough to make sure those carers who want to work together can. An overall template for Rural Clusters should be developed in collaboration with relevant professional bodies including the Rural Doctors Association of Queensland, the Australian College of Midwives Inc., the Australian College of Rural and Remote Medicine, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Australian and New Zealand College of Anaesthetists, the College of Emergency Medicine and the Royal Australian College of General Practitioners Rural Faculty. Women attending Rural Clusters of Care must have access to timely transfer to higher levels of care whenever this becomes necessary. For Clusters that do not have the capacity for caesarean birth, transfer times must be comparable with times in hospitals to access emergency caesareans.

Even if birth care cannot be provided in a community, pregnancy and post-birth care can be provided in a primary care approach, through midwives and GPs working together with other carers as needed.

Where maternity services (birthing in particular) cannot be provided, the health system must provide adequate funding for travel and accommodation, for each woman, her partner or support person and in some cases families.

Post-birth Care (Integration of Care)

The deterioration in community post-birth care has been raised by consumers, carers, professional bodies and support organisations who have written to or met with the Review.

Most maternity care in the public sector is provided in non-integrated episodes of pregnancy, birth and post-birth experience, with many different carers involved within and across different stages of care. For the consumer, care lacks integration from pregnancy to early parenting. Post-birth care is the final stage in care organised around structures and carers rather than around consumers and their care needs. Consumers must travel from place to place and explain to new carers at each link in the chain. Information can be lost, especially if systems are inadequate. Key issues are less likely to be picked up and acted on when the consumer is not known to the carer over time.

An issue related to integration of care is the use of hand-held records of pregnancy care which has been explored in some Health Service Districts. Hand-held records provide women with a measure of involvement and control in their care and assist integration but any scheme in which the hand-held record is the only official record of care creates difficulties for carers if women don't bring records to appointments. A number of submissions to the Review from general practitioners and others raise concerns about the use of hand-held records as the only record of a pregnancy experience, particularly in the context of GP shared care.

'I cried most days for the first few months and wondered if I would ever feel better again. I didn't feel like I was really coping for quite some time. I do not think I am unique or alone in this experience… I really felt I was on my own during that time and had to just deal with it.'

Early discharge particularly in the public sector has been raised by consumers and carers. The relationship between days in hospital and resource allocation in the public sector appears to favour short hospital stays. Women leave public hospital care within two to three days of a vaginal birth and four to five days of a caesarean birth. Average length of stay for maternity has reduced by two days for caesarean and a day to two days for vaginal births over the last ten years. Queensland has the shortest average length of stay for maternity care of any state in Australia (Productivity Commission 2005).

Increasingly, public hospitals are providing limited post-birth home visiting by midwives after discharge from hospital, but this is normally limited to women who live within the catchment area.

In birth centre care, women are generally discharged within 24 hours of birth and may be visited by a hospital midwife at home. In homebirth care, women will be cared for by their homebirth midwife.

In the private sector, care is more integrated, with an obstetrician providing continuity during pregnancy and supervision of birth care. Some private hospitals also provide post-birth home visiting, mostly on a fee-for-service basis.

Once home, women in public or private sector care can see their GP for post-birth care for themselves and their babies. Traditionally, they have also been able to access public child health facilities although child health resources appear to be shrinking overall and concentrating their limited resources on care for families at risk.

Queensland Health has established a Family CARE Nurse Home Visiting Program which has been taken up in seven Health Service Districts. The Program provides early intervention in a newborn's life for families exposed to violence and other key risk factors (eg. maternal depression, mood disorder, financial stress). Implementation of Family Care and other similar programs seems to be at the discretion of individual Districts.

The inadequacy of post-birth care is raised in consumer submissions in terms of care in hospital but especially care following early discharge. Many women needed more support than the system provided, particularly with a first baby. Some women felt inadequately prepared for breastfeeding, baby care and/or self care. Those with access to home visiting appreciate the visits but found them limited in number (often only one). For some access was difficult or impossible because of an administrative or distance limitation. Many submissions report difficulty accessing child health clinics, with delays of weeks or advice that a service is no longer provided for 'normal' mothers. Postnatal depression is raised in terms of the lack of access to post-birth care.

Some submissions to the Review report positive experiences of post-birth care, particularly in small community hospitals and child health clinics. 'The local Community Health nurses provided an excellent service to me, visiting at home for the first couple of weeks and providing support weekly after that for some time.'

A lack of information about post-birth care and new baby care and feeding goes hand in hand with the lack of access to care in this period. Breastfeeding is raised in a number of submissions, mostly in terms of the lack of helpful, consistent advice and support to establish breastfeeding in hospital and to maintain it once home. It seems some hospital nurseries work against breastfeeding. 'My baby was placed in a special care unit for 6 days, given formula and a dummy.'

One woman whose baby required nursery care expressly asked a midwife to wake her when the baby woke so she could breastfeed her baby. The midwife gave the baby bottles instead. One submission

'Sister Mac visited me in the hospital and made an appointment for me to see her at the infant welfare centre… She introduced me to two other mothers who had given birth about the same time, lived in my neighbourhood and like me did not have relatives in Australia. We started a morning coffee group and found that our children weren't that different from others their age. We started a babysitting club where only Mothers took care of children. My friend went on to head the committee that built the local kindergarten...'

A woman writing about her post-birth experience 30 years ago in Queensland.

suggests milk banks be supported so that women can donate breastmilk for babies who for some reason cannot be breastfed by their mothers.

A way ahead for post-birth (integrated) care

While any enhancement in community-based post-birth care in the public sector will be welcome – increasing home-visiting by hospital midwives in the first week post-birth especially following early discharge, increasing access to community child health clinics, allowing women to remain longer in hospital if this is what they want or need – these solutions will address post-birth care in isolation but not the fundamental problem that arises from a lack of integration of care across the continuum of pregnancy to early parenting and beyond.

The transition from hospital and birth care to community care must be seamless for the consumer and achievable for carers. In urban areas, this will be much easier if smaller teams of carers in smaller homelike environments have responsibility for smaller numbers of women than in the current large systems that process pregnancy rather than care for families in many public hospitals. For each woman, pregnancy, birth and post-birth care should involve the same small team of carers. For women in private or public care, there should be another seamless transition from post-birth care to long-term primary family care. A way of achieving this, through local community 'bub-hubs', is described later in the Report (see A way ahead for approaches to care).

Where GPs are involved in shared care arrangements with hospitals or likely to take on primary family care at the end of a maternity care experience, they need to be provided with timely information. Contemporary, effective health information systems should underpin any shared care arrangement. Responsibility for information cannot be left to the consumer. The issue of ensuring GPs maintain their skills and knowledge around pregnancy and post-birth care is dealt with later in the Report (see A way ahead for carers).

Government has recognised the key role played by the first year of life in later health. It is important that all relevant agencies work together to achieve outcomes that improve the health of mothers and babies. Data need to be collected on health effects of maternity care in the first year of life and the connection these have to pregnancy and birth experiences.

Approaches to Care in Queensland

The Women Who Had Babies in 2002

Of the 48,324 women who gave birth in Queensland in 2002:

- 8.7 per cent were born in a country where English is not the first language[8] (compared with 15.8 per cent nationally)
- 5.6 per cent were Aboriginal or Torres Strait Islander (compared with 3.6 per cent nationally)
- 6.3 per cent were under 20 years-of-age (compared with 4.9 per cent nationally)
- 15.5 per cent were over 35 years-of-age (compared with 18.1 per cent nationally)
- 18 per cent lived in rural or remote communities[9]
- 39.7 per cent were having a first baby (compared with 41.1 per cent nationally).

Queensland currently has the third highest number of births in Australia, behind Victoria and New South Wales. The number of births in the State is projected to increase by a third from the current 49,196 to 63,900 by 2021 (ABS 2003).

The Ways Women and Babies Were Cared For in 2002

In Queensland in 2002, 99 per cent of the women who gave birth were cared for through one of the following three approaches (compared with 97.6 per cent nationally):

[8] No data are currently collected on language and cultural needs of women.

[9] Excludes the Southeast corner and the seven regional centres (Cairns, Townsville, Mackay, Rockhampton, Gladstone, Bundaberg and Toowoomba).

- **Private care** (16,984 women or 35.1 per cent, compared with 31.1 per cent nationally) – an obstetrician in private practice for pregnancy care, birth as a private patient in a private or public hospital with midwives/obstetrician, and care following in hospital for a few days and then through child health clinics (or with GP). Hospital costs are met directly by the consumer, but may be covered partly or fully by private health insurance. Obstetricians and any other doctors involved may charge a fee that exceeds the Medicare-scheduled fee, with the consumer paying the difference.
- **Public care shared with GP** (16,813 women or 34.8 per cent, no national comparison available) – a GP for most pregnancy care, birth in a public hospital with midwives and/or doctor, and care following in the hospital for a few days and then with GP (or through child health clinics). Hospital costs are met by public funding. A GP may charge a fee that exceeds the Medicare-scheduled fee, with the consumer paying the difference.
- **Public care in hospital** (14,076 women or 29.1 per cent, no national comparison available) – a public hospital antenatal clinic for pregnancy care, birth in the hospital with midwives and/or doctor, and care following in the hospital for a few days and then through child health clinics (or with a GP). Costs are met by public funding rather than directly by the consumer.

There are significant variations within the overall care approaches outlined above and some of these have an impact on the experience of care.

- Some public sector care is shared between hospitals and community-based health services. For example, a number of Aboriginal and Torres Strait Islander Health services and services for adolescent women provide pregnancy and post-birth care, cooperating to varying degrees with a birthing hospital.
- The Review was advised that six public sector hospitals (Cairns, Hervey Bay, Mareeba, Mackay, Redland and the Royal Brisbane and Women's) have options where midwives in small teams work with women whose pregnancies have been assessed as low-risk throughout their pregnancy, birth and post-birth care experiences. A number of other public sector hospitals run clinics where midwives provide most pregnancy care for low-risk pregnancies.
- At least two private hospitals (Nambour Selangor and John Flynn Gold Coast) provide options where hospital midwives work collaboratively with private obstetricians to provide care.

In Queensland in 2002, 0.9 per cent of the women who gave birth accessed the following care (compared with 2.4 per cent nationally):

- **Public care in a birth centre**[10] (389 women, or 0.8 per cent, compared with 2.1 per cent nationally) – midwife or one of a small team for pregnancy, birth and post-birth care. Costs are met by public funding rather than directly by the consumer.
- **Homebirth care** (61 women or 0.1 per cent, compared with 0.3 per cent nationally) – midwife[11] in private practice for pregnancy, birth and post-birth care. The services of midwives are not covered by Medicare or private health insurance, so the consumer meets all costs.

In these approaches women normally see one carer (or one of a small team) for pregnancy, birth and in the week or weeks following birth. According to the two birth centres in Queensland, demand exceeds available places. At the Royal Brisbane and Women's Hospital Birth Centre a ballot system is used and the Birth Centre itself advises that one in four women is offered a place in the initial ballot.

Birth centre care is raised in over a third of consumer submissions to the Review, almost always positively, and 63 consumer submissions are letters about the Mackay Birth Centre and its care. A

'I am one of the few women who has experienced virtually all types of antenatal and birth care… My caesarean birth taught me that to follow the masses did not necessarily give me the best birthing outcome. My VBAC homebirth taught me that I am in control of my body and that the best way to give birth is to "let go". My hospital breech birth showed me that it is possible to have a great birthing experience in a hospital setting...'

[10] The Royal Brisbane and Women's Hospital Birth Centre and the Mackay Birth Centre.

[11] Obstetricians and general practitioners are unlikely to provide home care. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists Statement on Homebirth suggests members urge consumers to consider birthing in a suitably modified hospital environment such as a birthing centre rather than at home.

'My GP was also a bit of a letdown… after telling him of my decision to have a homebirth he raised his eyebrows and said, "Ah going the hippy, alternative route are you?"… He then went on to state that he couldn't have anything to do with me after that and not to see him again until after the baby was born… This was a little bit scary at first…'

quarter of consumer submissions mention a homebirth experience, always reporting positively.

Homebirthing women report problems accessing mainstream medical care when they need it. The transfer of care from home to hospital is at best traumatic for women who have written to the Review and at worst one in which they feel judged and punished.

The Continuum of Care

As discussed earlier in the report, most maternity care in the public sector is provided in non-integrated episodes of pregnancy, birth and post-birth experience, with many different carers involved within and across different stages of care. For the consumer, care lacks integration from pregnancy to early parenting.

There is general acceptance of the evidence that appropriate **pregnancy care and education** can contribute to healthier pregnancies, healthier babies and healthier families, but in Queensland, much of the pregnancy care currently delivered is grounded in tradition rather than contemporary ideas and evidence about care. Women who book into a public hospital care have a series of pregnancy care visits. Practice varies from place to place, but 12 visits is standard in many hospitals (monthly to 28 weeks, fortnightly to 36 weeks and weekly thereafter). There is evidence that outcomes are no different if women have a reduced program of health care visits in pregnancy, provided the visits focus on stages of pregnancy and need (Enkin et al, 2000).

In submissions to the Review and consumer surveys, women report long waiting times in both public hospital antenatal clinics and private practices (up to four hours in the public sector and long waits followed by 'five-minute appointments' in the private sector). Appointments do not suit women's work schedules and workplaces are not always supportive of pregnant employees' needs for care.

The educative component of pregnancy care is of prime importance in seeking to optimise attitudes and practices towards wellness, in providing information about birth processes, options for care and possible outcomes and in preparation for parenting. At no other time in a woman's life is she likely to be as receptive to advice or to act on information as when she is pregnant. The continuing impact of such influence is likely to be the enhanced lifelong health of the infant/child and future children.

Pregnancy education is variable across hospitals in both public and private sectors. The Review's consultations and submissions from consumers suggest that most education, particularly in the private sector, is provided by individual hospitals and focuses on preparation for birth in the hospital concerned rather than on health during pregnancy and the changes parenthood brings. Pregnancy education may be offered on a user-pays basis to women. In the public sector, women and providers report difficulties with access to pregnancy education classes.

A number of submissions suggest it might be useful to explore the application of technology such as the internet and videoconferencing for pregnancy care and education, particularly for women in rural and remote areas.

The issue of preconception care and advice has been raised in several of the Review's discussions in terms of the lack of ownership of this key area of care by any of the current maternity service providers. One submission mentioned the importance and proven role of folate in preventing neural tube defects and possible solutions to ensure women of an age to conceive are provided with folate.

As indicated in the approaches to care outlined above, **care during labour and birth** is mostly provided in a hospital in Queensland and in public care it is

'It is difficult to speak about hospital birth… My experiences left me victimised and abused with a hatred of doctors, nurses, midwives and hospitals and I was left traumatised and had to seek psychiatric help.'

mostly provided by a midwife. Perinatal data show that in the public sector in 2002, midwives and student midwives are listed as 'principal accoucheur' for 57 per cent of low-risk births, with obstetricians or obstetric registrars listed for 40.5 per cent of low-risk births, and the remaining births attended by a medical student or the mother herself. However even if a midwife is listed as principal accoucheur, a doctor will be responsible and accountable for care and will be designated as such in hospital records. Even in the State's birth centres, a hospital doctor is named on the records as the responsible officer for care.

In the public sector, different hospitals have different protocols on a range of issues, including the timing and use of analgesia and other pain relief and intervention in labour. Some of these differences may lead to significant differences in outcomes. There are also differences among hospitals in 'standing orders' for the administration of drugs and other aspects of care. These were raised by the National Health and Medical Research Council (NHMRC) in its 1998 *Review of the Services Offered by Midwives* which recommended inconsistencies in the implementation of existing State legislation be addressed. This matter has been raised in several submissions and consultations as a matter which needs to be examined carefully as apparently at present orders are regularly being signed after the event by doctors to meet legal requirements.

Clinical care decisions in the private sector are made by the individual clinicians. Again differences in practice may lead to significant differences in outcomes.

Lack of participation in care decisions and control over what happens to them in labour and birth are central to most of the other issues women raise about maternity care experiences. Many women who have written to or met with the Review feel disempowered in the maternity care system, in both public and private care environments. They report being given little or no information about what was happening to them during labour and birth, and inadequate preparation beforehand. They felt excluded from clinical care decisions, particularly about interventions. Some report that they did not give informed consent to clinical decisions. This is exacerbated for women who need and are not provided with an interpreter. 'I was asked to sign a document but I didn't know it was for a caesarean section.' Some women report a lack of even the most basic human respect from carers.

Several women in the private sector report having arrived at hospital in labour to discover that their obstetrician would not be there for the birth. They had never met the midwives who cared for them or the obstetrician who attended. At least three submissions from women report having been left in labour and frightened they will give birth alone and at least two women reported having given birth unattended. 'Our baby was born onto the bed without a medical attendant in the room and it was terrifying.' The fear of being alone is exacerbated for women who relocate for birth as they will have no support person.

'There was only one nurse rostered on the night of my labour and she had to leave me on several occasions to attend other mothers or answer the phone. I never knew from one minute to the next if I would be left alone at a crucial moment.'

'Being a first time mum I must have looked terrified yet not one single person stopped to reassure me.'

Care for Women with Special Needs

The Review's consultations and submissions suggest that women with special or different needs are not well catered for or in some cases even identifiable in the current system of maternity care.

Perinatal data do not currently give women an option to identify as having special cultural or language needs or a disability, and the Review has struggled with available information to understand the needs of these women. Unfortunately, an excellent 2003 Statewide patient survey conducted by Queensland Health inadvertently marginalised the ability of women with special needs to contribute to feedback about their care. Responses from several hospitals whose populations included strong representation from Aboriginal and Torres Strait Islander women were not included in the survey analysis because of poor response rates. No attempts were made to find alternative ways of seeking information. One question on the original survey

dealt with the need for an interpreter but was omitted from analysis as the questionnaire was only provided in English.

A number of support organisations prepared detailed submissions to the Review, based on consumer surveys, which have aided understanding, particularly in areas where no Statewide data are currently collected. Submissions from consumers and care organisations suggest women in marginalised circumstances feel judged, criticised, unwelcome and uncomfortable in maternity care environments. Care is not sympathetic to the cultural and social needs of Aboriginal and Torres Strait Islander women. Adolescent women feel judged and a threat of statutory involvement. Women from socioeconomic disadvantage feel judged and treated without respect.

Submissions from a range of support organisations suggest that the needs of women with cultural or language needs are not being met in maternity care environments. A number of submissions point out that women are not provided with a language interpreter during consultations. Women from some cultures will have experienced female genital mutilation and will require awareness, knowledge and appropriate and sensitive care.

A submission from a support organisation for women with disabilities suggests maternity care is complicated by public perceptions of disability.

The perinatal data collection does provide basic information about the care experiences of Aboriginal and Torres Strait Islander women, adolescent women and women from socioeconomic disadvantage. The data show that these women are less likely to access pregnancy care. As is shown in Figure 5, many women from these groups have fewer than two pregnancy care visits.

The unacceptable newborn baby death rates in Aboriginal and Torres Strait Islander populations are discussed earlier in the Report. Aboriginal and Torres Strait Islander women, who are most in need of care that can respond to them, are least likely to feel they can participate in care. They are also likely to experience many of the health challenges that make pregnancy care so important. Similarly, adolescent women and women from socioeconomic disadvantage are less likely to participate in care than other women.

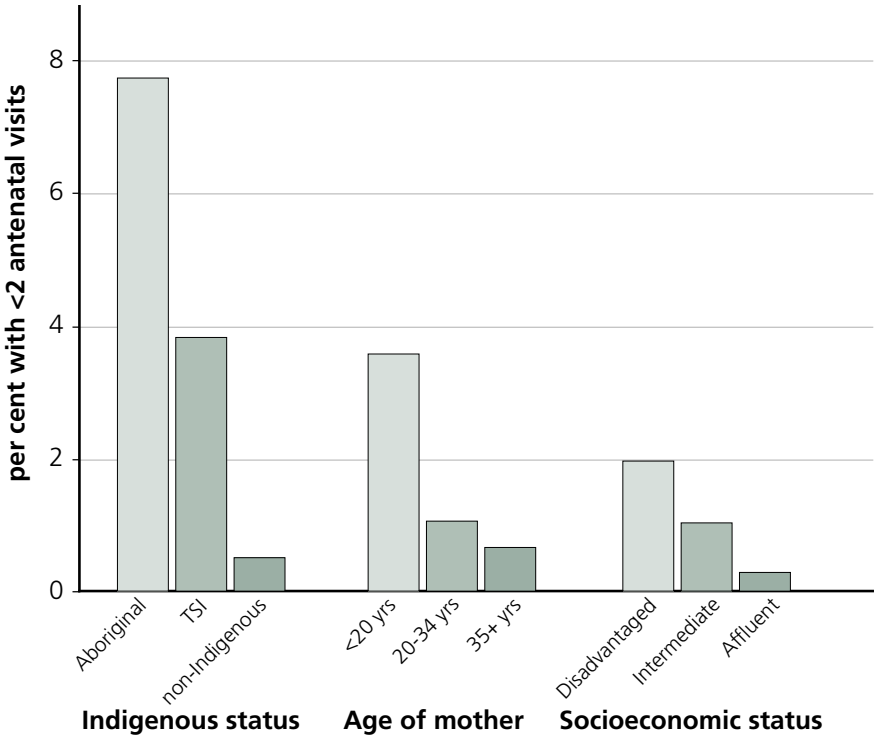
Advice from support organisations is that many women give up and forego pregnancy care rather than struggle with a lack of sympathy or respect in care.

Research suggests domestic violence against women is twice as likely during pregnancy (Burch 2004). While public sector care now incorporates a mandated detailed screening process for domestic violence, the Review has been advised by individual carers that in many care environments there are no resources or referral points which means women who report domestic violence cannot be appropriately cared for and supported. In some of the seven Health Service Districts that have a Family Care program, domestic violence is of itself enough reason to invest in Family Care.

Similarly, women likely to experience postnatal depression may be identified in screening processes but unless care programs are available, there is little the system can do to help. Work done by the National Health and Medical Research Council suggests that around 15 per cent of women who give birth in Australia experience postnatal depression. Research suggests the ongoing effects of maternal depression on children can be profound and can include cognitive and behavioural difficulties and later mental health impairment. Early detection and intervention are extremely important (NHMRC 2000).

A number of women who have written to the Review have experienced a stillbirth and whatever else they do in terms of counselling and support

Figure 5. Participation in Pregnancy Care 2001-2003 (<2 antenatal visits)



Socioeconomic status is based on the neighbourhood of usual residence of mother (ABS SEIFA index was grouped into deciles; disadvantaged: bottom decile, intermediate: middle 8 decile, affluent: top decile; see ABS Cat No 2039.0.55.001)

maternity care environments fail to meet their unique needs when they care for these women in the maternity ward alongside women with new babies. The lack of support and counselling for women who experience miscarriage is also mentioned in submissions.

Participation in the development and evaluation of pregnancy, birth and post-birth care by women with special or additional needs is of crucial importance, as their experience will likely be different from the experience of carers and when assumptions are made about what is appropriate they will do nothing to encourage women who already face great difficulties from engaging with the benefits that care can bring them.

Risk Assessment and Safety

There is no Statewide agreement on what constitutes risk in pregnancy or labour and no framework for how risk should be managed in individual women or in care environments. Different hospitals with similar facilities and staff have different risk protocols. A first pregnancy might be considered a risk in some hospitals but not in others that have similar resources. Carers in some hospitals will insist on a caesarean for any woman whose last birth was a caesarean while those in other hospitals allow a woman to labour and monitor her care.

Queensland Health in its submission to the Review points to its explicit responsibility to focus on quality and safety and report against national action areas. In maternity care, indicators for measuring quality and safety are still in the process of being developed.

Queensland Health has implemented a range of specific programs to support a quality health system, foster continuous improvement and more effectively manage risk.

According to Queensland Health, the *Clinical Services Capability Framework for Public and Licensed Private Health Care Facilities* released in 2004 is used in Health Service Districts to plan services and manage risk factors taking account of available physical and human resources. The Framework assists health facilities to identify risk factors and develop strategies to mitigate risk associated with birthing emergencies. The Framework '… articulates the aim of achieving a balance between local access to services and the safe provision of services for mother and baby.' However the rigid structural and resource requirements for different levels of care suggest that this is risk avoidance rather than risk management. The Framework takes a narrow view of risk assessment and management which may not accommodate relative risks, and the best example of this is provided in the earlier discussion about birthing arrangements put in place for women in rural and remote communities and how safety can create unsafety.

Within all of the existing maternity care approaches in Queensland, carers at various levels identify risk factors throughout the continuum of care. During pregnancy, certain risk factors will mean different levels of care are needed, with additional visits, attendance at special clinics or plans for a different hospital or level of care during labour and birth. During labour and birth care, risk is continuously assessed and monitored by the relevant carer.

> 'Because I was in the maternity ward people just assumed I had a baby that lived or that I was still pregnant… I had to explain over and over that I had had a baby boy and he had died.'

Clearly in order for risk management to be effective, all carers responsible for the pregnancy or birth care of women must have considerable knowledge and significant skills in recognising clinical situations which might indicate higher risk. This highlights the importance of continuing professional development and upskilling programs to ensure that all carers are up-to-date in terms of knowledge and skills.

A key area for risk management in any future approaches to care is the arrangement for transfer from one level of care to another which need to be clearly defined (even if the transfer is on the same floor of one building). This will need to incorporate transfer from care environments that can accommodate low-risk pregnancy and birth care to higher level care environments as risk profiles of women change during pregnancy and labour. Consideration needs to be given to the time involved in transfer, communication between carers and approval processes, and means of and access to transport.

Risk protocols should help to encourage those women who need to transfer from homebirth to hospital care to do so. In the current environment, women and their carers report the opposite

> The Young Women's Place in Toowoomba provides pregnancy and post-birth care based in a multidisciplinary women's support centre. Maternity services are integrated with life skills programs and other local services including accommodation, mental health, and drug and alcohol counselling.

'I received no support or follow up phone call from the hospital after my discharge. Fortunately this was my third baby and I had some experience to draw from, however, I did feel quite bereft when I came home.' The writer of this submission also reported experiencing postnatal depression after an earlier pregnancy.

experience. Hospital carers appear to be prejudiced against homebirth carers and consumers who report negative comments even before the hospital carer has assessed a transfer situation. This attitude puts unnecessary pressure on midwives considering transfer even when they are committed to (and practise) an early transfer approach.

The two cultures of maternity care are never more at odds than in discussion of safety and risk. Women's perceptions of safety must be taken into account in any determination of risk. Safety is a major contributor to women's decisions about approaches to care. A number of women who were able to access birth centre care felt they could have the aspects of care they wanted while being close to '…medical experts who could intervene instantly to save my baby or myself.'

Many women who choose homebirth do so primarily because they make a rational decision that this is the safest option based on considerable information which they have accessed. 'There will always be an element of risk in birth whatever the choice of birthplace. However, safety in childbirth is intrinsically related to the mother's emotional, psychological and physical well-being during labour. This, in turn, is influenced by the choices which are made during pregnancy, choices which should enable a woman to give birth at ease with her environment, her attendants and herself.'

A way ahead for risk assessment and safety

Risk management is important in all aspects and domains of patient care but nowhere is it more critical than in maternity care because of the unpredictable timing of inevitable events (labour). In many situations care is provided by carers from different disciplines but the over-riding risk management framework is driven by the perspectives of only one or two of those discipline groups. The others involved in care provision have no input and there is no ownership of the framework. It may even be perceived as having no relevance to the way those disenfranchised carers provide care.

Risk management frameworks and applications of such frameworks must be developed jointly by all those involved in care. Only then will all risks be captured and mitigated. If risk management plans derived from frameworks are to be effective in managing risk they must be believed and strictly adhered to by all concerned – hence the need for ownership. Consistency across the State is important because some carers work in more than one care environment.

The differences between the two cultures of maternity care are never more strongly represented than in discussions of safety and risk and the principles recommended by the Review in ***Maternity Care 2010*** *attempt to validate and respond to the legitimate concerns of both cultures, stressing the importance of each in contributing to effective care. The principles reiterate commitment to a quality and safety framework that has appropriate processes for risk management (which need to be much broader than risk avoidance). The principles also affirm that women and families need to feel safe in order to be safe.*

Adoption of principles, even with the most detailed of requirements for implementation, will be empty rhetoric unless carer roles can change and develop, care teams can be freed to work together and change can be championed and promoted at every level. These are the subject of the next sections of the Report.

Dimensions of Care

Over recent decades there has been an expansion of our understanding of the impact of the psyche on the physical state. This has led to a gradual acceptance that 'health' care must provide more than physical care and that psychological, emotional, social and cognitive dimensions of a person's being must be considered of equal importance in care in any health-promoting or care environment.

Submissions to the Review, consumer surveys from other places and consultations with carers and consumers make clear that the psychosocial dimensions of care are not being well managed and in some care situations are not even on the radar screen currently in Queensland. This situation in maternity care has developed to some extent because of the domination of the thinking around physical safety and reduction in death and injury through applications of science and technology. In the process of focussing on these aspects of care provision the other dimensions have been allowed to slide into the background.

One submission from a carer and consumer makes the point that while emotional support is the most important aspect of labour and birth, hospitals cannot be expected to provide emotional support to women. 'Hospital staff may be too busy to attend to a woman's emotional needs but I also believe that it is too much to expect of them. Labour is not the time to be discussing your birth plan or forming a relationship with a stranger. This needs to happen over time… all women must be encouraged to find a support person to guide them through labour. Whether this is a private midwife or a doula or a best friend or their own mother – the point is that birthing women need the support of an experienced woman.'

The effects of continuity of care have been evaluated and are reported in Enkin et al (2000). Two randomised controlled trials that compared care from a small team of midwives with that from a variety of midwives, obstetricians and general practitioners during pregnancy and birth found that women who had continuity of care experienced shorter antenatal clinic waiting times, were more likely to attend antenatal education, felt more able to discuss their concerns during pregnancy and feel well-prepared for labour. They used less analgesia or anaesthesia during birth care and experienced fewer other interventions. They felt more in control during labour, perceived the labour staff as more supportive and felt more prepared for parenthood. Fewer babies required resuscitation at birth. The continuity of care was provided by midwives, but the study could not make judgements about whether the benefits were due to midwifery care or continuity of care.

Incorporation of the psychosocial dimensions of care and continuity of care in current approaches and development of future approaches will be of key importance. This has implications for workforce needs which are discussed later in the Report.

Key Consumer Issues

The Review has no Statewide framework against which maternity services can be assessed. Currently Statewide data are not routinely collected on women's experience of maternity care. In the private sector, consumer feedback is left to individual providers. In the public sector, there have been two recent Queensland Health surveys of views about existing maternity services but no systematic process of feedback leading to improvements across maternity care environments.

The best practice principles described earlier in the Report[12] identify what Queensland Health might consider important in maternity care. A number of consumer surveys on maternity care experiences have been conducted in Queensland and elsewhere.

- A 2002 Queensland Health survey that included 1,967 maternity care patients who had accessed the public system over a two-month period found that 89 per cent of respondents were fairly or very satisfied with their care and 11 per cent were not too satisfied or not at all satisfied. The survey also showed the performance of maternity services on an overall care index[13] in the 'good'

'An endemic professional culture (including midwives) which lacks respect and patience for the process of birth and which can be both patronising and disparaging towards women; a culture which purports to know best but which often coerces women to conform to procedures which are mainly for the convenience of the system rather than for the safety and satisfaction of the woman concerned.'

[12] These were Safe, Appropriate, Responsible, Women and Family Centred, Accessible, Continuous care for women who are Informed of choices and who have and feel Autonomy and Control over birth, from Multi-disciplinary Teams, in care environments with necessary levels of Intervention and Technology available if needed that involve Consumers in Planning and Evaluating services.

[13] The overall care index is based on scores for responses to 27 individual measures of performance in the areas of access and admission, general patient issues, treatment and related information, complaints management, physical environment and discharge and follow-up. Maternity care was 66 across OCI dimensions (50 – 74 was the 'good' range. An OCI of 50 means that the 27 contributing measures have been rated on average as goode

range. Respondents were not asked to assess their care against Queensland Health's or any other desirable attributes of care, or in comparison with other care, so this is a useful large-scale picture of levels of satisfaction and dissatisfaction with currently offered care to women. Women with special needs were not well catered for in the survey methodology (see previous section).

- A 2003 Queensland Health review of maternity care in nine public hospitals sought feedback from women on the approaches to care provided through focus groups, survey and telephone follow-up. Over 400 women across the nine hospitals were included. Positive experiences reported were continuity of care in labour when this was provided, and good post-birth support and advice on breastfeeding in some hospitals. Women suggested improvements could be made in waiting times for antenatal appointments (up to four hours), more timely labour and post-birth care (staff were perceived as too busy), and more consistent post-birth advice especially about breastfeeding.
- The National Health and Medical Research Council (NHMRC), in developing its 1996 *Options for Effective Care in Childbirth*, drew on a number of sources that identified consumer concerns as safety, control over the birth process, access to and sharing of information and continuity of care. The NHMRC concluded that any proposed system of maternity care should provide, among other things, no compromise of safety, more time for consultation and discussion, better communication between consumer and carer and an acceptance of shared decision-making. Given the importance of continuity of care to women, the NHMRC stressed that approaches to care should not fragment care or make transfer of care among different levels more difficult. The NHMRC also stressed the importance of informed decision-making and access to information.
- The most recent *Victorian Survey of Recent Mothers* (Brown et al 2000) found a strong relationship between women's ratings of care and the quality of interactions and communication with carers. Women surveyed valued sensitivity and understanding in caregivers, being respected and taken seriously, continuity of care, access to information and support, and involvement in decisions. Only 51 per cent of women surveyed considered that post-birth care experiences, in hospital and at home, were good or very good.

In submissions to and consultations with the Review of Maternity Services, consumer and care organisations have identified the need for:

- choice in terms of care approaches, choice within a care approach especially during labour and birth, and access to care in local communities, raised directly in over half the consumer submissions
- information about a range of issues from care approaches and outcomes to basic pregnancy care and nutrition (the point is made repeatedly that without information women cannot make informed decisions), raised directly or indirectly in just under half the consumer submissions
- participation in care decisions and respect from carers which incorporates an experience of being listened and responded to, and having views which might be different from the carer's view understood and accepted, raised directly or indirectly in at least a third of consumer submissions
- continuity of care with a known and trusted carer, raised directly or indirectly in over half of consumer submissions (often raised in the context of not having met the person who will provide labour and birth care until arrival at hospital in labour, and related in a third of consumer submissions as associated with midwifery care)
- safety and the experience of safety, raised directly in nine consumers submissions and indirectly in 10 per cent of submissions (but the experience of safety is also related to trust and the confidence women have that they will be consulted about what will happen, particularly during the unknown experience of labour and birth).

The Midwifery Group Practice at Ryde Hospital in Sydney is a primary health care approach for women with low-risk pregnancy and birth. Multidisciplinary carer teams work collaboratively with other health care organisations and offer continuity through pregnancy, birth and post-birth care and safe and easy transition to the integrated secondary or tertiary levels of the model whenever necessary. The Practice operates as an integrated system centred around the Royal North Shore Hospital.

At national level, consumers have formed a Maternity Coalition which has developed a national action plan that advocates community-based care with midwives as primary carers. The Coalition was represented on the Review's Advisory Panel and the national action plan has informed the recommendations included in this Report.

A detailed analysis of consumer issues is included as Appendix 8.

Response to Consumer Issues

In terms of current approaches to care, consumer concerns are not being well catered for.

- Choice: 99 per cent of Queensland women (as described above) have one of only three choices for care. These approaches to care do not allow real choice about a known carer in labour and birth. Although no data are available, women report being restricted in the choices they have within approaches to care and the Review has found no evidence that the system provides flexibility or responds to women.
- Access: Women in 36 rural and remote areas have lost access to birthing services in the last 10 years. Many women in rural communities also have to travel for pregnancy care and education. Aboriginal and Torres Strait Islander women, young women and women in marginalised circumstances or with special or different needs are currently disenfranchised from mainstream pregnancy care, most likely to need care, and least likely to access care.
- Information: Women do not have access to consistent, objective information about pregnancy, birth and post-birth care options or even about pregnancy self-care and nutrition.
- Participation and Respect: Based on submissions and consultations with carers and consumers, the Review has formed a view that the psychosocial aspects of care are not well catered for in many current care environments.
- Continuity: Only one of the three approaches to care available to 99 per cent of women provides continuity (and depends on access to private hospital care). Even continuity in private care will not extend to labour care, with obstetricians only likely to attend for some of the labour and most care provided by midwife strangers.
- Safety: Risk and safety are discussed above. Based on submissions and consultations with carers and consumers, the Review has formed a view that women's subjective experience of safety is not accorded importance in current care environments.

Approaches to Care Elsewhere

The Review has explored approaches to maternity care in other States of Australia. Reviews of maternity services have set in place programs of reform in Victoria and New South Wales, although the pace of change has been slow according to researchers and policy makers in these States. More recently, the Northern Territory has announced extensive changes to its community midwifery program, to better meet the needs of Territory women.

In other States of Australia, women are provided with a wider range of choices that extend to community-based primary care and homebirth care supported by a hospital, although data on uptake of options are not available. Homebirth care from a midwife is a public sector care option for women in Western Australia and South Australia, with plans to extend community midwifery to homebirth care in the Northern Territory.

Access to care in rural and remote communities is a problem in all States of Australia and the Commonwealth Government has a number of educational and workforce programs designed to encourage carers to return to rural and remote communities.

> The Community Midwifery Program in Western Australia offers continuity of pregnancy care with a midwife as primary carer, in homes or in one of four resource centres across Perth. Birth care is offered in hospital or home environments. The program is managed by a community board and funded by the Health Department of Western Australia. The Department has a Homebirth Policy and Guidelines for Management of Risk Factors.

Independent information is provided to women in a number of States, with the Victorian *Having a Baby in Victoria* website (www.health.vic.gov.au/maternity/) particularly accessible with a high level of independent information on a range of care approaches and issues. In New South Wales, a multi-language website gives general information about approaches to care.

A number of submissions to the Review mention maternity care in The Netherlands where homebirth care with a midwife and support person are an integral part of the health system. Midwives provide primary care, with referral to other levels of care as needed. The Netherlands has a highly trained midwifery workforce and a concentrated population over a small area. The system has some interesting features, including the provision in pregnancy care of a support person who acts in a doula role, and provides care for other children, breastfeeding support and home help in the week or weeks following birth.

In Canada which shares similar geographical challenges to Queensland and an Indigenous population at extreme disadvantage, an approach of returning local birthing to Indigenous communities with trained Indigenous midwives has been widely reported. The success of such programs is invariably tied to the extent to which they are owned and managed by Indigenous communities, with adequate training and facilitation from experienced carers where needed.

In New Zealand, a major reform of maternity services led in 1990 to the introduction of a system based on 'lead maternity carers' who can be midwives or medical practitioners. At the outset of pregnancy, a woman identifies a lead maternity carer who is funded by Government. The lead carer provides pregnancy, birth and post-birth care, in the home or hospital environment. More than 70 per cent of women now opt for one-to-one care with a midwife. Data collection has been limited to the last few years and so it is difficult to evaluate outcomes of the New Zealand system. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists has expressed concerns about the New Zealand system in terms of safety.

A 2002 consumer satisfaction survey in New Zealand reiterated findings of earlier surveys that women consider some key aspects of maternity services crucial, including that they can choose a Lead Maternity Carer (LMC) and that this LMC will then ensure that the woman has many choices in the management of her care and involvement in the decision-making.

A Way Ahead for Approaches to Care

Currently other States of Australia and other places in the world are moving towards new approaches to maternity care that recognise pregnancy and birth as whole-of-life experiences, incorporating wellness and psychosocial care needs, valuing continuity, within a framework that appreciates and manages heightened risk.

The Review is recommending ***Maternity 2010*** *as a set of principles and strategies whose implementation will result in approaches to care that meet the needs of women and their families, in public and private sectors, in urban and rural and remote areas, and with special or additional needs.*

The principles incorporate steps that will be needed to achieve integration of care around the experience of women and their families not the needs of care environments and funding bodies. They emphasise local access to care where possible (and in a way that feels local where not) and a focus on the psychosocial dimensions of care. Safety and quality remain paramount.

Implementation of the principles will mean the gradual adoption of new approaches to care that give all women more choice, access and continuity, in a framework of quality and safety, with appropriate processes for risk management.

In the longer term, pregnancy and post-birth care would leave hospital environments and be provided in integrated, community centres or family general practices. Local 'bub-hubs' in existing child health facilities or in new community facilities, in urban areas and in the bush, could bring together teams of hospital carers for pregnancy, birth and post-birth care of women and their families, with other carers who currently provide family and child health care and other agencies relevant to mental health, early parenting, return to work, care for children with special needs etc. In cities, large hospitals could establish a number of community bub-hubs, with birth care provided in the hospital by the same care team that provides pregnancy and post-birth care in the bub-hub. Bush bub-hubs could be part of Rural Clusters of Care that include carers from different towns in a rural or remote community in a formal arrangement that can provide local pregnancy, birth and post-birth care. Schools might be appropriate homes for bush bub-hubs. Across Queensland but particularly in the Cape a close association with the Department of Communities Child Care Hubs would be beneficial. With positive outcomes from a carefully structured and evaluated demonstration project, birth at home as part of an integrated hospital team service might be considered for the few women who might choose it.

Specific principles in ***Maternity Care 2010*** *provide for involvement of consumers in determining their care and of the ways in which care might better cater for women with special or additional needs. A key principle, echoing most contemporary health care policies,*

In 1994 Mareeba Hospital introduced a collaborative approach to maternity care that is flexible and family-focused and that involves midwives as primary carers for pregnancy, birth and post-birth. Of the 220 women who birth at Mareeba each year, 18 per cent identify as Aboriginal or Torres Strait Islander (compared with a Queensland average of 5.8 per cent). The hospital can report high levels of participation in pregnancy care, (a zero no-booking rate for 2003) low analgesia use during labour (most women use water), and a caesarean birth rate of 12 per cent. In the three years to 2003, 589 women had babies at Mareeba, and 70 per cent birthed with primary midwife care.

is that Aboriginal and Islander peoples determine Aboriginal and Islander maternity care.

Carers of Women and Families

The Review's brief to '…examine models of care particularly midwifery models of care in order to recommend strategies to enhance choices for women…' makes the nature of care and the carers of women and babies an inevitable subject for discussion. The Review can point to the current disjunction between what consumers want and need and what care provides. It can point to the barriers that need to be overcome in order to make changes that will help. It can suggest training and retention programs to help carers. But it is the carers themselves who will carry through the recommendations of this Review or not, regardless of Government's response. It is carers who decide approaches to care. And for each woman and her baby, it is one carer at every step in the care relationship who will continue to decide how care is provided.

The Review's initial call for submissions elicited responses from most of the key professional bodies and organisations involved in maternity care as well as from support organisations. Individual carers also made submissions. In addition to the submissions received, the Review has met personally with hundreds of individual carers and with professional organisations and support groups everywhere it has visited, in Queensland and in other States. A summary of carer issues raised in submissions and consultations is included as Appendix 9.

In its short life, the Review has encountered many individual carers from a range of professional and discipline backgrounds who make a major contribution to care and its ongoing review. They have dedicated their lives to the care of or education or research about the care of women and babies and their efforts need to be acknowledged.

A number of key carers are involved in pregnancy, birth and post-birth care, including midwives, obstetricians, general practitioners and Aboriginal and Torres Strait Islander health workers. Details on the roles of carers are described in Appendix 10.

There are a number of issues impacting on carers at the present time and a number of separate issues that arise with the prospect of change in maternity care. Any changes need to be made in a context that understands midwives and obstetricians and GPs and health workers are people, with aspirations, desires, fears and needs that all contribute to their capacity and willingness to change.

Current Workplace Tensions

This Report echoes many preceding reports on maternity care in Queensland in demonstrating the need to change the way maternity services are planned and delivered. There are probably many reasons why changes recommended in previous reviews have not been widely implemented but chief among them is the resistance that characterises care environments and the conflict over what changes are desirable. The foundations of these tensions, the different cultures of care at work in maternity services, are discussed earlier in the Report.

Like many areas of health care, maternity care operates in multiprofessional environments. Skills, knowledges and cultures are different among different professional groups involved in care. This can be an extremely positive quality in any field of work as different individuals are able to play different roles and contribute to the whole experience of care. In a genuinely multidisciplinary approach, differences can be celebrated and honoured to everyone's benefit and there are examples of this in maternity services in Queensland. Where this is not appropriate or possible, a team approach can function adequately, as long as there is a framework of mutual respect and clear statements about roles and responsibilities. In some care environments in Queensland, this happens but in others it does not.

> In the Corangamite Shire in South West Victoria, local medical, midwifery and health administrators and University academics have joined forces in a State-funded pilot project to develop a Managed Clinical Network that will provide maternity services to the region. The network means birthing will remain in home territory for families, and carers can provide a safe, sustainable, high quality service.

The two cultures at work in the design and delivery of maternity care – the organics and mechanics – are at odds in many current care environments. It seems from the outside that individuals who are firmly entrenched in either culture do not understand the other and make little effort to do so. From their perspective mechanics tend to see the organic way of doing things as underestimating risk. They might conclude, for example, that midwifery-led care could compromise the physical safety of the baby for a mother's experience of birth. Organics for their part cannot understand why mechanics want to intervene in birth proactively and when nothing is wrong, because they have confidence that the natural process of birth will continue.

There is evidence in practice in Queensland and elsewhere in Australia that carers can learn to understand

'There are only 2 GPs in Kingaroy who deliver babies. The Med Super at the Kingaroy Public Hospital delivers most of the babies (in the South Burnettt) and has just had his first holiday in 3 years. He is very popular… What concerns me most is that if the 2 doctors currently delivering babies cease, many mothers will have to go out of town.'

each other's thinking, develop mutual respect and work together extremely effectively for the benefit of consumers. Interestingly this co-operative and understanding spirit is close to the norm in small rural and remote care situations.

Queensland Health supports models of care based on best practice principles that 'involve collaborative processes which recognise the complementary and specialist skills of the available health providers, rather than a focus on the health providers.' The Department's submission to the Review notes that while secondary and tertiary carers (obstetricians or general practitioners) deliver primary care, '…other primary caregivers (midwives, Indigenous health workers) are also placed to deliver aspects of care, such as parent education, support in early labour, breastfeeding support, counselling re birth outcomes and expectations, and routine clinical care within their scope of practice.'

In many current care environments in the public sector, responsibilities among various professionals are not clearly delineated and this is exacerbating tension. In particular, the delineation of roles and responsibilities between doctors and midwives is unclear in some clinical situations. According to Queensland Health, in public hospital traditional care, most pregnancy care is provided by obstetricians, registrars or residents in antenatal clinics. In shared care, most pregnancy care is provided by GPs, with care shifting to a hospital clinic when the pregnancy reaches 36 weeks. In the public sector, birth care will be provided by a midwife unless complications arise in which case a medical officer will attend.

In all public hospitals, however, even if a midwife provides care, the ultimate responsibility resides with the admitting obstetrician. This extends to birth centres. Even if a midwife provides almost all pregnancy care, birth care and post-birth care in a birth centre, a doctor will still be named in hospital records as the responsible officer for care. Such unclear role delineation sits uncomfortably for both doctor and midwife and needs to be resolved as a matter of priority.

The professional silos that characterise hospitals and workforce organisations seem also to characterise our universities and professional colleges so that while medical and obstetric education and training have the rhetoric of teamwork and cooperation, they are in the context of medicine. Similarly, nursing and midwifery work with nursing and midwifery. Midwifery students train with medical students in hospitals only accidentally and Schools of Nursing and Midwifery can have little to do with Schools of Medicine even within individual faculties of universities. How can we expect our new carers to work together when even the places they learn from cannot do so? Encouragingly the Review has heard that in many places ongoing skills development programs are attended by midwives and obstetric registrars together and that many carers in many places of care would want to extend this process to other learning situations.

Key Workforce Issues

A number of key workforce issues identified by the Review and supported in submissions from professional organisations and individuals will require action in order to implement the recommendations of this Report.

- There are chronic shortages of GP obstetricians and midwives to work in rural and remote areas, along with limited incentives and training and development opportunities for those who do and few retraining opportunities for those who might wish to return to this work. This situation must be addressed, especially if maternity services are to come back to life in rural and remote communities.
- Queensland Health's Strategic Plan includes *Healthier Staff* as one of its five strategic intents. The Review has met with and heard from many carers over the course of its consultations who feel overworked and undervalued in a large system that provides them no flexibility and that they do not experience as caring for them. It is important that carers learn and employ skills in self-care and that workplaces support them.

- Professional indemnity has been an issue of increasing importance over the last decade and it reached crisis point in 2000/2001. Specialist and GP obstetricians experienced significant increases in premiums and many ceased obstetric practice. More recently, tort law reform has led to fewer claims and the Commonwealth Government has put in place several effective rescue programs. Queensland Health has provided indemnity support for doctors providing maternity services in rural practice which has been welcomed by practitioners. Thus in the current situation this particular pressure on obstetric practice has been reduced however it is a potentially volatile area and will need to be carefully monitored for ongoing effects on care.
- While the most recent national review of midwifery workforce planning notes that lack of data makes predictions unreliable, professional and regulatory bodies report current and likely shortages in the midwifery workforce unless there is an influx of young people into the profession. The profession is aging, with 80 per cent of midwives licensed to practise in Queensland 40 or over and many midwives leaving practice.
- The midwifery profession believes it lacks a strong, independent voice in decision-making about approaches to care and even about its own future direction (Midwifery is regulated under the *Nursing Act* in Queensland). Individual midwives feel they are accorded little professional respect, provided with limited career pathways and have low levels of work satisfaction. Reversing the devaluing of the profession of midwifery and encouraging recruitment and retention are important, and will be vital to any changes in approach to care that strengthen the role played by midwives.
- Currently in Queensland, midwifery education programs are only open to registered nurses and as postgraduate courses are not eligible for HECS support. Potential students who can work as nurses indicate they are not willing to pay fees and forego salary for the course duration and only a few courses offer paid part-time clinical placement with the course. When midwifery was a hospital diploma, there were up to 300 graduates a year. Currently, there are around 90 graduates a year from the six universities.
- Many midwives working in the current maternity care system have specialised in just one of the three areas across the continuum of care (pregnancy, labour and birth or post-birth care) and might wish to work across the continuum if more approaches were available. Many others have left midwifery and may wish to return. Those who wish to train in new roles or reskill need to be provided with refresher or retraining programs appropriate to needs.
- There are likely problems with future provision of obstetric services which have been recognised in the latest national workforce review. In Queensland, contributing factors include the aging obstetric workforce, difficulties in attracting trainees, unusually high attrition among current trainees, high attrition from obstetric practice (retirement or ceasing obstetric practice for lifestyle/indemnity concerns), and the impact of a higher number of female trainees.
- GP roles in maternity services have changed, with fewer GP obstetricians providing birthing services and an increasing number of GPs involved in shared care arrangements with hospitals. Continuing education and training may be needed for non-obstetrician GPs who become involved in pregnancy and post-birth care. There are also issues, reported by GPs, relating to the interface between GP and hospital. Timely reporting, shared systems and a seamless integration for the consumer are needed.
- Aboriginal and Torres Strait Islander Health Services report shortages in the number of health workers trained to assist in pregnancy and post-birth care. Advice from education providers is that student recruitment programs into midwifery and medicine have produced very few Indigenous graduates (or current students). If Government accepts the Review's recommendations for Aboriginal and Torres Strait Islander maternity services, a dedicated strategy to encourage, recruit and train Aboriginal and Torres Strait Islander health workers, midwives and doctors will be a priority.
- Organisations and individuals have raised the need for training for emergencies (preferably joint training) for all carers, including neonatal resuscitation and the Advanced Life Support in Obstetrics (ALSO) program.

Changing Roles for Carers

Maternity carers are preparing for change. Many who have written to or met with the Review either want or recognise the need for change in the way care is provided across the State. Every professional organisation which has made a submission to the Review would support the view that maternity care as it stands is not meeting the needs of Aboriginal and Torres Strait Islander women. All professional bodies support care that is more women-centred. All professional bodies believe that choice and access are important.

At the same time, many individual carers who have written to or met with the Review are feeling bruised in the current climate of maternity care. Change is frightening for some who respond with a flight or fight response. Change is not happening quickly enough for others. Change is never going to be welcomed by a few. Midwifery in particular is a profession in transition, and in some ways a profession under siege.

The obstetric workforce in Queensland and Australia is currently under great pressure. National reviews and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists report major problems in the future provision of obstetric services throughout Australia. In Queensland, the College has taken steps to encourage students to enter obstetrics

'I have witnessed inappropriate swearing, yelling and threats to refuse care by a medical officer… when women do not comply with the request. This would intimidate me into complying as I would be scared the care would be compromised if I did not…'

but attrition from the profession and from training remains a problem.

The Review has met with many individual GP and specialist obstetricians in hospitals in Queensland who are under pressure at work. In many care environments, particularly in rural and remote areas, there are too few doctors for the work required of them. In addition to providing care for women with high-risk pregnancy, obstetricians are providing routine pregnancy care, some labour and birth care and post-birth care to women across the spectrum of care needs.

Obstetricians are a precious human resource, with initial training over 12 years and ongoing professional training. It is crucial that they continue to be available to care for those who need them.

The Review has been asked to recommend specifically on midwifery-led care and its potential to enhance choices for women. There are a number of obstacles which would need to be overcome before midwives could assume primary carer roles across pregnancy, birth and post-birth care in Queensland. They are not insignificant.

According to education providers and the Australian College of Midwives Inc., graduates from university postgraduate midwifery programs are fit for beginning practice as primary care providers across the continuum of care for low-risk pregnancy, birth and post-birth environments and through their knowledge of pregnancy are able to recognise the need for referral to secondary or tertiary levels of care. But there are currently few care environments in which beginning midwives can use and hone their skills and gain the clinical experience needed to become experienced practitioners. There are few senior clinicians in the existing workforce who are in a position to mentor these beginning practitioners. In the current workforce, most midwives in large hospitals work in one or two areas of pregnancy, labour and birth or post-birth care. Few midwives work across the continuum of care.

The Australian College of Midwives Inc. is working with education providers and the Queensland Nursing Council on a direct-entry midwifery program which they believe will be more appropriate for practice and attractive to potential students. The direct-entry program will provide more clinical experience but beginning midwives will still need mentoring in approaches to care for which they have been trained. Direct-entry trained midwives will not be able to fill nursing roles and arrangements will need to be made for those who might also wish to specialise in other areas of care such as child health care.

Currently, there are Award restrictions which prevent midwives from working in a caseload model but increasingly annualised salaries are being accepted across Australia.

The Queensland Nursing Council which authorises midwives to practise in the State has advised that current annual licence renewal does not include any specific requirement to have practised in midwifery in order to be endorsed as a midwife. While there are over 10,000 endorsed midwives licensed to practise in Queensland, only a quarter are currently practising midwifery. The Council is currently considering continuing competence for practice standards which might also apply to endorsements such as midwifery (which will further reduce available workforce).

The Australian Nursing and Midwifery Council is working with other organisations including the Australian College of Midwives Inc. to research the role and scope of practice of midwives in order to develop national competency standards for midwifery. This will provide a generic description for midwives on entry to practice, validated national competency standards for midwives, and a strategy and tools for the evaluation and review of the role and standards for midwives.

Advice from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists is that if midwives are to effectively provide primary care we need to train more midwives and ensure their training covers all the skills they require to provide primary care, upskill midwives in antenatal and postnatal care and develop an ongoing program of professional development, encourage midwives and provide incentives (family-friendly shifts) for them to stay in the workforce, and develop and agree guidelines for transfer of care between midwives and obstetricians.

There has been resistance among some obstetricians to a change in role for midwives, mostly focusing on the need to ensure safety and effective management of risk. Interestingly, in some other countries, leadership on the journey to a primary care model with the option of a midwife as carer has been provided by the obstetricians themselves. In Canada, for instance, where Government has embarked on an $800 million primary care based transformation of the health system, the Society of Obstetricians and Gynaecologists in at least one Province is working with midwives in the development and implementation of models of collaborative care that involve midwives as primary carers for well women.

Safety and risk management are discussed in other sections of the Report. The Australian College of Midwives Inc. has developed its 2004 *National Midwifery Guidelines for Consultation and Referral.* The guidelines are currently being considered nationally by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists which has stressed in its submission to the Review the need to develop for Australia jointly with midwives a minimum standards document for maternity services. These issues are dealt with in recommended principles and their implementation for carer teams.

In any change process, the existing workforce must be accommodated. Many practising midwives have been trained and have worked in a system in which their role is that of obstetric nurse and some will be comfortable remaining in this role.

For those midwives who do want to work differently, provision must be made for reskilling and retraining so that they can meet the needs of care across pregnancy, birth and post-birth experiences. Retraining must extend to those midwives who have 'retired' from the midwifery workforce and wish to return. There are currently no means by which these practitioners can rejoin the workforce.

Change processes also need provide encouraging and appropriate facilitation so that carers who do want to change can do so. Queensland Health's Clinical Practice Improvement Centre has a potential role in working with willing carers to bring about change through its Collaboratives for Healthcare Improvement which provide a model of working together to improve patient care by sharing resources and learning in order to resolve local issues.

The role of the Australian College of Midwives Inc. is developing nationally and in Queensland. The Review of Maternity Services would strongly urge all players to help midwifery establish an appropriate professional body that will provide standards for clinical practice, continuing professional education and credentialing across various levels of midwifery care.

Education providers will have to graduate more midwives who can meet community needs and focus dedicated attention on attracting Indigenous midwifery, medical and obstetric students and students who will work after graduation in rural and remote areas of Queensland. An advanced clinical course in midwifery might enable experienced practitioners to assume positions of leadership in the profession, working with other carers including obstetricians to develop clinical programs, act in supervisory positions and as clinical mentors for less experienced colleagues. All providers should be working together to prepare carers who can work together. All carer courses should include communication skills which are so important to care.

> The St George Outreach Maternity Project (StOMP) in Sydney offers continuity of care and provides pregnancy and post-birth care in the community. Antenatal clinics are run through early childhood centres by two midwives and an obstetrician or registrar. At the St George Birth Centre, a group practice/ caseload model (Tango) approach means that each woman has a known midwife providing most of her pregnancy, birth and post-birth care.

Dimensions of Care and Roles of Carers

As discussed in an earlier section of the Report, in many instances maternity services in Queensland are not catering for the psychosocial aspects of care. In many environments these aspects of care are not considered part of essential care but are regarded as an additional extra and not included in descriptions of carer roles and responsibilities.

Many submissions to the Review express a view that midwives are able to provide the psychosocial dimensions of care which are not well accommodated in the current care system. While this may

be so, over time, it may be that the role of midwives as primary carers for well women in pregnancy reduces the availability of midwives to spend the time and effort needed to ensure these aspects of care are accommodated.

In some care environments and in other parts of the world, paraprofessional support people, often called doulas, provide emotional and physical support to women in labour and birth, sometimes extending to a support role through pregnancy and assistance with post-birth care. Some doulas undergo training, although there is no formal accreditation or regulation of the profession in Australia. The role of doulas should not be confused with the roles of nurses or midwives. Doulas come with the birthing woman and are not part of the hospital system. In some Aboriginal and Torres Strait Islander communities, traditional birth attendants continue to work in a doula role to support Aboriginal and Torres Strait Islander health workers. Doulas are a potentially useful workforce in dedicated facilities either as volunteers or paid workers.

Women cared for by specialist obstetricians in private care could be provided with additional support across the non-physical dimensions of care either by a midwife or a paraprofessional doula or similar. Such support could be provided across primary, secondary and tertiary levels of care and would be particularly valuable in the care of women with identified risk factors and with special needs. Medicare item numbers would need to be modified to make this achievable in private group obstetric practice. Negotiations with private health funds would have to occur to provide for more flexible arrangements for pregnancy and post birth care.

Different models and approaches need to be explored to meet the needs of women and maintain safety and quality in care.

Communication skills among carers have been raised directly and indirectly in many of the Review's consultations and submissions. Poor communication is a major contributor to dissatisfaction among women and their families about care. It is the key contributor to legal actions arising from care. It has also been raised as an issue by staff in recent Queensland Health studies of maternity care. The development and enhancement of communication skills for all carers should be an integral part of the framework of training for student and working carers.

A Way Ahead for Carers

Maternity 2010 will have impacts on carer roles. Government will need to take steps to ensure appropriate bodies are:

- *Valuing and rewarding the carers who continue to provide maternity services, respecting the professional knowledge and contribution carers bring to their work and providing adequate staffing so that the system does not inadvertently take advantage of its most dedicated members who, in some environments, are overworked to the point of fatigue in trying to provide quality care*
- *Recognising the special role of GP obstetricians in rural and remote communities, including offering a specific consultant title to Visiting Medical Officers in appropriate circumstances (to be negotiated with the Rural Doctors Association of Queensland and the Australian College of Rural and Remote Medicine)*
- *Supporting recognition of rural doctors (including GP obstetricians) as a group having special skills which require specific training and regular upskilling and that the training for this work could be provided in a variety of ways including crossover with other specialty training programs*
- *Offering appropriate incentives to attract and retain GP obstetricians in rural and remote communities which complement Commonwealth initiatives in this area (through, for example, support for administrative work, backfilling of vacancies, encouraging supervision of less experienced GPs by providing time for supervision to more experienced GPs, encouraging relevant colleges to recognise rural placements with accredited GP*

'My widwife, J Bayles, was great. I felt awkward at first but she soon calmed me and had me on a birthing ball. She kept saying supportive words . I felt very strong with her support.

obstetrician 'teachers', providing respite time for professional development in flexible packages eg. 6 weeks every five years in addition to 1 week every year to provide upskilling and reflective practice development, and/or exchange programs between small units and larger non-tertiary hospitals to transfer skills, knowledge and learning both ways)

- *Working with the Rural Doctors Association of Queensland to consider alternative remuneration arrangements including fee for service*
- *Supporting more continuing educational opportunities to be incorporated into shared care programs that will ensure that GPs who participate are appropriately trained and skilled to provide optimal and integrated pregnancy and post-birth care*
- *Offering appropriate incentives to attract and retain midwives in rural and remote communities (through, for example, backfilling of vacancies, encouraging supervision of less experienced midwives by providing time for supervision to more experienced midwives, providing respite time for professional development to provide upskilling and reflective practice development, and/or exchange programs between small units and larger non-tertiary hospitals to transfer skills, knowledge and learning both ways)*
- *Providing more flexibility for the midwifery workforce to allow flexible working hours or even caseload arrangements, particularly for midwives working in rural settings, and annualised salaries (pro rata) that will allow those midwives who wish to focus their careers on midwifery to do so*
- *Establishing formal Rural Clusters of Care (obstetrics, midwifery, anaesthetics and newborn baby care) that provide essential clinical skills and experience across the cluster, back-up and clinical care support, with regular combined clinical audits and professional meetings so that carers learn together and together support their communities*
- *Supporting the midwifery profession in its ongoing development, including registration of midwives based on recency of practice, involvement in continuing professional education and demonstrated core competencies. Just as the medical colleges administer and control registration and continuing education requirements for doctors it would seem appropriate for the Australian College of Midwives Inc. to provide these services for midwives, at an appropriate time in the future*
- *Supporting regulation of the midwifery profession as an independent profession in the most appropriate way (under its current head of power or a separate Act)*
- *Provision for recognition of senior clinical experience in midwifery, based on experience and additional clinical training, which will contribute to leadership of the profession and a more equal professional relationship with senior obstetricians*
- *Providing resources for continuing professional education and upskilling programs for all carers, through (preferably multidisciplinary) programs in neonatal resuscitation, the Advanced Life Support in Obstetrics program and tailored programs in the Clinical Skills Improvement Centre (including upskilling programs for midwives and GP obstetricians moving into new roles)*
- *Providing training and education opportunities for traditional birth attendants and Indigenous health workers to train as midwives, with appropriate (and if necessary, alternative) educational pathways to midwifery practice*
- *Supporting education providers who are seeking to introduce multiple pathways for midwifery education, for example, direct-entry undergraduate programs leading to registration as a midwife*
- *Supporting and encouraging education providers in their efforts to recruit Indigenous students into courses (medicine, obstetrics, nursing and midwifery) and to prepare Indigenous health workers who can provide maternity care in communities*
- *Supporting and encouraging education providers in their efforts to recruit students who will work in rural and remote communities after graduation*
- *Supporting and encouraging education providers in their efforts to produce graduates with adequate communication skills who can work collaboratively to provide care.*

Care Environments

Physical Spaces for Care

Currently in Queensland 20 private hospitals and 48 public hospitals provide some maternity services.

There are two birth centres in the State, one within a hospital (Royal Brisbane and Women's Hospital) and one in a house on hospital grounds (Mackay). Detailed planning is currently underway for a third birth centre to be opened at the Gold Coast Hospital (election promise 2004).

In submissions to the Review, carers and consumers raise issues relating to the physical space in which care is provided. In a presentation at the Review's Forum on Maternity Care, Townsville Mums and Babies Senior Medical Officer Katie Panaretto pointed out that separating well mothers and babies from the sick was an important factor in the program's success. According to Panaretto, the focus of the main Health Service will invariably be on treating sickness and injury which does not mesh well with the Mums and Babies Program's focus on building connections and families. The separate space also provided opportunities for families to network and for carers to network as they were all coming to the one physical location.

Birthing spaces are of key importance to women and the freedom and calm atmosphere of small hospitals and home environments are mentioned repeatedly in submissions from consumers.

The Review's consultations suggest the physical environments in which maternity care is currently provided are developed with little reference to families and their needs. Consumers may not be involved in space planning. Decisions have been made as recently as during the construction of the new Townsville Hospital in 2000 to locate the birth suite adjacent to the

Table 1. Public and Private Maternity Hospitals and Birthing Centres in Queensland 2005

Public	Private
Atherton Hospital	Allamanda Private Hospital, Southport
Ayr Hospital	Cairns Private Hospital
Biloela Hospital	Friendly Society Private Hospital, Bundaberg
Bundaberg Base Hospital	John Flynn – Gold Coast Private Hospital
Caboolture Hospital	Mater Misericordiae Hospital, Mackay
Cairns Base Hospital	Mater Misericordiae Hospital, Rockhampton
Charleville Hospital	Mater Misericordiae Hospital, Gladstone
Charters Towers Hospital	Mater Misericordiae Hospital, Townsville
Chinchilla Hospital	Mater Misericordiae Women's Private Hospital, Brisbane
Cunnamulla Hospital	Mater Private Hospital, Redland
Dalby Hospital	Nambour Selangor Private Hospital
Dysart Hospital	North West Brisbane Private Hospital
Emerald Hospital	Pindara – Gold Coast Private Hospital
Gladstone Hospital	St Andrew's – Ipswich Private Hospital
Gold Coast Hospital	St Stephen's Private Hospital, Maryborough
Goondiwindi Hospital	St Vincent's Hospital, Toowoomba
Gympie Hospital	Sunnybank Private Hospital
Hervey Bay Hospital	The Sunshine Coast Private Hospital, Buderim
Innisfail Hospital	The Wesley Hospital, Brisbane
Ipswich Hospital	The Wesley Hospital, Townsville
Kingaroy Hospital	
Logan Hospital	
Longreach Hospital	
Mackay Base Hospital	
Mackay Base Hospital Birth Centre	
Mareeba District Hospital	
Mater Mothers Hospital	
Miles Hospital	
Monto Hospital	
Moranbah Hospital	
Mount Isa Base Hospital	
Nambour General Hospital	
Proserpine Hospital	
Redcliffe Hospital	
Redland Hospital	
Rockhampton Base Hospital	
Roma Hospital	
Royal Brisbane & Women's Hospital	
Royal Women's Hospital Birth Centre	
Springsure Hospital	
St George Hospital	
Stanthorpe Hospital	
Theodore Hospital	
Thursday Island Hospital	
Toowoomba Hospital	
Townsville Hospital	
Tully Hospital	
Warwick Hospital	

'I was taken to a labour room and was confronted with harshness, metal, loud blaring radio of Country n' Western, strangers, hospital smell, hard surfaces, bright lights, machines and boxes of plastic gloves.'

operating theatre on the second floor of one building, with the neonatal intensive care unit understandably adjacent to the birth suite. But the maternity unit was located on the ground floor of another building. This means women must walk along one corridor, take a lift two floors up, and walk 50 metres along another corridor to see their babies. This is even more problematic for women who have had a caesarean birth. In Rockhampton, a recent refurbishment created a facility with no space for families to wait or private space to meet, and no place to counsel and advise in private.

A way ahead for physical spaces

Consumers need to be involved in decisions about their care, including the physical places in which care is provided.

The Review is recommending a gradual transition to community-based centres or bub-hubs for pregnancy and post-birth care, with hospital midwives and doctors working in teams in each centre.

Bub-hubs might well be based in upgraded community child health facilities but their design and development would have input from local consumers.

Care in Tertiary Hospitals

Queensland has three hospitals which are expected to deliver the international standards of tertiary care needed for women with certain risk factors during pregnancy, birth or post-birth. These hospitals also care for ill newborn babies from around the State and accept transfers of women and babies at any time they are necessary. This is a major responsibility for the three tertiary hospitals, requiring extensive highly skilled human and other resources. These hospitals are the only places in Queensland which are able to provide this level of care.

Both of the Brisbane tertiary hospitals are also expected to deliver a high-quality, high-throughput (unlimited in the case of the Royal Brisbane and Women's Hospital) service to women with low-risk pregnancies. In 2002 there were 1,237 low-risk births at the Royal Brisbane and Women's Hospital and 1,600 at the Mater Mothers Hospital.

These are two very different tasks that often require different kinds of care, different levels of technology and a different skill base in carers. There is no reason one hospital cannot provide both levels of care, so long as resources are adequate and appropriately deployed. Clearly the system will work most efficiently if the most technologically skilled individuals focus on the care of women and babies at high risk and the less technologically skilled focus on the care of women and babies without the risk factors associated with tertiary care. Efficient transfer and referral processes from one to another should be in place, ideally mirroring those for transfer from a more distant primary or secondary care facility to tertiary care. However, when such large specialist institutions attempt to provide everything to everyone all the time something has to give especially when resources are constrained from the outset.

There are a number of undesirable consequences of mixing levels of care in the current maternity care system. With resources stretched to the maximum, staff will be working under high levels of pressure all the time, in order to continue meeting the needs of those in tertiary care. The constancy of such pressures over time is likely to create a service where bare essentials are provided and where staff are so stressed that they are unable to continue to give and where issues and problems which in any other setting would be dealt with easily become impassable mountains.

A way ahead for care in tertiary hospitals

The strategies underpinning the goals of simultaneously providing unlimited primary care and the best in the world tertiary care need to be reviewed with a view to providing adequate human and financial resources, and appropriate physical and organisational arrangements to reduce loads to manageable size so that care for neither group is compromised in seeking the optimal goals for the other.

Care Outcomes for Women and Families

In the absence of an overall strategic framework for maternity care in Queensland, the Review cannot make judgements about outcomes as there are few specific goals or objectives to measure performance against other than deaths in mothers and babies. These are vitally important, crude measures of outcome in maternity care but they are not the only outcomes.

Death rates among women and newborn babies in Queensland and Australia have been decreasing over a long period of time, to the point where nowadays we have an expectation that pregnancy will almost always have an outcome of a healthy mother and healthy child. The assumption that care will always have a positive outcome combined with the lack of an overall strategic direction for maternity care means that care environments tend to focus on aspects of care which see this as the only important outcome.

There are other outcomes of maternity experiences including the number of vacuum/forceps-assisted births and caesarean births and their effects on health, the incidence of postnatal depression and breastfeeding rates and the long term health effects of maternity care on mothers and babies.

There is a need for a more holistic approach to data collection in maternity care and its outcomes based on an understanding of the context of child growth and development and its relationship with pregnancy and very early life experience. Outcomes which could assist in understanding causality for problems occurring in growth and development of the child in the first year would be invaluable in promoting safer and healthier children and families.

Consumer submissions to the Review suggest that outcomes should include access to care especially for rural and remote women, choice, information, the degree of continuity in care, participation in care, respect from carers and safety in its broadest sense. These are not easy aspects of care to measure.

Figure 6. Maternal Deaths in Queensland 1911-2001

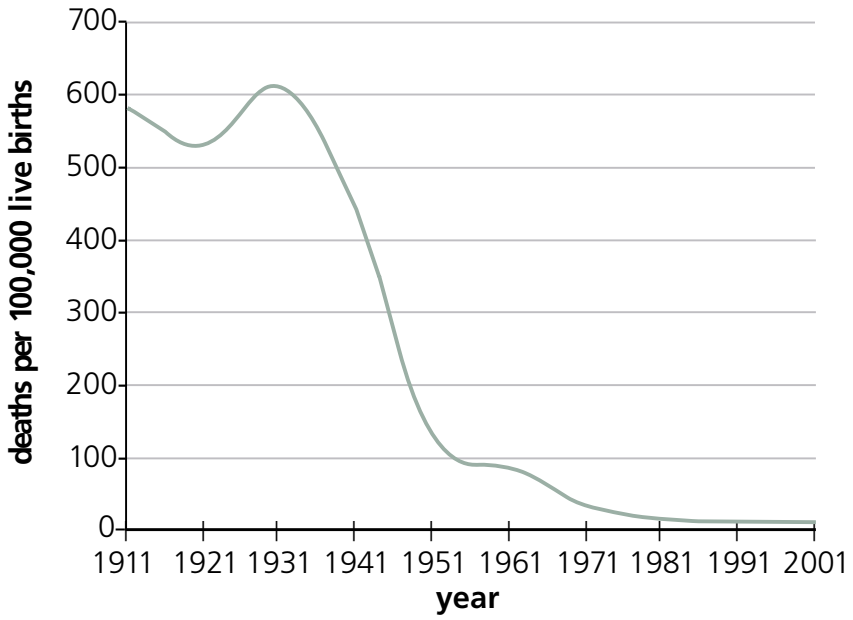
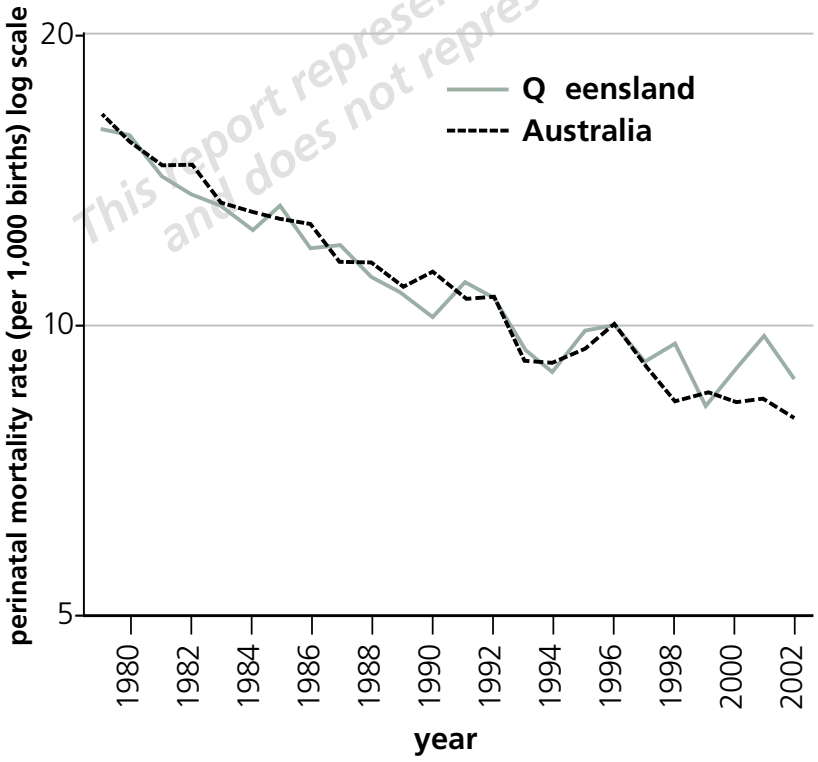


Figure 7. National Newborn Baby Deaths 1979-2001



[14] Only includes deaths directly or indirectly related to pregnancy and birth.

[15] Deaths among liveborn babies in the first year. Records of infant deaths have been kept for over a century.

[16] In Australia, the newborn baby death rate or 'perinatal mortality' rate includes stillbirths of >400g/20 weeks gestation and liveborn babies who die in the first 28 days of life, expressed as deaths per 1000 births. Records of perinatal mortality have only been kept for the last four decades.

[17] International comparisons are gene rally based on a perinatal mortality rate which includes stillbirths of >400g/20 weeks gestation and liveborn babies who die in the first 7 days of life, expressed as deaths per 1000 births.

Some of these outcomes may or may not relate directly to maternity care experiences. Data on some are not currently collected. However, they are no less important and the Review has used available data and consumer views in an attempt to construct a meaningful picture. But the picture remains incomplete.

Deaths among women having babies are rare in Queensland and Australia. Figure 6 shows that since 1911 when accurate records were first kept, maternal deaths[14] in Queensland have declined from 600 per 100,000 births to less than 10 per 100,000 births (one in 166 to one in 10,000 women).

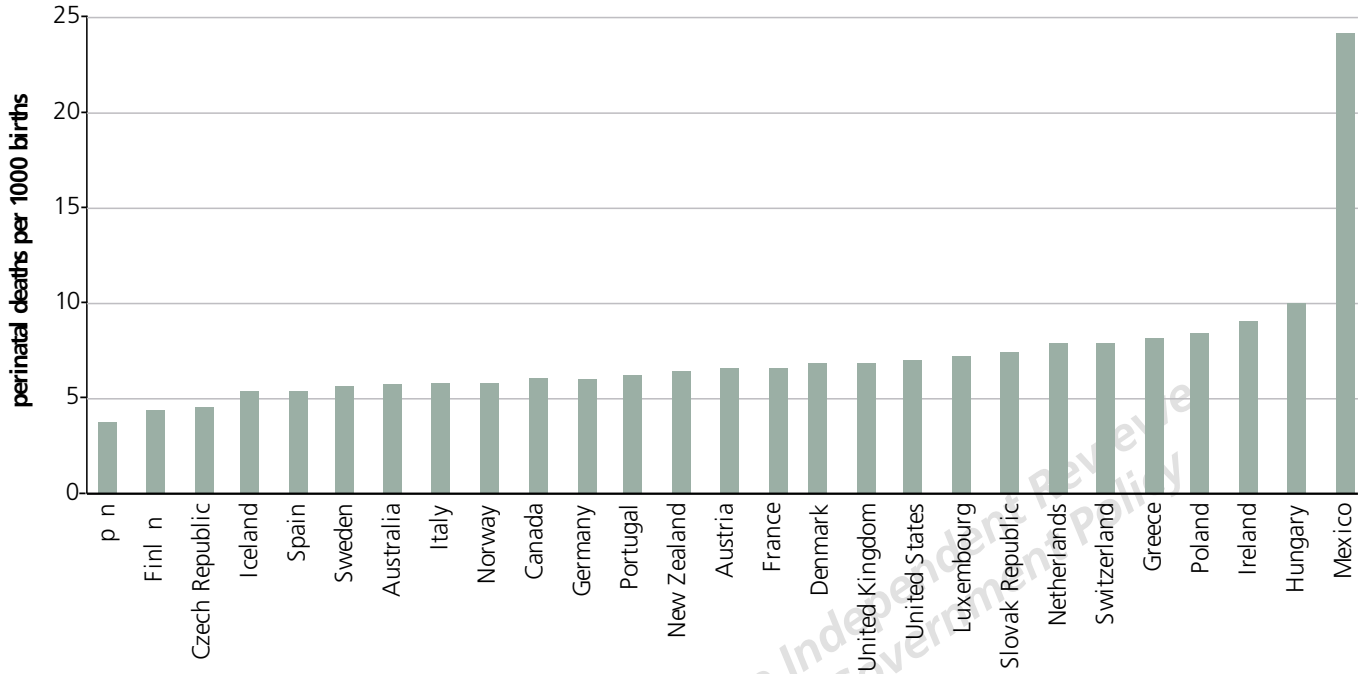
Deaths among babies in Queensland and Australia are also rare. Records show that infant deaths[15] declined from 100 per thousand live births in 1902 to 5.8 per thousand in 2002. Figure 7 shows that newborn baby deaths[16] halved in the period 1979 to 2002 in Queensland from 16.06 per 1000 to 8.8 per 1000 births. This is consistent with national trends.

While improvements in maternity care have been a contributing factor in reducing newborn baby death rates during the last century there is now uncertainty as to how much further changes in obstetric care can further reduce baby deaths. Some experts believe that a peak has been reached and that the downward curve in newborn baby death rates is flattening despite further advances in obstetric procedures and technological developments (Wagner 2000, Bewley 2002).

Figure 8 shows Australia's newborn baby deaths relative to other OECD countries for the year 2000[17]. Australia's rate of newborn baby death is lower than the rate in many other developed countries.

Birth outcomes for babies of **Aboriginal and Torres Strait Islander** women are discussed earlier in the Report. Babies of Aboriginal and Torres Strait Islander women are twice as likely to die as babies of non-Indigenous women and this has

Figure 8. International Newborn Baby Deaths 2000[18]



been included in the Review's priorities for reform discussed earlier in the Report.

The issue of relocation for late pregnancy and birth that is the reality for an increasing number of **women who live in rural and remote areas** is another key issue for reform discussed earlier in the Report.

Other health effects of maternity care on mothers and babies are not systematically monitored. In relation to maternal outcomes, the Perinatal and Maternal Quality Council has been unable even to agree on what health effects might reasonably be analysed. Perinatal data are collected on maternal health in pregnancy and newborn baby health immediately following birth, but work is needed to relate these factors back to the experience of maternity care. Work is also needed to relate these factors forward to later health challenges that might result from pregnancy and birth experiences. In this and many other areas, suitable outcome indicators need to be developed to provide more sensitive measures to assess the quality of maternity services and improve the ongoing health of families.

Caesarean birth rates are increasing nationally and in Queensland. Perinatal data show that 29.5 per cent of all births in Queensland were caesarean births in 2002, compared with 27 per cent nationally. Queensland's rate of caesarean births was second only to South Australia in 2002.

The World Health Organisation has suggested that caesarean birth rates should lie between 5 and 15 per cent of births – 10 per cent for general populations and 15 per cent for high risk populations. This rate was originally struck in 1985 based on a comprehensive study of the risks and benefits that took into account the fact that at that time there was no evidence that caesarean birth rates above these levels generated a further reduction in newborn baby deaths.

Many developed countries now have rates higher than the WHO recommended rate. A 1999 Senate Community Affairs References Committee inquiry into childbirth procedures condemned the then national Australian caesarean rate of 21 per cent as too high (Commonwealth of Australia 1999). The National Health and Medical Research Council, in its 1996 *Options for Effective Care in Childbirth*, saw an urgent need to change the culture of obstetric services so that the benefits and hazards of caesarean births could be properly evaluated (NHMRC 1996).

Concern over current caesarean rates has been expressed by almost everyone to whom the Review has spoken but few experts are confident about suggesting a rate which might be considered appropriate for today's social and ethical environment and opinion varies widely.

Currently in Queensland, there are wide variations in clinical practice for caesarean births between sectors and among individual hospitals.

Figure 9 shows trends over time. In the 14 years to 2003, caesarean birth rates increased by 59 per cent in public hospitals and by 75 per cent in private hospitals.

Figure 10 shows caesarean birth rates among women with low-risk pregnancies in individual private and public hospitals in Queensland in 2002.

[18] Copyright OECD Health Data 2004

Figure 9. Caesarean Births in Public and Private Hospital Sectors in Queensland 1990-2003

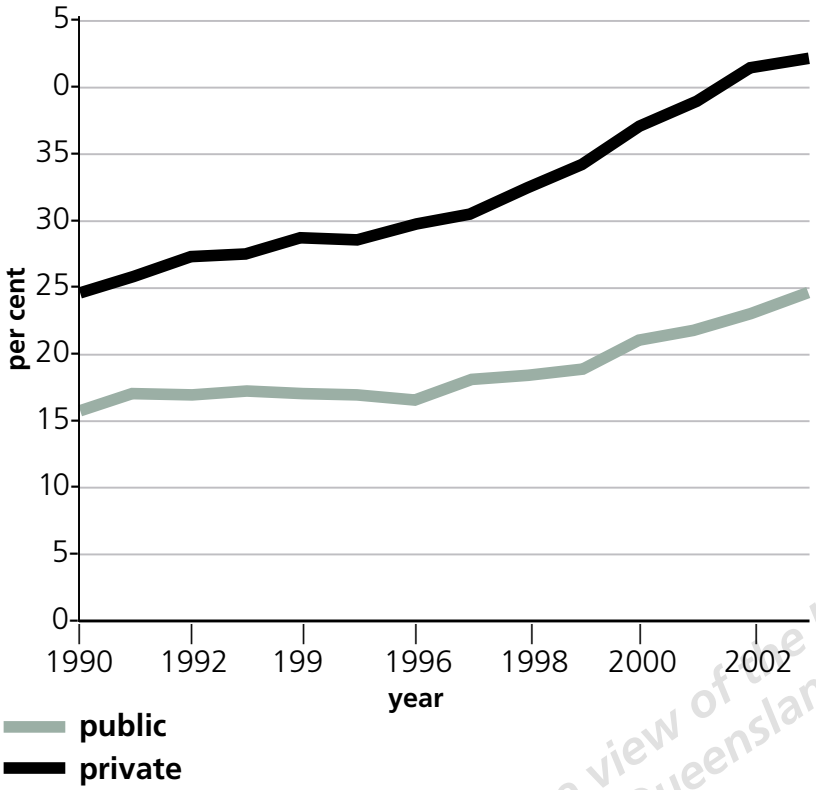
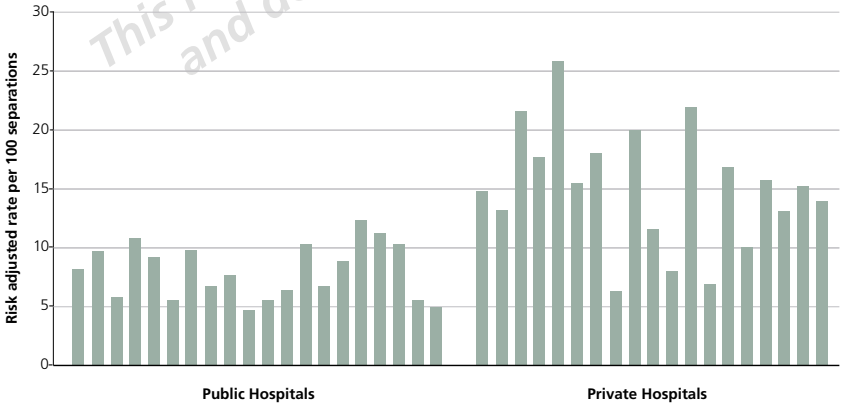


Figure 10 Caesarean Births in Unnamed[19] Individual Private and Public Hospitals 2002



Births of full-term mothers who had no medical complications in pregnancy and no previous caesarean births with a single baby who presented normally (vertex). Excludes planned home births and babies not born in hospital. Rates have been risk adjusted for mother's age, weight of the baby, congenital anomalies, and a number of other medical conditions and complications that could be expected to impact on the method of delivery and that may occur with different frequency at different facilities.

[19] Hospital names not available to the Review.

Caesarean births may be elective, which means they were planned during pregnancy and occur prior to the onset of labour, or emergency, usually decided upon during labour. Both elective and emergency caesareans are increasing in Queensland and nationally.

While data are collected on reasons for both elective and emergency caesarean births, they are not particularly helpful in understanding the issues surrounding recent increases. There are many conditions where the decision to undertake a caesarean or not depends on the individual situation of previous obstetric history, medical history and condition, knowledge, attitudes, emotions, geographic location of the mother, her partner and family and also the attitudes, knowledge and clinical preferences of the carer.

Elective caesareans are increasing faster than emergency caesareans. There are complex social determinants contributing to elective caesarean rates which are not yet well understood and there is a worldwide debate about the risk benefit ratio of elective caesareans and also the ethics of performing major abdominal surgery with its inherent risks upon request. In addition there is the unresolved issue of how best to utilise the precious health dollar and the opportunity cost of the rising elective caesarean rate.

A further issue arising from the increasing number of elective caesarean births which by definition are undertaken prior to the onset of labour is the resultant increased rate of admission of babies to special care nurseries. In an article putting a strong view against elective caesareans on demand, British obstetrician Susan Bewley points to a doubling of respiratory morbidity with each week earlier a caesarean is performed between 37 and 40 weeks. 'A laissez-faire attitude to elective caesarean section sends a mistaken signal to the public and professionals alike that all caesarean sections are safe and the request debate can be misinterpreted as such.' (Bewley 2002).

Queensland perinatal data show that in 2002 while only 7 per cent of babies born at 40 weeks and 8 per cent of babies born at 39 weeks were admitted to special or neonatal intensive care nurseries, 12 per cent of babies born at 38 weeks, 25 per cent of babies born at 37 weeks and 54 per cent of babies born at 36 weeks were admitted to special or neonatal intensive care nurseries[20].

While many factors may be contributing to increased elective caesarean birth rates, there is still insufficient evidence about the benefits and risks of planned caesarean versus vaginal birth which means decisions continue to be made in the face of uncertainty. It is clear however that caesarean births lead to more caesarean births. Perinatal data show that 67 per cent of women with a previous caesarean birth have a subsequent elective caesarean birth and in addition, almost half of those who attempt a vaginal birth after caesarean have an emergency caesarean birth.

Interventions in labour and birth include induction or augmentation of labour, use of epidurals for pain management and birth assisted by forceps/vacuum extraction. Many submissions to the Review mention the 'cascade of intervention' in which an initial intervention such as induction or augmentation leads to further interventions. The notion of a cascade of interventions has been explored by research and is supported by perinatal data. Among women whose pregnancies were otherwise low-risk[21] whose labour was induced in 2002, the incidence of caesarean birth was more than one and a half times higher than among women with low-risk pregnancies whose labour was not induced. Among women whose pregnancies were low-risk who had an epidural for pain relief, the incidence of caesarean birth was more than three times higher than among women with low-risk pregnancies who did not have an epidural for pain relief.

Breastfeeding is beneficial to women and babies and its uptake can be influenced in pregnancy, birth and post-birth care. The National Breastfeeding Strategy includes a target that at least 80 per cent of babies will be breastfed at least partially to six months of age, and Queensland Health has set a target that by 2008, at least 50 per cent of babies will be exclusively breastfed for the first six months of life.

Perinatal data show that 80 per cent of mothers are breastfeeding when they leave hospital. Six Queensland hospitals have World Health Organisation Baby-Friendly accreditation which means, among other things, they work to establish and encourage breastfeeding, towards a goal of 60 per cent of women still breastfeeding at three months.

Many women who have written to the Review would have liked more support in establishing breastfeeding. Conversely, some women felt heavily pressured by hospital staff to breastfeed, despite expressing a clear preference or requirement to use an alternative method of feeding.

Postnatal depression affects many women and is discussed earlier in the Report under the priority area of post-birth care. Postnatal depression is an outcome in that it can be mitigated and affected by maternity care. Further work is needed in this area to develop a better understanding of the relationship between birth experiences and postnatal depression.

A way ahead for outcomes

The recommendations of the Report include the establishment of an independent Centre for Mothers and Families which will have a role in establishing performance indicators for maternity care which carers and care environments can work towards. The Centre will work with Queensland Health to ensure timely collection of data on a range of issues to inform continuous improvement. These include:

- *Outcomes and other data about the experiences of women with special or different needs (by providing these women with the opportunity to self-identify as part of the perinatal data collection)*
- *Data on approaches to care women can access during pregnancy, birth and post-birth through the perinatal data collection, so that data about issues like continuity of care can be gathered*
- *Better linking of perinatal data with subsequent hospital admission data (to build a more comprehensive picture of outcomes).*

A comprehensive set of outcome measures needs to be agreed among carers and consumers so that care environments can monitor and improve performance in an agreed way.

Consumer views need to be sought to inform improvement at all levels.

[20] Liveborn babies only.

[21] For this purpose, low-risk pregnancies are those of women aged 20 – 35 years (in public beds) who are having a single first baby, with a vertex presentation, are labouring and are delivered at term.

A Way Ahead for Maternity Services

The Review of Maternity Services has had eight months to understand an area of work and human experience that many others have spent most of their professional lives serving. Many of these individuals are still working in the system of maternity care in Queensland, but some have given up and have left the State in the hope that other places will provide a greater opportunity to develop care approaches that meet the needs of women and families. All have added a richness to the Review's work.

Most of the work of this Review of Maternity Services has already been done before, some of it more than once. Recommendations for changes in maternity care have piled one on top of the other over the last ten years with few changes of any consequence in care provided. It is fair to say that in Queensland, both carers and consumers have lost faith in the ability of the existing system to achieve meaningful change in maternity care. Frustration and the underpinning tensions between carers defeat many attempts at positive change.

There is currently no Statewide policy framework for public and private sector maternity care from which care approaches might be developed or reviewed or through which consistency of approach across the State might be achieved. There is no Statewide body with perceived independence to which care providers can turn in order to review and improve their own approaches to care. There is no Statewide provision for consumer involvement in the planning, delivery and evaluation of maternity services. Consumer organisations exist, but they are marginalised in mainstream care and have no formal means of influencing policy or practice.

These strategic issues need to be addressed if any meaningful change is to happen in maternity care. While it may be argued that this is the way many aspects of the overall health care system operate, and that planning and change in maternity services are the responsibility of individual health care providers or Districts and Zones which are accountable within the system and participate in its overall planning and review frameworks, maternity care has demonstrated its inability to make the kind of changes that are needed to improve care for women and their families. Change is always difficult in a devolved system of professionals. When conflict among carers is added to the change mix, it is virtually impossible without strategic direction, leadership and care for carers.

In the best of all worlds, this Review would recommend a hundred specific actions that could bring about change in maternity care. This has been a great temptation these past eight months. But in Queensland at the present time, few of these recommendations would be delivered effectively even if given the go-ahead by Queensland Health. This Report would become number 20 on the pile of reports that have been done on maternity services over the last decade.

Queensland right now has an opportunity to transform maternity care or not. The Queensland Government has a policy platform built around families and their importance to community life. The Minister and Director General of Health in the State are committed to changes in maternity services that benefit women and families. They join hundreds of carers the Review has had the privilege to

meet in wanting to give the community a voice in maternity care. There is nothing more important to the community than its families. There is nothing more important to families than the birth of a child.

Consumers are perhaps the strongest driver of all for change in maternity care. They will not go away. Their commitment and energy are laudatory and they will continue to agitate for change that puts the woman and child at the centre of care until they achieve their goal. In the current system they are disenfranchised from making a difference to the care of women and babies. Involving consumers in the change process is of key importance. A mechanism must be found which can help consumers and carers work together to the future.

The Review was asked to recommend sustainable strategies that improve choices for women, within a framework of quality and safety. In the current context of maternity care in Queensland, the Review has managed, in eight short months, to garner wide support for overall principles and an implementation plan which form the first major recommendation to Government. *Maternity Care 2010* sets out both the broad principles on which changes to existing care approaches and new care approaches should be based, along with detailed actions that will turn principles into maternity care.

Maternity Care 2010 *remains broad enough to accommodate differences of view and approach as they currently remain in the Queensland context. Its principles flow logically from priorities and needs for change identified through the Report.*

- *The principle of returning birth to Aboriginal and Torres Strait Islander communities in the long term must be affirmed by Government, with steps taken to empower women and educate more Aboriginal and Torres Strait Islander carers so that this can happen safely. In the short term, increasing participation of Aboriginal and Torres Strait Islander women in culturally and socially appropriate prepregnancy and pregnancy care and education can improve birth outcomes (increasing birthweight and reducing premature birth).*
- *The reopening of maternity services in some or all of the 36 rural and remote communities where birthing has closed needs to be a priority. Sustainable Rural Clusters of Care that recognise local community needs and respond accordingly could do much to alleviate the drain of care from communities. Where maternity services cannot be provided, the health system must provide adequate funding for travel and accommodation, for each woman, her partner or support person and in some cases families.*
- *Approaches to maternity care should recognise pregnancy and birth as whole-of-life experiences, incorporating wellness and psychosocial care needs, within a framework that appreciates and manages heightened risk.*
- *The transition from hospital and birth care to community care must be seamless for the consumer and achievable for carers. For each woman, pregnancy, birth and post-birth care should involve the same small team of carers. For women in private or public care, there should be the same seamless transition from post-birth care to long-term primary family care as for pregnancy and birth to early post-birth care.*
- *Pregnancy and post-birth care could be provided in integrated, community centres or family general practices. Local 'bub-hubs' in existing child health facilities or in community facilities, in urban areas and in the bush, could bring together teams of hospital carers for pregnancy, birth and post-birth care of women and their families, with other carers who currently provide family and child health care support and education.*
- *Risk management is important in all aspects and domains of patient care but nowhere is it more critical than in maternity care because of the unpredictable timing of inevitable events (labour). Risk management frameworks and applications of such frameworks must be developed jointly by all those involved in care.*
- *Consumers need to be involved in the development, implementation and evaluation of approaches to maternity care, including determinations about how and where care is provided.*
- *Data collected on outcomes of maternity care need to include the care experiences of women with special needs, better linking of perinatal and hospital data and development of a comprehensive set of indicators.*
- *The strategies underpinning the goals of simultaneously providing unlimited primary care and the best in the world tertiary care in the State's three tertiary hospitals need to be reviewed with a view to providing adequate and appropriately allocated human and financial resources.*

The second major recommendation of the Review sets out the best process for achieving *Maternity Care 2010*. This key recommendation is for the establishment of a Centre for Mothers and Families which is a sustainable strategy for developing and implementing evidence-based maternity care approaches in the Queensland milieu.

The Centre for Mothers and Families will facilitate change. Some of its work should be easy: establishing a web-site for women and families to find out about maternity care in the State (although even the information included will need to be carefully negotiated among carer and consumer groups), or, through carefully evaluated demonstration projects, assisting hospitals to set up community-based bub-hubs as centres for family care. Some of the Centre's work will be very difficult indeed and will need working parties of carers and consumers, demonstration projects or commissioned research to gather data and confidence before change can be widely implemented.

Demonstration projects, real life clinical care approaches and situations which can be carefully constructed, monitored

and evaluated, are one of the tools with which the Centre for Mothers and Families can test and evaluate a number of aspects of care including some that are currently in contention. The projects will need to be adequately resourced and planned before implementation, with strict protocols for evaluation and assesment. This is a model that can offer a safe, controlled environment in which to assess safety, resource requirements, costs, sustainability and benfits of change. In the planning stage, agreement can be reached on how projects will be evaluated and what recomendations might be made to Queensland Health as a result of evaluation. The structure of the Centre for Mothers and Families will be able to ensure that those involved in care make decisions about what projects will be undertaken and what their outcomes will mean.

On any issues in contention, gradual change introduced under controlled conditions guarantees that safety as measured by deaths among mothers and babies will not be jeopardised. Professionals will together design projects to provide solutions to current and future clinical dilemmas or professional stalemates. Professionals together with researchers, epidemiologists and consumers will progress and guide ongoing change accordingly. To allow such essential processes for change to occur an independent governing and guiding enterprise is required. Without an independent body, effective change will become stymied in the ways it has over the last decade.

The Centre for Mothers and Families will also work with Queensland Health on data collection and with stakeholders to establish a comprehensive range of performance indicators for maternity care which are absent in the current system.

Recent media controversy on a number of care issues suggests Government needs an independent source of clinical and care advice on all aspects of maternity care to which it can refer consumers, carers and administrators. The Centre for Mothers and Families has the potential to bring people together at State and local levels and facilitate their sorting out their differences.

The Centre's independence is of key importance. Maternity care is and should be a whole-of-government issue, incorporating the legitimate interests and informing the work of a range of areas of government, including Health, Aboriginal and Torres Strait Islander Policy, Child Safety, Communities, Disability Services and Education. Stakeholders have no faith that the current system has either the will or ability to effect change. Consumers feel disenfranchised in the system, disenfranchised in a sense from decisions about the birth of their children. Many carers are withdrawing from service. Others are stressed, tired or angry. The culture of conflict in care environments cannot be resolved without leadership and without the influence of an independent broker who has no vested interest in a particular outcome. While the Clinical Practice Improvement Centre can work with individual services to promote change, it is a process facilitator and has made clear that while it can facilitate change it cannot play a leadership role in maternity services, to set overall policy direction and lead care environments towards change.

The notion of an independent centre has the support of the panels advising the Review which represent consumers, carers, professional bodies, Queensland Health and the wider community, and of the key individuals at State level in various professions. Over the eight months of the Review, considerable enthusiasm and positive energy for change has been generated. This will likely be lost if key groups do not continue to feel they have direct involvement in governance and leadership of change.

By involving the professionals themselves working alongside one another to solve problems and agree differences, the Centre can imbue ownership among professionals which is imperative for any real adoption of change.

The Review has also made recommendations about the ways in which Government can help to achieve *Maternity 2010* through its support and attitudes to maternity carers. These form the final group of recommendations of the Review.

Throughout the Review's life, a number of organisations and individuals have pointed out that money is not what is needed to fix maternity care in Queensland. In terms of costing the recommendations which follow, the Review has taken the position that while some of its recommendations will require resources in order to be implemented, especially in the establishment and maintenance of the Centre for Mothers and Families, the emphasis of change in the Report is on carers and care teams rather than high-cost technological solutions or capital development. The changes proposed are not without costs, but they could be expected to generate savings as well.

The process recommended by the Review of rolling out change following demonstration projects will allow costs for any change to be fully evaluated in a real world setting. At the completion of each project, costing will be one issue which will influence the decision as to wide implementation of the proposed changes.

Establishment and maintenance of the Centre for Mothers and Families, including the costs of demonstration projects, are the key immediate costs. While there are no direct parallels with the Centre in maternity care in Australia, other similar centres in areas of health care and research suggest establishment costs of $500,000 to $750,000 and recurrent costs of $1.5 million to $2 million per annum.

Demonstration projects costs will vary with the project and timing of projects but an estimate could be in the order of $2 million per annum in the initial years only. Demonstration projects must be adequately resourced in order to lead the way for change and the Review has suggested a modest first group of projects in order to ensure resource estimates are appropriate.

Integration of pregnancy and post-birth care into bub-hubs will have some medium to longer term capital

development costs, and some travel costs for carers, however these will be mitigated by fewer domiciliary post-birth visits, fewer cancelled appointments, greater efficiencies in inter-carer communication and fewer interventions in labour (with more confident calm women). Detailed costings on issues such as these need to be provided by Queensland Health.

Managing change and bringing relevant people to the table for care planning and development will also generate costs but the fact that these will lead to sustainable integrated services may be a cost benefit in the longer term.

Taking birthing back to the Aboriginal and Torres Strait Islander communities will incur costs in the demonstration project and initial mainstreaming phases however long-term estimates suggest a reduced cost of service and potential benefits for communities. There will also be costs associated with skill programs for Aboriginal and Torres Strait Islander carers.

Similarly, establishing Rural Clusters of Care will have some establishment costs but these will be small and in the longer term should lead to cost savings in having more women birth safely in local communities. The added cost to support providers professionally and in upskilling will be a fragment of the costs saved in travel and resourcing of other facilities to cover load.

Recommendations

Maternity Care 2010: Principles and Strategies

It is recommended that the following principles be adopted by the Queensland Government for development of any new approaches to maternity care as well as for modifications to existing approaches:

Principles for Maternity Care in Queensland

- Care is safe and feels safe
- Care is open and honest
- Care is local or feels local
- Care belongs to families
- Carers work together and communicate.

It is recommended that the following strategies be adopted to implement the principles for 2005 to 2010:

Care is safe and feels safe

Deaths among mothers and newborn babies are rare and must remain so. Other health effects of maternity care should be better understood. Changes in approach to care should work to mitigate negative health effects.

All care must be provided within a framework of safety and quality with appropriate processes for risk assessment and management.

New approaches and practices must be based on best available evidence. Over time, current practices should be reviewed against best available evidence.

New approaches to care and changes to existing approaches will improve a family's experience of safety by:

- offering pregnancy, birth and post-birth care with a known carer (one of a small team)
- re-framing pregnancy education to prepare new parents for life post-birth as well as for birth itself
- providing pregnancy care with an appropriate emphasis on wellness and helpful interventions (integrated with other services) for smoking, drug or alcohol use, depression or other mental illness and risk of domestic violence
- providing culturally safe environments for all women, including appropriate pregnancy care for adolescent women and language interpreters for women who require them.
- providing a range of non-pharmaceutical options for pain relief in labour, accommodating active labour, and welcoming partners and support people
- providing environments of ease and calm for labour, birth and post-birth care across all levels of care as possible
- providing post-birth care and a support network in the community that eases the transition to life as parents (and helps establish and maintain breastfeeding).

For Aboriginal and Torres Strait Islander peoples, deaths among mothers and babies are not rare, and approaches to care must do all the above and recognise that cultural safety for Aboriginal and Torres Strait Islander women is different:

- maternity care of Aboriginal and Torres Strait Islander women belongs to Aboriginal and Torres Strait Islander women
- Aboriginal and Torres Strait Islander people must determine Aboriginal and Torres Strait Islander maternity services
- culturally-appropriate pregnancy care

and education, birth support and post-birth care are a right of all Aboriginal and Torres Strait Islander women
- birthing in home communities may not yet be safe as care is not always available in local communities. At the same time birthing on their own lands may be integral to the cultural safety of Indigenous women. Care providers need to work to make community birthing safe. A determined strategy to prepare Aboriginal and Torres Strait Islander midwives, doctors and health workers who can work in communities must be a priority
- cultural safety may include changes to birth registration to allow Aboriginal and Torres Strait Islander people who birth far from home to include their lands or groups on certificates and to provide for cultural adoption. For some women, cultural safety may require a woman carer.

Care is open and honest

The Centre for Mothers and Families and individual carers will provide comprehensive information on all aspects of pregnancy, birth and post-birth experience by:

- offering all women and families timely, independent, accessible information to make decisions about their care, including information about preconception care, approaches and their outcomes (eg. intervention rates, caesarean birth rates etc)
- providing pregnancy education that prepares families for birth and beyond
- providing a known carer who can listen, answer questions and respond to concerns as they arise throughout care
- providing post-birth information, support and networking opportunities for new parents.

Care is local or feels local

In urban centres hospitals will establish integrated, community-based bub-hubs which provide primary care based pregnancy and post-birth care. Bub-hubs will be organised by the hospital in conjunction with community health and managed by a group made up of carers and administrators from the hospital, consumers and other health care providers. A large hospital might have six bub-hubs in strategic community locations (appropriately resourced child health centres or community health centres would be ideal).

In rural or remote areas, bush bub-hubs will be built around formal Rural Clusters of Care through which an appropriate level of care is available through a number of carers. Local birthing places will re-open as staff become available through the formal Cluster structure.

Women who must relocate to birth will automatically receive an allowance that covers reasonable travel and accommodation costs and the travel and accommodation costs of a support person. For women in marginalised circumstances, costs for travel of other children will be considered, with decisions based on needs and risk to women and families who are separated.

Bush bub-hubs that provide birth care will have appropriate provision for emergency transfer should this be necessary, with an effective, coordinated, Statewide acute retrieval service (which might well be the subject of a separate review by the Centre for Mothers and Families).

Care is integrated

Care is integrated and in accord with a family's experience of a new life rather than the stages in which care is currently structured (antenatal, birth, postnatal or kind of carer).

As many aspects of family care as possible will be provided in a local community setting or bub-hub (child health, immunisation, lactation counselling, social welfare, parenting education, child protection, sexual health care and family planning) and working with Child Care Hubs where they exist.

Transition from maternity services to child health care or GP care will be seamless at whatever point in time it occurs.

Women and families will be able to access a known carer (one of a small team) to be with them through their pregnancy, birth and post-birth care experiences.

In the public sector, the known carer will mostly be a midwife from the relevant hospital, who will work alongside the obstetricians and other hospital staff who provide integrated care at the woman's bub-hub and birthing place. Women will also get to know other members of the care team.

A GP or GP obstetrician in a shared-care arrangement with the hospital (through the local bub-hub) or in rural and remote areas might be the known carer.

In private care, the known carer will likely be a GP or specialist obstetrician.

If for any reason the known carer (midwife or GP or specialist obstetrician) will not be involved in labour and birth care, this will be made clear to families.

Women identified with risk factors will also be offered continuity of care with a known carer but in these situations, others on the care team may become more involved with responsibilities and accountability in accordance with agreed protocols.

Care belongs to consumers

Government recognises that the systems responsible for the care of pregnant women and their babies ultimately belong to families.

Women and families will be represented on the Centre for Mothers and Families Board, Working Partners, other Statewide bodies involved in maternity care and on District and bub-hub planning, management and evaluation groups.

There will be a register of interested consumers to serve on management groups, and training programs for consumers to enable them to become effective advocates for women.

Consumers with recent experiences will be asked about their experience of care at Statewide, District and local bub-hub level – perhaps participating in nationally based surveys.

Carers work together and communicate

Obstetricians, midwives, GPs, and others work together in an integrated system to provide care for all women and their families from pre-conception to early parenting/early childhood care.

Care approaches will operate in a clinical governance framework based on teams of carers with equal input in the team planning and day by day operations. Teams will have agreed:

- how care is provided
- how risk is managed during pregnancy and during labour and birth care
- how satisfactory oversight and monitoring of quality by team leaders is achieved.

These decisions will be embedded in protocols which are revised at least annually.

Planning for care and providing clinical care at all levels will require accepted leadership with clearly defined responsibilities. Teams will have agreed:

- roles, responsibilities and accountabilities of carers in the team
- arrangements for referral between carers and transfer arrangements for women between levels of care
- who carries the formal responsibility in each clinical situation (level of care).

All carers in the team will be involved in multidisciplinary clinical audits and continuous clinical improvement processes. This will be an important component of assuring safety for woman and baby but also carers. The climate will be collegial, open and honest. Trust relationships between carers will underpin listening, participating and learning.

As care environments change, there will be the provision of choice in the way carers participate i.e. shift work, team care and caseload. The choice however will vary depending on the particular hospital situation.

Given the fundamental role of effective communication in

- provision of information and consequent understanding to women and families about care
- optimal clarity of clinical information sharing between carers
- building of relationships with individual women and their families and minimising litigation

all carers will be encouraged to acquire appropriate communication skills and be supported in acquiring them through multidisciplinary communication skills development courses.

The Centre for Mothers and Families

It is recommended

- That a Centre for Mothers and Families be established in Queensland, responsible to the Minister for Health and providing annual reports to the Minister for Health and to the Ministers for Aboriginal and Torres Strait Islander Policy, Child Safety, Communities and Disability Services, and Education and the Arts;
- That the Centre be governed by a 10 to 15 member board which includes representation from carer organisations, consumer organisations, the Director General of Health, other Government Departments (Aboriginal and Torres Strait Islander Policy, Child Safety, Communities, Disability Services, and Education and the Arts), hospital sectors and the broader community and at least one recognised leader in the field from interstate to provide a national perspective;
- That an independent Board Chair be appointed by the Minister from the community;
- That the Centre be appropriately resourced to carry out its role and functions, with a full-time Chief Executive Officer at an appropriately senior level, and with a staff that includes research capacity, project coordination and administration;
- That Board members be appointed by the Minister for Health, for an initial period of three years, with provision for extension to seven years;
- That the Centre be funded for an initial period of seven years with a progress review at the end of three to confirm ongoing funding;
- That a Steering Committee be established by the Minister for Health to progress the necessary administrative arrangements to set up the Centre for Mothers and Families and commence the program of work; with members drawn from the Advisory Panels to the Review of Maternity Services and an Interim Chair from the community;
- That the role and functions of the Centre for Mothers and Families be as follows:
  - The Centre for Mothers and Families exists to improve and continuously monitor the appropriateness, effectiveness, quality, safety and evidence base of maternity services in Queensland and to make cross-sector recommendations to the Minister for Health.
  - The Centre does this by working with Queensland Health, other relevant Government departments, professional bodies, private hospitals and private health funds, consumer organisations, education providers, independent researchers and other relevant organisations or individuals to facilitate best practice changes to care.

Outcomes in the First Five Years

A Centre for Mothers and Families could deliver the following positive outcomes in its first five years:

- Aboriginal and Torres Strait Islander women with low-risk pregnancies birthing in their own communities with increasing numbers of Aboriginal and Torres Strait Islander carers and with a reducing level of newborn baby death

- combined and integrated multidisciplinary pregnancy and post-birth care in the community, further integrated with birth care in the relevant hospital with seamless transition to child health care
- reintroduction of birthing services in some of the 36 rural and remote communities in which birthing has been discontinued in the last ten years, through Rural Clusters of Care providing integrated multidisciplinary pregnancy, birth and post-birth care across a community
- pregnant and birthing women informed and respected and involved in care decisions
- carers working together and communicating in integrated care systems providing different levels and choices of care for women with different needs
- demand for positions in maternity services across the relevant workforce in Queensland, turning around the current drain from care positions in the State and placing Queensland in a leadership role in maternity care in Australia
- carers eager to face the challenges of working in rural Queensland in Rural Clusters of Care and the women and families of the Queensland bush content that birthing is closer to home
- professional bodies that promote their members' skills and competencies and their interconnectedness with other care professions for the benefit of women
- some early measures of short and medium term health effects of maternity care on mothers and babies being collected, analysed and reported, and means of measuring long term effects (on a national scale if possible) in place
- a range of services across Queensland hospitals providing integrated primary and secondary care:
- a small number of tertiary services with appropriate human and other resources providing international standard pregnancy, birth and post-birth care as necessary for women and babies at high risk and accepting transfers from across the State
- many small/medium services for women and accessible across Queensland providing choice in pregnancy, birth and post-birth care for women with low-risk pregnancies in conjunction with bub-hubs and with midwife carers providing primary care in teams with obstetricians and GPs

Program of Work

To achieve these outcomes the Centre's work will include

Setting standards for clinical performance

- promoting and facilitating the achievement of *Maternity Care 2010* by working with consumers, carers and relevant organisations
- developing, in conjunction with relevant organisations, consumers, professional bodies and Queensland Health, key performance indicators for maternity services and monitoring the performance of services against these indicators
- reporting the performance of maternity services against these indicators through the Minister for Health to the community.

Encouraging collaborative approaches among carers

- working with carers to develop a more collaborative approach to providing a broader range of services across the State for all women in all places
- working with carers to assist them to reach agreement on the future management of the many clinical situations in which currently there is uncertainty, controversy and disagreement by facilitating round table conversations and change management programs among different groups of carers (and where such processes fail to achieve consensus, overseeing the establishment, monitoring and evaluation of demonstration projects which seek to provide solutions to clinical questions).

Establishing and managing demonstration projects and their evaluation to resolve issues in clinical care

- joint planning, design, implementation and evaluation of demonstration projects on any issue related to maternity care in Queensland. An initial group of projects might include
  - a workable model for transferring pregnancy and post-birth care from hospital to community settings (establishing the first community bub-hubs linked to a birthing hospital)
  - in conjunction with an established bub-hub assessing the establishment of a primary care facility which is an integral part of a hospital unit with agreed protocols and risk management processes but which provides primary care by midwives
  - a workable model for care in rural and remote areas through a Rural Cluster of Care approach that can maximise multidisciplinary team clinical load sharing, support and back up, incorporating professional development and clinical audit for participants
  - a birthing service in an Aboriginal or Islander community, using bush bub-hubs (midwives, GPs and GP obstetricians) that focus on both providing a maternity service and training Aboriginal and Torres Strait Islander Maternity health workers, midwives and doctors
  - a limited homebirth option for women selected on the basis of specific criteria as part of an integrated hospital maternity unit combining with bub-hubs for pregnancy and post-birth care but providing an alternate place to birth
  - appropriateness of midwives being able to order specified drug treatments and tests in approved settings

- facilitating broad uptake of changes in care environments throughout Queensland, based on successful demonstration projects.

Working with carers and consumers to align practice with evidence

- establishing working parties comprised of all relevant carers to consider current practice against current evidence eg. programs for pregnancy care, use of different means of pain relief in labour.

Resolving debate and stalemate among carers and groups and promoting consistency in clinical care across the State

- undertaking critical analyses of specific clinical care situations over which there is debate in order to reach agreement around appropriate clinical governance protocols eg. waterbirth, caesarean birth rates, vaginal birth after caesarean
- working with colleges, carers, consumers and organisations to develop evidence-based clinical guidelines where inconsistencies in approach exist or persist and monitoring the uptake of such guidelines in practice eg. interventions in labour, management of pregnancy post 40 weeks, optimal pregnancy care, psychosocial care of women in labour
- acting as an independent assessor where disagreement arises about elements of clinical practice which apparently cannot be resolved by reference to evidence.

Assisting administrators, carers and consumers to work together to develop the most appropriate care approaches that will achieve *Maternity Care 2010*

- in situations where hospital care environments are ready and willing for change, enabling the transfer immediately of pregnancy and post-birth care from hospital to community-managed settings by establishing local bub-hubs (linked to local hospitals) which provide pregnancy and post-birth care in community-based, family-friendly centres, along with child health, child care and protection, mental health, dental health, nutrition, social service and support programs (this if hospital units are willing and ready to institute change)
- with support from Queensland Health's Clinical Improvement Centre, facilitating change management processes that ensure cooperative care where possible and clear delineation of roles and responsibilities in multidisciplinary teams.

Brokering and disseminating information about maternity care and services to the community

- disseminating information to the community in a variety of relevant ways, for example, maintaining a 'Bub-hub Central' website and 1800 information line which can provide up-to-date independent and evidence-based information on a range of issues including care approaches and their outcomes, pregnancy and early parenting and locality of available services (included information would be compiled by the Centre sourcing working parties of consumers, carers and organisations)
- acting as a point of debate between the community and carers to ensure that the community is involved and active in determining the appropriateness of maternity services and where necessary and/or appropriate providing explanatory information to consumers regarding policy.

Ensuring broadly-based consumer involvement in development of policy in maternity services and seeking to ensure that involvement adds value

- commissioning, overseeing and widely publishing the results of regular Statewide consumer surveys on maternity care experiences, preferably as part of a national endeavour that will provide for interstate and national benchmarking
- ensuring that there is broad representation of consumers in the processes described above, including consumers with special needs
- facilitating consumer effectiveness in contributing to the work of committees etc in which they are involved by enhancing their knowledge and skills.

Influencing priorities and agendas in research and other activities related to maternity services aligned with clinical care issues

- advising research agencies and funding bodies on priority areas in clinical maternity research and where possible encouraging the undertaking of clinical research in these defined areas eg. the long term impact of high intervention rates on women.

Assisting in the timely provision of all emerging data and evidence to carers

- disseminating information to care providers on recently published or emerging evidence related to clinical care in conjunction with professional bodies to ensure that all carers are being exposed to the same evidence and new information.

Enhancing clinical governance and quality assurance across the sectors and developing a consistently applied risk management framework for the State

- working with professional bodies and craft group associations to ensure appropriate clinical governance processes are in place for private practitioners and private practice
- supporting and working with Queensland Health's maternity services quality assurance and management bodies to ensure that Statewide clinical audits are undertaken in the most effective way and outcomes acted upon
- working with state and national perinatal data collections to ensure appropriate data are collected in the

most efficient and effective way and made available to clinical services and maternity services quality assurance and management bodies in a timely fashion
- working with Queensland Health to ensure data on the experiences of women with special needs are collected
- working with Queensland Health and its quality assurance and management bodies to determine frequency, level of detail and method of publication of perinatal data
- working with carers, administrators and emergency services to develop a consistent approach to the management of risk in maternity services.

Working with professional bodies, regulators and education providers to ensure courses and practical training prepare carers who can continue to meet community needs at appropriate levels

- working with education providers to enhance capacity to recruit and retain Aboriginal and Torres Strait Islanders into maternity carer courses
- working with education providers on multidisciplinary education and training approaches that involve students from different programs in care teams and that develop appropriate carer communication skills
- working with Queensland Health and professional bodies on training and reskilling programs for midwives, obstetricians and GP obstetricians in areas including emergencies and neonatal resuscitation.

Working with funding bodies to maximise the potential for carers to work together in providing integrated services across community and hospital

- encouraging private health funds to design fee/reimbursement structures which promote flexibility and choice while maintaining quality of care and safety for mother and baby
- working with Queensland Health and the Clinical Improvement Centre to assess different models of remuneration for midwives, rural obstetricians and others – models which enhance flexible working hours and utilisation of broader skills i.e. combining mental health with midwifery, or child health with midwifery
- working with Queensland Health, relevant bodies, professionals and consumers to determine templates for the organisational structures and care provision in large hospitals providing optimal tertiary, primary and secondary care
- assisting in the process of determining whether care for any one group in such a setting should be capped on the basis of allocated resources.

Providing advice to Government on any issue relating to maternity care.

Achieving Maternity Care 2010: Caring for Carers

Maternity 2010 will have impacts on carer roles. Government will need to take steps to ensure appropriate bodies are:

- Valuing and rewarding the carers who continue to provide maternity services, respecting the professional knowledge and contribution carers bring to their work and providing adequate staffing so that the system does not inadvertently take advantage of its most dedicated members who, in some environments, are overworked to the point of fatigue in trying to provide quality care
- Recognising the special role of GP obstetricians in rural and remote communities, including offering a specific consultant title to Visiting Medical Officers in appropriate circumstances (to be negotiated with the Rural Doctors Association of Queensland and the Australian College of Rural and Remote Medicine)
- Supporting recognition of rural doctors (including GP obstetricians) as a group having special skills which require specific training and regular upskilling and that the training for this work could be provided in a variety of ways including crossover with other specialty training programs
- Offering appropriate incentives to attract and retain GP obstetricians in rural and remote communities which complement Commonwealth initiatives in this area (through, for example, support for administrative work, backfilling of vacancies, encouraging supervision of less experienced GPs by providing time for supervision to more experienced GPs, encouraging relevant colleges to recognise rural placements with accredited GP obstetrician 'teachers', providing respite time for professional development in flexible packages eg. 6 weeks every five years in addition to 1 week every year to provide upskilling and reflective practice development, and/or exchange programs between small units and larger non-tertiary hospitals to transfer skills, knowledge and learning both ways)
- Working with the Rural Doctors Association of Queensland to consider alternative remuneration arrangements for Visiting Medical Officers in rural Queensland including fee for service
- Supporting more continuing educational opportunities to be incorporated into shared care programs that will ensure that GPs who participate are appropriately trained and skilled to provide optimal and integrated pregnancy and post-birth care
- Offering appropriate incentives to attract and retain midwives in rural and remote communities (through, for example, backfilling of vacancies, encouraging supervision of less experienced midwives by providing time for supervision to more experienced midwives, providing respite time for professional development to provide upskilling and reflective practice development, and/or exchange programs between small units and larger non-tertiary hospitals to transfer skills, knowledge and learning both ways)
- Providing more flexibility for the midwifery workforce to allow flexible working hours or even caseload arrangements, particularly for midwives working in rural settings, and annualised salaries (pro rata) that will allow those

midwives who wish to focus their careers on midwifery to do so

- Establishing formal Rural Clusters of Care (obstetrics, midwifery, anaesthetics and newborn baby care) that provide essential clinical skills and experience across the cluster, back-up and clinical care support, with regular combined clinical audits and professional meetings so that carers learn together and together support their communities
- Supporting the midwifery profession in its ongoing development, including registration of midwives based on recency of practice, involvement in continuing professional education and demonstrated core competencies. Just as the medical colleges administer and control registration and continuing education requirements for doctors it would seem appropriate for the Australian College of Midwives Inc. to provide these services for midwives, at an appropriate time in the future
- Supporting regulation of the midwifery profession as an independent profession in the most appropriate way (under its current head of power or a separate Act)
- Provision for recognition of senior clinical experience in midwifery, based on experience and additional clinical training, which will contribute to leadership of the profession and a more equal professional relationship with senior obstetricians
- Providing resources for continuing professional education and upskilling programs for all carers, through (preferably multidisciplinary) programs in neonatal resuscitation, the Advanced Life Support in Obstetrics program and tailored programs in the Clinical Skills Improvement Centre (including upskilling programs for midwives and GP obstetricians moving into new roles)
- Providing training and education opportunities for traditional birth attendants and Indigenous health workers to train as midwives, with appropriate (and if necessary, alternative) educational pathways to midwifery practice
- Supporting education providers who are seeking to introduce multiple pathways for midwifery education, for example, direct-entry undergraduate programs leading to registration as a midwife
- Supporting and encouraging education providers in their efforts to recruit Indigenous students into courses (medicine, obstetrics, nursing and midwifery) and to prepare Indigenous health workers who can provide maternity care in communities.
- Supporting and encouraging education providers in their efforts to recruit students who will work in rural and remote communities after graduation
- Supporting and encouraging education providers in their efforts to produce graduates with adequate communication skills who can work collaboratively to provide care.

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Bewley, S., & Cockburn, J. (2002). 2. The unfacts of 'request' caesarean section. BJOG: a*n International Journal of Obstetrics and Gynaecology*, 109, 597-605.

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Appendix 1
Review Terms of Reference

Review the provision of maternity services (ante-natal, birthing and post-natal, including community follow-up) across Queensland, with a view to enhancing the choices available to women within the context of continuing to provide contemporary best practice and safe and sustainable care, wherever consumers live.

1. Examine existing and future models of care, in particular midwifery models of care, and recommend strategies to enhance choices for women, with specific consideration of the:

- Current and future demand and trends in morbidity and mortality
- Definition of specific models of care
- Evidence base of practice
- Relative outcomes of all models in relation to consumer choice, settings and population groups
- Appropriateness in different contexts and settings, including the necessary parameters and supports required for best practice, safety and cultural security
- Effectiveness of service models in meeting the specific health and cultural needs of Aboriginal and Torres Strait Islander women
- Costs and benefits of different models
- Clinical governance and safety implications of any recommended models
- Workforce, change management and capital infrastructure implications of any recommended models
- Funding arrangements, health insurance, professional indemnity, industrial and legislative environments
- The public and private health systems and their relationship with each other and the community sector, including the Aboriginal and Torres Strait Islander community-controlled health services
- Service linkage and integration to support continuity of care, improved consumer outcomes and in particular the management of at-risk mothers and babies

2. Consider ongoing mechanisms to support the implementation, monitoring and evaluation of endorsed recommendations.

The Review must:

- Consider evidence and develop strategic recommendations in the context of the national quality and safety agenda
- Engage all stakeholders, ensuring the range of views are canvassed
- Seek the views of consumers on the accessibility and choice of maternity services available to them
- Recognise the cultural and geographic diversity within Queensland
- Draw on existing state, national and international literature and reports
- Draw on the current work of AHMAC working groups (including SCATSIH) relevant to the subject
- In forming its recommendations consider short, medium and long terms strategies, and their relevant costs and benefits.

Appendix 2
Review of Maternity Services in Queensland Team

Review Team

Audrey Dickson
Administration Officer

Sandra Eyre
Principal Project Officer
(July – October 2004)

Sarah Grealy
Researcher

Mary-Rose MacColl
Advisor

Eva-Marie Seeto
Principal Project Officer
(from October 2004)

Individuals who assisted the Review with Report reading

Jane Stanfield

Suzette Jefferies

Appendix 3
Call for Submissions

Print Media features in:

September 2004

The Brisbane Courier-Mail
The Weekend Australian
Sunday Mail
The Koori Mail

October 2004

Logan West Leader
Mt Isa North West Star
Southwest News
Maryborough Heritage Herald
Torres Strait News
Qld Country Life
Beaudesert Shire News
Emerald CQ News
Rockhampton Morning Bulletin
Toowoomba Chronicle
Weipa Bulletin
Gladstone Observer
Cairns Post
Hervey Bay Observer
Fraser Coast Chronicle
Sunshine Coast Daily
Bundaberg News Mail
Townsville Bulletin
The Courier-Mail - Life Section
Sunday Mail


Help improve maternity choices for women.

Tell us what you think.

maternity


maternity

Invitation for public comment

The health services provided to pregnant women across Queensland are under review.

The Review is looking at existing health services for pregnancy, birth and one month post-birth care and will recommend strategies to improve choices for women, within a framework of safety and sustainability, and with particular attention to midwifery models of care.

Anyone who has used maternity services, or with knowledge in maternity care and services, is encouraged to contribute to the Review.

Contributions focusing on the needs of Indigenous women, women with particular cultural or language needs and women in rural and remote areas are particularly welcome.

Contributions are sought by Monday 1 November 2004.

Mail: Community Submissions
Review of Maternity Services in Queensland
PO Box 910 Brisbane Albert Street Q 4002

Email: info@maternityservicesreviewqld.net.au

For further information about the Review call (07) 323 59038 or fax (07) 323 59033 or visit www.maternityservicesreviewqld.net.au


maternity

Queenslanders asked about maternity choices

Queenslanders who have used maternity services, or who have knowledge of maternity care and services, are being asked to contribute to an independent state-wide review.

The review, announced by the Health Minister Gordon Nuttall in July, is looking at existing health services for pregnancy, birth and one month post-birth care. It will recommend strategies to improve maternity choices for women, within a framework of safety and sustainability, and with particular attention to midwifery models of care.

"Incorporating the views of women and their families as well as those of professionals and the wider community is crucial to this Review," said Dr Chemiti Hirst, Chair of the Review of Maternity Services in Queensland.

"We want to include as diverse a range of comment on maternity services as possible and develop recommendations for future services in partnership with the community, interested organisations and service providers.

"Anyone who has used maternity services, or has experience as a service provider, is invited to contact us with their thoughts about how maternity services can best meet the needs of Queensland women in a safe and risk-managed way.

"We are especially keen to embrace the views of Indigenous women, women with particular cultural or language needs and women in rural and remote areas. This call for contributions as well as our community consultation will specifically provide opportunities to include their views," said Dr Hirst.

Dr Hirst is assisted by an expert advisory panel representing professional service providers and a broad range of consumers. The panel met for the first time late last month.

Contributions are sought by Monday 1 November 2004.

Information is available at www.maternityservicesreviewqld.net.au or contact the Review at:

Phone: (07) 323 59038 **Fax**: (07) 323 59033

Mail: Community Submissions
Review of Maternity Services in Queensland
PO Box 910 Brisbane Albert Street QLD 4002

Email: info@maternityservicesreviewqld.net.au

Media enquiries: Review of Maternity Services in Queensland (07) 323 59038

Appendix 4
Submission Writers

ist of Submissions

A small number of confidential submissions were also received and do not appear in this list.

Adamski M.

Alexander N.

Alister K.

Anderson E.

Andrews B. & S.

Australian and New Zealand College of Anaesthetists, Queensland Regional Committee/Australian Society of Anaesthetists, Queensland Executive Committee

Armstrong E.

Association for Australian Rural Nurses

Australian College of Midwives Inc, Capricornia Branch Steering Committee

Australian College of Midwives Inc, Queensland Branch

Australian Lactation Consultant Association

Australian Women in Agriculture

Baby Friendly Hospital Initiative, Queensland

Baker A.

Barker M.

Barlow J.

Barnard J.

Barnes M.

Bauhinia Shire P & T Association

Baxter W.

Beaudesert Shire Council

Beaumont J.

Beckingham N.

Belson R.

Bennison E. & V.

Bentley S. & L.

Bethel S.

Beutel S.

Bidgood R.

Birth Trauma Support Group

Birthtalk

Bishop A.

Black S.

Blatchly-Read J.

Bleier R. & L.

Blonde-Haining C.

Blythe A.

Bone J.

Boom Baby

Bottcher L.

Bottcher M.

Bousfield A.

Boyd B.

Boyle L.

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Bruijn M.

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Council of Remote Area Nurses of Australia

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Lodder S.
Love C.
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McLaren M.
McLauchlan S.
McMullen C.
McNamara K.
McPherson S.
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Mothers' Milk Bank

Mott S.

Knox M.

Midwifery Education Providers in Queensland

Mufsud K.

Muller K.

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Myers J.

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Nambour Selangor and Caloundra Private Hospitals

Natural Parenting Magazine

Newman V.

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Noller P.

Novikov Z.

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Positive Birthing Choices

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Queensland Aboriginal and Islander Health Forum

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Zieschank K.

Appendix 5
Advisory Panels

Expert Advisory Panel

Terms of Reference Membership

- Support to the Principal Reviewer based on specific issues
- Expert input on existing and future models of care
- Informed comment on alternative options
- Advice and facilitation of broader consultation
- Advice on flexible workforce options
- Input to communication strategies

Cherrell irst AO
Chair

Gail Baker
Senior Educator, Childbirth Education Association Brisbane Inc

anet Blair
Clinical Nurse, Aboriginal and Islander Health Service, Queensland Health, Rockhampton

Fiona Bogossian
Snr Lecturer, School of Nursing, Australian Catholic University

Mary ou Fleming
Acting Head of School, School of Public Health, Faculty of Health, Queensland University of Technology

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Kevin Forbes
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enny Gamble
President, Qld Branch Australian College of Midwives Inc.

Dulcinea ernandez
Representative, Ethnic Communities Council of Queensland

Clare Maher
Representative, Qld Faculty, Royal Australian College of General Practitioners

Glenda Mc aren
Chairman, Queensland Regional Committee, Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Debra Moen
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on Outridge
Representative, Australian College of Rural and Remote Medicine

ucinda Pallis
Staff Obstetrician, Gold Coast Hospital

Marie Pietsch
Chair, Ministerial Rural Health Advisory Council, Rural Community

Sharlene Pyke
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Robyn Sharpe
Chair, Women's Health Network, Australian Physiotherapy Association

oan Sheldon
Former Deputy Premier, Treasurer and Minister for the Arts, Community Representative

Bruce Teakle
President, Queensland Branch Maternity Coalition Inc.

David Tudehope
Director, Division of Neonatology, Mater Health Services

Note: The following attended the inaugural meeting (25 August 2004) of the Expert Advisory Panel: Claire Jackson, Chairperson Queensland Faculty, Royal Australian College of General Practitioners and, Ian Muil, Executive Manager, Ethnic Communities Council of Queensland.

Indigenous Maternity Services Advisory Panel Membership

anet Blair
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Health/Report/ author /date	*Queensland Health (2004) Evaluation of Midwifery Model of Care – Fraser Coast Health Service District (FCHSD)*
Informed by	Review of implementation of Maternity Services – Fraser Coast Health Service District (FCHSD) recommendations (see QH 2002 on page 8). Review team visited the District, consulted with stakeholders, community representatives and consumers. Analysis of data (birth numbers, outcomes, antenatal visits, operation of the team)
Summary	Evaluation of the first six months of operation of the Midwifery Model of Care in the FCHSD. In implementing the recommendations of the Review of Maternity Services – Fraser Coast Health Service District, a team midwifery model was established (six FTE Midwives, drawn from existing staff, working between two hospitals).
Recommendations	This was an evaluation of implemented recommendations from Queensland Health 2002 Review of Maternity Services – Fraser Coast Health Service District (FCHSD).
Health/Report/ author /date	***Queensland Health (2003) Maternity Services Review – Banana HSD & Central Highlands HSD [HSD: Health Service District]***
Informed by	
Summary	The issue of providing safe and sustainable maternity services is of increasing concern to Queensland Health (QH) especially in rural communities. Recruitment and retention difficulties in rural and some provincial areas, both now and into the future, will increasingly define the level of maternity services able to be provided. A review of maternity services in Central Zone at the request of some Central Zone District Managers, aiming to examine current models for the delivery of maternity services and make recommendations for models considered safe and sustainable for the future. Six hospitals were reviewed (Biloela, Theodore, Moura, Emerald, Springsure, Blackwater). During the review process, several issues were consistently raised by stakeholders in relation to the maternity services: safety and sustainability of the services; meeting community expectations (including QH local staff) regarding access to maternity services; and minimising risk and litigation exposure whilst providing acceptable working conditions for the participating clinicians (both doctors and midwives). A solution to the current and future service issues in maternity is believed to be achievable if clinicians and community representatives collaborate to ensure that the model of care provided is 'client focussed'. The safety of the mother and baby, above personal interests, must be paramount when considering the provision of sustainable maternity services in rural centres and the current level of litigious activity in relation to O&G services makes this even more imperative.
Recommendations	Recommendations specific to the Banana and Central Highlands Health Service Districts relating to: • recruitment and retention, as well as general numbers, of skilled clinicians; • consolidating birthing sites; • antenatal and postnatal care.
Health/Report/ author /date	***Queensland Health (2003) Background Paper. Part 1. Maternity Services Care Patterns and Models***
Informed by	Summary of Queensland Health (2002) report: (see page 4)
Summary	A background paper to advise the Australian Health Ministers' Advisory Council: • Defines maternity services: The purpose of a maternity service is to provide mothers and babies with safe, effective and holistic health care before, during and after delivery. • Summary under headings: External pressures and trends/ Changing demand/ Changing clinical practice/ Increased proliferation of policies, standards and strategic directions/ Professional & workforce issues/ best practice principles/ models of care (selected models of maternity care)
Recommendations	N/A. Summary document

Health/Report/ author /date	*Queensland Health (2002) DRAFT. Clinical Services Framework for Public Sector Maternity Services. A synthesis of the literature examining service frameworks including models of care and best practice principles*
Informed by	References referred to in the 'Summary' and 'Recommendations' section can be found in Attachment 1 at the end of this document.
Summary	This is a draft paper that provided a synthesis of the literature examining service frameworks, including models of care and best practice principles for maternity services. Similar papers prepared for closely related clinical services including Neonatology, Gynaecology, and Paediatric services. These documents were expected to form part of a larger body of work then in progress within the Queensland Health Procurement Strategy Unit, Clinical Strategy Team, involving the development of service frameworks and service specifications across a range of clinical areas. Best practice principles In canvassing the literature, the following set of best practice principles for delivering maternity services were identified: • Safety is paramount for all women during all phases of pregnancy and childbirth (NSW Health, 2000:7). • Maternity Services should be culturally appropriate and responsive to the individual needs of each woman (MHCCS, 2001). • Maternity care should be women and family centred (WHO, 1996; MHCCS, 2001; Personal Communications C. Davies, 2002). • Maternity care should be provided by multi-disciplinary teams, where appropriate, with the necessary knowledge, skills and experience and there should be an emphasis on coordination and integration of services (Rowley and Russell, 2000). • Maternity services should have available the necessary levels of intervention and technology, in accordance with the facilities delineation role (NSW, 2000:25). • It is important to ensure continuity of care, and wherever possible continuity of carer, throughout pregnancy and postnatal care (WHO, 1996; CA, 1999:17; Rowley and Russell, 2000; Hodnett, 2001). • Woman should be given and informed of the full range of choices in maternity care (NSW Health, 2000:7; WHO, 1996). • Women should have, and feel, autonomy and control over the birthing process (WHO, 1996). • For pregnancy and postnatal care it is important to provide as much care locally to enable a high level of access to services (Rowley and Russell, 2000; SOGC, 1998:2). Even so, the perceived benefits of local community access will need to be balanced with quality considerations and medico-legal risks (MNCAHS, 2000). "There is a general acceptance that local access to services must never be provided at the expense of quality" (TSO, 2000:1) • High quality maternity services across the continuum of care should be ensured (NHPC, 2000). • Consumer participation and consultation in planning and evaluating maternity services should be promoted (NSW 2000:25)
Recommendations	Key recommendations from endorsed documents and evidence The following is a synthesis of key recommendations derived from authoritative reports, related evidence and previous endorsed work of Queensland Health, as they pertain to the planning and development of maternity services. Preconception and very early pregnancy care • Preconception care is most cost-effectively provided as an integral part of primary care services during routine health promotion. Preconception care includes a comprehensive health history and physical exam with initiation of health promotion interventions prior to conception (Perry, 1997). • Queensland Health should take a leading role in the development of comprehensive reproductive technology legislation for Queensland, and should promote the need for nationally consistent legislation. This legislation should include requirements for accreditation, licensing and quality assurance of all ART facilities (QH, 1999).

Health/Report/ author /date	*Queensland Health (2002) DRAFT. Clinical Services Framework for Public Sector Maternity Services. A synthesis of the literature examining service frameworks including models of care and best practice principles (continued)*
Recommendations (continued)	• Termination of pregnancy, specifically for serious genetic disease and major chromosomal and congenital abnormalities, should be performed in appropriate public maternity units in Queensland (QH, 1998:11). The unit where the termination is to be carried out should have the appropriate experience in both the methods of termination and the care of families in this situation (RCOG – UK, 2000) Ante-natal care • All pregnant women should be provided with a maternity record by their principal carer giving details of their health as it relates to their pregnancy and any tests results or treatments with a duplicate to be held by their principal carer (NHMRC, 1996: Recommendation 5.6; CA, 1999:5). • Comprehensive, accurate and objective information should be made available to all pregnant women on the antenatal and birth options available to them (NHMRC, 1996: Recommendation 1; QH, 1998; CA, 1999:5). • A list of accredited obstetric specialists, GPs and midwives in their local area should be maintained. Team care should be encouraged and identified in these lists and should be available to women (NHMRC, 1996: Recommendation 8.1). • Antenatal education classes should be generally available (CA, 1999:6). • Antenatal clinics should be adapted to enable the development of links with GPs, obstetricians and midwives to improve and expand models of shared ante-natal care (NHMRC:1996: Recommendation 5.1; CA, 1999:18). • Public antenatal clinics should take all necessary steps to enable women to have continuity of care and carer, in hospital or with a medical practitioner or midwife (NHMRC 1996: Recommendation 5.2) based on state-wide guidelines for share care (QH, 1998:8) • The timing and the number of screening and specials tests (including basic, routine tests and measurements such as blood pressure and haemoglobin counts as well as more sophisticated tests such as ultrasound scanning, amniocentesis and chorionic villus sampling) should be determined by a local maternity services committee (NHMRC 1996: Recommendation 5.5). These guidelines should be consistent with national best practice guidelines where available (CA, 1999:45-53) • Routine screening for domestic violence should be undertaken as part of the ante-natal assessment. • There should be a continuation and expansion of hospital birthing centres (CA, 1999:7). • Birthing centres should be a considered option for all women. The centres should contain midwifery teams with supporting medical staff linked to a traditional obstetric and midwifery unit (ACIL,1996: 3; NHMRC 1996: Recommendation 6.3; QH, 1998:10) • All major maternity units should incorporate the philosophy and practice of collaborative, comprehensive midwifery care (NHMRC recommendation 6.1) • A target rate should be determined for Caesarean sections, moving towards the target of 15% recommended by the World Health Organisation (CA, 1999:7). • Hostel and other accommodation should be provided for those who need to stay close to a major centre during pregnancy and post-natally (NHMRC, 1996: Recommendation 5.8; QH, 1998:12). Postnatal care • Training programs should increase awareness of psychological changes and postnatal depression in the postnatal period (NHMRC, 1996: Recommendation 9.3). • Professionals and voluntary groups should facilitate successful breastfeeding (NHMRC, 1996: Recommendation 9.4). • Early discharge should be an option for all women (NHMRC, 1996: Recommendation 9.1; QH 1998:11). • In a climate of early discharge, it is imperative that adequate and comprehensive post-natal support is readily available to support women with problems including difficulties with breast-feeding, multiple births and post-natal depression (NHMRC, 1996: Recommendation 9.2; CA, 1999:8).

Health/Report/ author /date	*Queensland Health (2002) DRAFT. Clinical Services Framework for Public Sector Maternity Services. A synthesis of the literature examining service frameworks including models of care and best practice principles (continued)*
Recommendations (continued)	High risk situations • Specific funding should be provided to ensure tertiary centres continue with their state-wide obstetric and neonatal retrieval and transfer services (NHMRC, 1996: Recommendation 13.2, QH, 1998:10). • Hostel and other accommodation should be provided for those who need to stay close to a major centre during pregnancy and post-natally (NHMRC, 1996: Recommendation 5.8; QH, 1998:12). Risk management • There should be a further examination of the complexity and costs of indemnity and their effects on current maternity services. The review should also examine their implications for an effective range of options for future maternity care (NHMRC, 1996: Recommendation 10.1). Data collection and analysis • Queensland Health should support the development of national integration of data collection and analysis (NHMRC, 1996: Recommendations 14.1 – 14.8; QH, 1998:14) • Queensland Health should develop a common minimum data set for all birthing services (i.e. minimum data set for alternative birthing services should be the same as for other maternity services) within the state with standardised medical records to facilitate a state-wide database management system for management and planning of obstetric services in Queensland (ACIL, 1996:1; QH 1998:14). Research and evaluation • Evaluation and research into recent initiatives, new strategies/models of care in childbirth, principal causes of maternal and prenatal mortality and morbidity, and strategies for reducing the continuing high morbidity and mortality rates of Aboriginal and Torres Strait Islander people should be encouraged and supported. The research and evaluation priorities should also have thorough input from consumers (NHMRC, 1996: Recommendations 15.1-15.4; ACIL, 1996:2; QH, 1998:10). Selective and indicated groups Indigenous Nationally, a very diverse range of programs have now been conducted aimed at improving access to and quality of antenatal programs for indigenous women. Many of these programs have also been carefully evaluated. As a result it is possible to identify elements common to successful programs. Such elements include: • consultation with Aboriginal communities, especially women leaders, at every stage of development, implementation and evaluation of service provision (NHMRC 1996: Recommendation 3.3) • the provision of culturally appropriate services • the training of indigenous health workers (including attendants, medical practitioners, obstetricians and midwives) to provide such services (NHMRC 1996: Recommendation 3.5) • the training in cultural issues for non-indigenous staff involve in programs • a team approach involving the Aboriginal Medical Service, general practitioners and rural GPs as well as community midwives and health workers • links with hospitals, especially through Aboriginal outreach and liaison workers • links to broader health services and • adequate transport and support services (CA, 1999:25) It is recognised that improving Aboriginal and Torres Strait Islander health generally is a crucial step in improving the outcomes of childbirth for Aboriginal and Torres Strait Islander women (NHMRC 1996:xi). It is also recognised that the health standards of Aborigines and Torres Strait Islanders will be improved and maintained through the promotion of primary health care principles and evidence-based practice. Establishment or enhancement of maternal health services in indigenous communities should be consistent with the recommendations from the following endorsed Queensland Health reports (QH, 1998:13): • Delineation of Maternal Health Services in Aboriginal communities (QH, 1998d:Appendix A). • Standards for Maternal Health Services in Aboriginal Communities (QH, 1998d:Appendix B).

Health/Report/ author /date	*Queensland Health (2002) DRAFT. Clinical Services Framework for Public Sector Maternity Services. A synthesis of the literature examining service frameworks including models of care and best practice principles (continued)*
Recommendations (continued)	Additional recommendations from other authoritative sources pertaining to the provision and development of maternity services for indigenous communities include: • Antenatal information should be made available to all indigenous women in a language and format that meets their needs (CA, 1999:6) Culturally appropriate birthing services, either in hospitals or stand alone, should be provided in centres with large Aboriginal and Torres • Strait Islander populations (CA, 1999:7). • Patient transfer assistance schemes should extend to an accompanying family member for Aboriginal and Torres Strait Islander women who have to give birth outside their communities (CA, 1999:7) • Hostel and other appropriate accommodation should be made available for those women who are required to leave their communities and need to stay close to a major maternity centre during pregnancy and post-natally, (NHMRC, 1996: Recommendation 5.8; QH, 1998:12). Adolescence Key recommendations from authoritative sources pertaining to the provision and development of maternity services for adolescent women/mothers include: • Antenatal and postnatal programs, in particular outreach support programs, designed specifically for young women/adolescent mothers should be promoted (CA, 1999:5). • Special services within maternity units and elsewhere need to provide for young women who are pregnant. Where possible these should include "drop-in" services with staff who are aware of the special needs of this group (NHMRC 1996: Recommendation 4.4). Women from Non-English speaking backgrounds Key recommendations from authoritative sources pertaining to the provision and development of maternity services for women from non-English speaking backgrounds include: • Antenatal information should be made available to all women from non-English speaking backgrounds in a language and format that meets their needs (CA, 1999:6) • All documents made available to pregnant women need to be in their language of first choice with interpreter services available for cover for obstetric care including emergencies (NHMRC 1996: Recommendation 4.2 and 4.3) • The providers of maternity services need to be informed of and implement maternity services in keeping with the cultural and religious requirements for childbirth amongst new and established migrant groups (NHMRC 1996: Recommendation 4.1) Women in rural and remote areas Key recommendations from authoritative sources pertaining to the provision and development of maternity services for women residing in rural and remote areas include: • Major tertiary hospitals should be supported to extend the provision of satellite clinics and visiting teams of obstetricians to assist women in rural and remote areas (CA, 1999:22) Workforce The following is a continuation of the synthesis of key recommendations derived from authoritative reports, related evidence and previous endorsed work of Queensland Health, as they pertain to workforce issues in the development of maternity services. Professional training and development • Effective health care provision should include continued training and professional eduction for all maternity care providers. This includes health professionals in rural and remote areas, general practitioners and community health workers (NHMRC, 1996: Recommendation 11.2; QH, 1998:12). • Priority areas for training and professional development include: – Special needs of parents whose baby has died before or after birth – Increasing awareness of physiological changes and postnatal depression with management strategies for care providers – Women's health issues, including domestic violence – Cultural awareness of indigenous and ethnic minority groups (QH, 1998:12)

Health/Report/ author /date	*Queensland Health (2002) DRAFT. Clinical Services Framework for Public Sector Maternity Services. A synthesis of the literature examining service frameworks including models of care and best practice principles (continued)*

- All major maternity units should educate health staff to incorporate the philosophy and practice of collaborative, comprehensive midwifery care in the delivery suite (NHMRC, 1996: Recommendation 6.1; QH, 1998: 10)
- Access to public sector maternity services by independent (visiting) accredited midwives should be permitted (NHMRC, 1999: Recommendation 7.5; QH, 1998:12).
- Queensland Health should develop policy guidelines for accreditation of visiting midwives and these should be adopted by both public and private maternity units. These guidelines should recognise the need for an integrated maternity service with appropriate consultations with other professionals, in particular with obstetricians and other medical practitioners (NHMRC recommendations 7.1 – 7.4; QH, 1998:12).
- Queensland Health should liaise and negotiate with the Royal Australian College of Obstetrics and Gynaecology (RACOG) to ensure intake numbers for first year trainees remain adequate (AMWAC 1998:71).
- With respect to improving the health outcomes of Indigenous and Torres Strait Islander communities it is essential to:
  – Increase the number of permanent positions for indigenous health workers trained in the principles of primary health care.
  – Provide increased support in universities to enable Indigenous students training as registered nurses, midwives and doctors to complete their courses and provide "bridging courses" to assist Indigenous people to enter such training programs.
  – Develop strategies to increase the number of permanent female indigenous health workers (both medical and allied health), and recognise the role of traditional indigenous birth attendants.
  – Develop a module providing information about traditional and contemporary maternity care practices to be included in the training of Aboriginal and Torres Strait Islander Health Workers (ACIL, 1996:3).

NB. Medical

The Medical Workforce Advisory Committee of Queensland (MWAC-Q on which medical specialist colleges are represented) and the Office of the Principal Medical Advisor oversee the application and implementation of the Australian Medical Workforce Advisory Committee recommendations in Queensland. This includes recommendations relating to the Obstetricians and General Practitioners. The Office of the Principal Medical Advisor, supported by MWAC-Q, is undertaking a review of the "generalist" senior medical officer workforce in rural communities with a view to improving sustainability of workforce vital to maternity services in rural Queensland.(Personal Communication D. Lennox, 2002).

NB. Nursing

A series of high-level recommendations for nursing, including midwifery, recruitment, retention and education have previously been formulated and include:

– Queensland Health, Ministerial Taskforce nursing recruitment and retention (QH, 1999c)

The Commonwealth Senate Community Affairs References Committee are currently undertaking an inquiry into nursing to examine the shortage of nurses in Australia, and opportunities to improve current arrangements for the education and training of nurses (www.aph.gov.au/senate/committee/clac_ctte/nursing/index.htm). In addition, the Commonwealth Department of Education, Training and Youth Affairs (DEST) are coordinating a National Review of Nurse Education (www.detya.gov.au/highered/programmes/nursing/#announce). Recommendations from these initiatives should be available later in 2002.

The Australian Health Minister's Advisory Council (AHMAC), Workforce Advisory Committee (AHWAC), is currently investigating workforce issues pertaining to midwifery and critical care. Recommendations from this committee should be available mid 2002 (Personal Communications S. Norrie, 2002).

Other national mechanisms currently examining nursing workforce issues and undertaking workforce planning include:

– The Australian Workforce Officers Committee (AWOC). AWOC will supersede AHWAC once this committees work is completed mid 2002 (Personal Communications S. Norrie, 2002).

– The National Health Workforce Committee (Personal Communications S. Norrie, 2002).

Health/Report/ author /date	*Queensland Health (2002) DRAFT. Clinical Services Framework for Public Sector Maternity Services. A synthesis of the literature examining service frameworks including models of care and best practice principles (continued)*
Informed by	Consultation with stakeholders, community representatives and consumers.
Summary	The review of maternity services at FCHSD was commissioned by District management, on the advice of the District Health Council, to examine the current model for the delivery of maternity services and make recommendations for model/s of service delivery that is/are safe and sustainable for the future. Two issues consistently raised by stakeholders were: • safety and sustainability of the service; and • meeting community expectations of the service. The review highlighted workforce issues including recruitment and retention of staff. Risks relating to the recommended model: • lack of commitment from staff to working in a collaborative model of care across two sites • potential for community dissatisfaction/ confusion with no spontaneous/induced births at Maryborough Base Hospital (MBH) • risk of clients still presenting to birth at MBH • Private hospital birthing service not supported after hours • lack of public transport between sites.
Recommendations	Collaborative District team model of maternity care, with both sites (Hervey Bay and Maryborough Hospitals) to provide a full range of maternity services, with the exception that spontaneous/induced vaginal births should occur only at Hervey Bay Hospital. Model to include: • two hospitals (30 minutes apart) • 24 hour access to consultant medical staff during birthing • elective caesarean section performed • utilisation of multiskilled midwives • client-focused model of care • staff working across continuum of birthing care across the two sites • a training registrar in O&G • Level 1 & Level 2 nurseries.

Health/Report/ author /date	*Queensland Health (2001). Midwifery Model of Care Working Party – Recommendations. Obstetric & Gynaecology Advisory Panel*
Informed by	Midwifery Models of Care Working Party Members: • Sue Betts • Kay Chapman (Chair) • Kathleen Fahy • Vicki Flenady • Jenny Gamble • Catherine Kilgour • Shirley Perkins • Jan Roberts • Patricia Schneider • Lyn Schuh • Jane Stanfield • Susan Stratigos • Cathy Styles Co-opted participants • Tina Davey • Narelle Daniels
Summary	Report sets out principles based on a collaborative partnership between Midwives, General Practitioners and Obstetricians and should be read in conjunction with the guidelines of the NHMRC which state, 'Public antenatal clinics should take all steps necessary to enable most women to have continuity of care and carer..' (Recommendation 5, xi). Policy issues, guide to implementation, (including mode of delivery), workforce issues and outcomes are outlined.

Health/Report/ author /date	*Queensland Health (2001). Midwifery Model of Care Working Party – Recommendations. Obstetric & Gynaecology Advisory Panel (continued)*
Recommendations	1. All women to be offered the option of care under the midwifery model with at least 20% of women attending Level Three, Four, Five and Six Queensland Hospitals being cared for under this model. Smaller hospitals to be encouraged to offer care under the midwifery model depending on their ability to do so. The model to be part of the mainstream maternity service provision. 2. Midwives to formulate, in collaboration with key stakeholders including women, policies and agreed quality standards including reporting requirements and performance indicators. 3. Funding allocation within QH Maternity Services to include ongoing monitoring and evaluation of all maternity services according to predetermined Statewide valid and uniform data collection criteria. 4. Private midwives who meet predetermined criteria to be given due recognition through admitting and visiting rights to major public maternity hospitals, as per the NHMRC Guidelines, 1996, endorsed by Queensland Health. 5. Within three years, all District Health Services to offer the following options to childbearing women (as per the NHMRC Guidelines, 1996): a. Freely available information with regard to choices/options b. Freely available information with regard to outcome data relevant to individual institutions c. The choice of carrying and retaining, as their property, a copy of their antenatal record 6. Midwives to attain and retain a voice in the affairs and advancement of midwifery i. Midwifery education should be reviewed by all participating educational institutions in light of these recommendations. ii. Midwifery skills must be appropriately employed to maximise the use of midwifery expertise. iii. Clinical privileges committees considering applications from midwives are to have, as a minimum, equal representation from midwives who are active members of the Australian College of Midwives, to other disciplines iv. District Health Services to undertake a commitment to facilitate access to clinical and support services for midwives and women involved in Midwifery Model of Care/ 7. Queensland Health to implement the NHMRC Guidelines relating to midwives ordering routine drugs/ screening.
Health/Report/ author /date	***Queensland Health (2001). Paper 1. Advice to Queensland Health on developing a position statement on women choosing different frameworks of maternity care including home births. Obstetric & Gynaecology Advisory Panel***
Informed by	Panel (as above). QH, NHMRC, Australian Council for Healthcare Services and Quality Improvement Council documents, guidelines from other Australian States and hospitals, articles from medical and other journals and consultations with obstetricians and midwives.
Summary	Advice to Queensland Health to assist in the formulation of a position statement on women choosing different frameworks for maternity care including homebirths. The diverse range of community needs and expectations in Queensland give rise to the need to explore different models for maternity care…. the right of women to choose various forms of care should be respected and the highest possible standard of service should be available to them. The primary concern in any framework for maternity care is the needs of women (NHMRC Options for Effective Care in Childbirth 1995). It is therefore important to provide services that enhance safety, efficiency, effectiveness, quality and accessibility.
Recommendations	1. Queensland Health to recognise the right of women to choose homebirths 2. Queensland Health to provide relevant information to consumers which allows them to make informed decisions regarding their own healthcare including: • Acknowledgement of the right of women to choose homebirth, have their choice respected and be provided with the highest possible standard of service to optimise health outcomes

Health/Report/ author /date	*Queensland Health (2001). Paper 1. Advice to Queensland Health on developing a position statement on women choosing different frameworks of maternity care including home births. Obstetric & Gynaecology Advisory Panel (continued)*
Recommendations (continued)	• The position of the Royal Australian College of Obstetricians and Gynaecologists which, whilst not accepting that homebirths are a safe alternative, acknowledges the right of women to choose, and its responsibility to support and develop measures that will 'ensure, as far as possible, maximum safety in these circumstances' (NHMRC 1989, Statement on Homebirths, RANZOC College Statements 1999/2000). • The scope and practice of midwifery care, and the Queensland Nursing Council Code of Practice for Midwives • World Health Organization statements/ recommendations • The responsibility of District Health Services to have policies and procedures in place to optimise safety • Information explaining that the appropriate alternatives should be set in place as early as possible. • Information regarding breastfeeding.
Health/Report/ author /date	***Queensland Health (2001). Paper 2. Advice to Queensland Health on developing a position statement on transferring women who choose home births from home to hospital. Obstetric & Gynaecology Advisory Panel, 2001***
Informed by	Queensland Health, NHMRC, Australian Council for Healthcare Services and Quality Improvement Council documents, guidelines from other Australian States and hospitals, articles from medical and other journals and consultation with obstetricians and midwives.
Summary	• Advice to Queensland Health on the transfer of women who have chosen homebirths to hospital because of changing circumstances. • Notes that the number of homebirth transfers to hospital is small but that on occasions obtaining the best result may require services or treatments that can only be provided in a hospital setting. Planning for homebirths must therefore involve appropriate arrangements for the possibility of transfer to hospital. • Outlines barriers to providing the safest possible environment for homebirth as: ineffective communication among those involved in providing care (NHMRC Statement on Homebirths, 1989) and women having difficulty accessing standard maternity care tests/equipment/ consultation (eg prescriptions for oxytocics). • Coordination, communication and appropriate professional relationships among carers are critical to safety (NHMRC Statement on Homebirths 1989, p2). Improved access and greater use of and compliance with available, recommended, standard maternity care tests/ equipment/ consultation are desirable to minimise risks in homebirths. • Principles noted: equity; access; rights; participation; providing services which are as safe as possible, efficient and effective; supporting the needs of the consumer for safety, control, access to information and continuity of care; providing an environment which respects individual choice, involvement and confidentiality.
Recommendations	Detailed recommendations The recommended service delivery model is one of improved collaboration between midwives in private practice and hospital staff. (Outlined in detail) 1. Queensland Health policies and protocols which enhance collaboration between midwives in private practice and public health facilities to be developed 2. Contact midwives and relevant medical officers to be designated at each public hospital to liaise with parents choosing homebirth and their private midwives. • contact teams to: incorporate Queensland Health guidelines, adjust to local conditions, oversee ongoing implementation and evaluation and seek methods of improving collaboration with parents, midwives in private practice and allied health services • full grievance procedure to be available in the event that unresolvable issues arise at a local level

Health/Report/ author /date	*Queensland Health (2001). Paper 2. Advice to Queensland Health on developing a position statement on transferring women who choose home births from home to hospital. Obstetric & Gynaecology Advisory Panel, 2001 (continued)*
Recommendations (continued)	3. General practitioners and the public system to facilitate expectant mothers' access to standard maternity care including: • pathology tests • prenatal diagnosis through local GP and Medicare rebates • immediate postpartum drugs, in particular Syntocinon, Syntometrine, Vitamin K and Anti-D • access to sterilising equipment • specialist medical consultation through Queensland Health facilities as needed. 4. The Quality Improvement Council Limited Australian Health and Community Services Standards for Maternal and Infant Care services to be the guiding document for implementation and evaluation of community-based maternity services (homebirth and visiting midwives) and associated admitting/ transferring protocols.
Health/Report/ author /date	***Queensland Health (2001). Paper 3 - Advice to Queensland Health on developing a Position Statement on Admitting Privileges for Private Midwives. Obstetric & Gynaecology Advisory Panel, 2001***
Informed by	QH, NHMRC, Australian Council for Healthcare Services and Quality Improvement Council documents, guidelines from other Australian States and hospitals, articles from medical and other journals and consultation with obstetricians and midwives.
Summary	Advice to Queensland Health on the option of admitting privileges for private midwives. Notes examples in other states. The most common process involves initial accreditation by the Australian College of Midwives, ensuring indemnity cover and completing some hospital requirements and orientation. South Australia and the Home Midwifery Association (Qld) have developed other models (outlined). Implications, benefits and disadvantages of granting admitting privileges for private midwives are outlined.
Recommendations	1. Formal processes to be delineated for accreditation or granting of clinical privileges as a precursor to visiting privileges at public hospitals for midwives in private practice. 2. Queensland Health to explore, then delineate (with key stakeholders), methods for maintaining and enhancing competencies of midwives in private practice in line with Queensland Health policies/ stated values 3. Ongoing quality assurance programs to be defined, in consultation with key stakeholders, to identify measurable outcomes; and compliance to be monitored and evaluated by Queensland Health. 4. Relevant legislation to be reviewed in terms of visiting (admitting) privileges for midwives and scope of practice pertinent to basic prescribing, and processes to be set in place to change these, if required, to enable midwives to offer professional and safe services to women seeking these care options. Recommended approach of granting admitting privileges to Private Midwives: Competencies of private midwives could be assessed by annual review of delineated competencies through a formally recognised protocol, reaccreditation procedures and maintenance by the Midwives of the 'Practice Record/ Birth Register' and a 'Professional Development Portfolio', subject to regular peer/ consumer review. As an example, The Home Midwifery Association, Queensland, has a formal structure of a 'guiding group', comprising peers, members of the association and clients of the midwife, to whom the midwife is accountable on (minimum) a yearly basis. This group reviews birth outcomes and professional development for the year, and guides in planning/ challenging and changing practice, as deemed necessary. A similar system exists in New Zealand, where midwives undergo regular reviews with a formal body of elected professionals and consumers.

Health/Report/ author /date	*Queensland Health (1999). Report on the Maternity Care Project 1998. Health Systems Strategy Branch, Health Outcomes Unit 1999*
Informed by	Consultative workshops to develop strategies for the Maternity Care section of the Women's Health Outcomes Plan, and Mothers and Babies: an evidence based synthesis of Queensland Health endorsed documents to guide the development of public sector services for mothers and neonates
Summary	The Project was set up following a Health Systems Strategy Branch Planning Day in December 1997. The Health Funding, Health Outcomes and Aboriginal and Torres Strait Islander Health Units participated in the project which was coordinated by the Principal Policy Advisor (Women's Health). Subsequently other Corporate Office Units were invited to join the group. The group met monthly between January 1998 and January 1999. Objectives: • to inform strategies designed to optimise maternal and neonatal health outcomes in Queensland; • to guide and inform the development and implementation of the Department's population health outcomes plans; • to improve allocative efficiency in purchasing services for public sector maternity care; and • to produce recommendations as a basis for a strategic approach to achieving these objectives. Report includes the Women's Health Outcomes Plan – Maternity Care Outcomes (not published)
Recommendations	Services, Resources and Outcomes - 1. Queensland Health should undertake a Statewide audit of hospital and community based ante- and postnatal services detailed enough to indicate the range of models currently applied. 2. Queensland Health should undertake a comparative analysis of expenditure on these services in relation to maternal and infant outcomes. Data, Maternal Health, Early Discharge, Assisted Reproductive Technology – 3. Collaborative ongoing refinement and modification of Perinatal Data Collection forms is needed to ensure they take into account current policy and planning needs. 4. Funding agreements between Corporate Office and the Mater Perinatal Epidemiology Unit should ensure appropriate prioritisation of issues relevant to the policy and planning needs of maternal health services. 5. A study to monitor maternal health during the twelve months after birth should be undertaken as a matter of priority. Evaluation 6. A study to monitor and evaluate the short and medium term (to six months post partum) impact of early obstetric discharge as practices in Queensland should begin as soon as possible. It should consider resource implications for hospitals, community based services and families as well as maternal and infant health outcomes. Ongoing themes & other important issues 7. Queensland Health should consider the development of standard guidelines for the review and evaluation of maternity services to ensure they take corporate policy and planning needs into account. 8. The Project Group should continue to meet to discuss maternity services in terms of corporate policy and to provide a link with relevant work across QH. The Group should be formalised and expanded to include other branches and services.

Health/Report/ author /date	*Queensland Health (1998). Mothers & Babies: an evidence based synthesis of Queensland Health endorsed documents to guide the development of public sector services for mothers and babies.*
Informed by	Queensland Health endorsed documents: • Commonwealth Department of Community Services and Health (1989). The National Women's Health Policy • Queensland Health (QH) (1994). Queensland Public Patients' Hospital Charter • QH (1995). Queensland Health Guide to Consumer Health Rights and Responsibilities • NHMRC (1995). Options for Effective Care in Childbirth • ACIL Economic & Policy Pty Ltd (1996). The Birthing Services Program: An independent review of services funded under the Commonwealth Alternative Birthing Services Program and related services in Queensland. • QH (1997). Obstetric & Gynaecology Services Advisory Panel: Progress Report • QH (1998). Maternal Health Services in Aboriginal Communities: A clinical needs assessment of five communities and a framework for service enhancement The recommendations from these reports are considered in relation to QH Perinatal Data Collection and the evidence based strategies being developed for the maternity care section of the Women's Health Outcomes Plan.
Summary	Section 1: Background • Purpose • Population • Current trends & emergent issues • The QLD maternity and health system • Service utilisation • Funding for maternity care • Work in progress in Corporate Office Section 2: Synthesis of Recommendations from the endorsed reports. • Characteristics of service delivery • Professional & Workforce Issues • Selected & Indicated Groups • Assisted Reproductive Technology • Data Recommendations. Notes "maternity care options for women (in Queensland) are limited" (from NHMRC 1996) (see Aust table). Acknowledges that specialised obstetric care is needed in cases of high risk pregnancy (NHMRC). Notes there is considerable unmet consumer demand for options in maternity care.
Recommendations	**Synthesis of Recommendations from the Endorsed reports** **Characteristics of service delivery:** • Public antenatal clinics, health care providers and community health centres should inform women of their maternity care options and provide details of accredited obstetric specialists, share care general practitioners and midwives in their local area when first contracting the health agency (NHMRC, O&GSAP) • Public antenatal clinics should provide continuity of care and carer, in hospital or with a medical practitioner or midwife based on statewide guidelines for share care (ACIL, NHMRC, O&GSAP) (list of references) • Timing and the number of screening and special tests should be determined by a local maternity services committee comprising hospital specialist staff, general practitioners, midwives and representatives from liaison committees, including local divisions of general practice (NHMRC) • Specific funding should be provided to ensure tertiary centres continue their statewide obstetric and neonatal retrieval and transfer facilities (NHMRC, O&GSAP)

Health/Report/ author /date	*Queensland Health (1998). Mothers & Babies: an evidence based synthesis of Queensland Health endorsed documents to guide the development of public sector services for mothers and babies. (continued)*
Recommendations (continued)	**Characteristics of service delivery: (continued)** • Consultation between consumers of services and providers of maternity services should be undertaken to develop planning and policy directives that ensure acceptable and accessible maternity services for Indigenous women (MHSIAC, NHMRC). Appropriate accommodation be made available for Indigenous women required to leave their communities to await the birth of their babies at regional centres and following discharge to assist with problems establishing breastfeeding etc. (MSIAC, NHMRC, O&GSAP); • All pregnant women should be asked to carry a maternity record providing a summary of their health, pregnancy and test results. Duplicate maternity records should be held by a service provider responsible for care (NHMRC); • A research and development component including consumer input should be built into future implementation of midwifery models of care (ACIL) • Access to public sector maternity hospitals by independent accredited midwives should be permitted (ACIL, NHMRC) • All major maternity units should educate health staff to incorporate the philosophy and practice of collaborative, comprehensive midwifery care in the delivery suite and encourage visiting midwives to provide their services in both birthing centres and hospital labour wards (ACIL, NHMRC, O&GSAP) • Birthing Centres should be an option for all women. The Centres should contain separate midwifery units which have supporting medical staff but with direct links to a traditional obstetric and midwifery unit (NHMRC, ACIL) • Early discharge should be an option for all women (NHMRC, O&GSAP) • Adequate and comprehensive postnatal support should be available to all women (NHMRC, O&GSAP) • Termination of pregnancy, specifically for serious genetic diseases and major chromosomal and congenital abnormalities, should be performed in all public maternity facilities in Qld (O&GSAP) • Funding of maternity services with the public sector should be based on clearly defined service agreements which specify the appropriate clinical and consumer outcomes to be achieved. Funding levels should reflect best practice costs and intervention rates (ACIL) • Hostel or other accommodation should be provided for those who need to stay close to a major centre during pregnancy and post-natally. Mechanisms for funding this accommodation should be explored (NHMRC, O&GSAP, MSIAH) **Professional & Workforce Issues** • Effective health care provision should include training and professional education for all maternity care providers. This includes health professionals in rural and remote areas and community health workers to maintain skill levels (priority areas outlined) (ACIL, MSIAC, NHMRC, NWHP) • Hospitals should grant admission rights to independently practising midwives and policy should be developed by QH for accreditation of visiting midwives which recognise the need for an integrated maternity service including consultations with other professionals, in particular with obstetricians and other medical practitioners (ACIL, NHMRC) **Selective and Indicated groups – (at risk women)** Selective population groups: Indigenous women, women from ethnic minority groups, young women. Indicated population: high risk groups (eg women with a diabetic condition during pregnancy) • Future service planning, evaluation design and the selection of outcome and performance indicators should be developed in consultation with service providers and consumers including Indigenous women, young women, and women from ethnic minority groups, who would be involved in ongoing program monitoring and liaison committees with the community and major hospitals. (ACIL, NHMRC, NWHP, MSIAC, O&GSAP) • Antenatal and postnatal outreach support programs designed specifically for adolescents have been shown to improve health outcomes and should be adopted by Queensland Health (NHMRC, O&GSAP)

Health/Report/ author /date	*Queensland Health (1998). Mothers & Babies: an evidence based synthesis of Queensland Health endorsed documents to guide the development of public sector services for mothers and babies. (continued)*
Recommendations (continued)	**Selective and Indicated groups – (at risk women): (continued)** • QH should progress programs which develop appropriate models of maternity services involving Indigenous women in their planning and delivery which meet the standards for Maternal Health Services In Aboriginal Communities. Establishment or enhancement of maternal health services in each community should be consistent with delineation of Maternal Health Services in Aboriginal Communities (ACIL, MHSIAC, O&GSAP) • Women's groups should be resourced to include exchanges of information about traditional (doula) and non-traditional practice between the community and non-indigenous maternity staff. A module providing information about traditional and contemporary maternity care practices should be included in the training of Aboriginal and Torres Strait Islander Health Workers (ACIL). • All documents made available to pregnant women need to be in their language of first choice with interpreter services available for cover for obstetric care including emergencies (NHMRC).
Health/Report/ author /date	***Queensland Health (1998). Maternal Health Services in Aboriginal Communities. A Clinical Needs Assessment of Five Communities and A Framework for Service Enhancement.***
Informed by	Consultations with women from Cherbourg, Doomadgee, Mornington Island, Palm Island and Yarrabah. The reports Some Good Long Talks (1992) and Childbirth Business (1993) provided antecedents for these clinical needs assessments and the development of the framework for service enhancement.
Summary	Leading experts in the areas of obstetrics and neonatology, and senior Aboriginal women with extensive knowledge and experience in women's health issues were commissioned by QH to participate in the assessment team which prepared the report. Conclusion: despite considerable efforts of health care providers, existing maternal health services in Aboriginal communities visited had been developed in an ad hoc fashion, dependent upon the availability of existing resources. Consequently, the services were fragmented, under-resourced and lack direction, limiting their effectiveness
Recommendations	Service-wide recommendations: • The establishment or enhancement of maternal health services in each community be consistent with the Delineation of Maternal Health Services in Aboriginal Communities • Maternal health services for any community meet Standards for Maternal Health Services in Aboriginal Communities. General recommendations for all communities: • Maternal health care be integrated between the regional hospital, community hospital and community health service to meet client needs. • The community midwife works in collaboration with Aboriginal Health Workers and facilitates Aboriginal Health Workers in taking an active role in the provision of maternal health services. • The cultural requirements of Aboriginal women be identified in consultation with women from the community and these requirements be accommodated in the provision of maternal health care. • Participation of the community and health care providers in organisational planning and policy development of maternal health services be facilitated by QH • All women have access to female health care providers, including where possible female medical practitioners. • Women who are to give birth outside their own communities have the opportunity to be accompanied by an escort (as outlined in the Patient Transfer Assistance Scheme section 3.2) and be supported in labour by a family member or friend. • When women are evacuated from their community to await the birth of their baby in a regional centre every effort be made to reduce the time they spend away from their community • The skills and knowledge of Traditional Birth Attendants be recognised and their role promoted to assist in raising cultural awareness in relation to women's business.

Health/Report/ author /date	*Queensland Health (1998). Maternal Health Services in Aboriginal Communities. A Clinical Needs Assessment of Five Communities and A Framework for Service Enhancement.*

Facilities and equipment

- Community based maternal health services have adequate facilities, clinical equipment and health education resources to facilitate provision of comprehensive antenatal and postnatal care and education.
- Consulting and education rooms be air-conditioned
- Resources such as vehicles be available to provide outreach services to meet the needs of women from the community.
- Portable ultrasound machines be available for use in remote communities and doctors and Aboriginal Health Workers providing antenatal care be trained and supported by specialist, in the use of portable obstetric ultrasound machines.

Staffing

- Selection criteria for recruitment of doctors and midwives for Aboriginal communities include adequate obstetric skills and commitment to provide the prescribed level of service.
- All community hospitals employ female Aboriginal health Workers and female midwives for maternal health services.

Staff training

- Cross cultural awareness training be provided to all health care providers (Aboriginal and non-Aboriginal health care providers).
- All Aboriginal Health Workers be provided as a minimum, the opportunity to participate in the Health Worker Certificate and Diploma course and the maternal health course.
- All staff providing maternal health services have ongoing education to improve knowledge and maintain adequate skills through participation in education programs at least twice a year.
- Funding be made available for community midwives and medical practitioners to spend at least two weeks per year at a major hospital maternity ward to maintain their skills in management of women in labour and neonatal resuscitation.
- The community midwife facilitates the skill development of Aboriginal Health Workers.
- Aboriginal Health Workers and community midwives providing maternal health services have a minimum of three hours per week dedicated to staff development.

Health education

- Women from the community be involved in the ongoing development of health education programs for the community
- Education resources and strategies related to maternal health should also target men and adolescents within the appropriate context.

Specific recommendations for each community were also outlined.

Health/Report/ author /date	*Queensland Health (1998). Obstetric & Gynaecology Advisory Panel. Progress Report (2)*

Informed by

Panel

- Dr John Menzies (Previous Chair)
- Dr Roger Brown
- Ms Kay Chapman
- Dr Deryck Charters
- Ms Leane Christie
- Dr John Evans
- Dr Kevin Forbes
- Dr Eric Green
- Prof Michael Humphrey
- Dr James King
- Dr John MacMillan
- Dr Jeremy Oats
- Ms Shirley Perkins
- Ms Jane Stanfield
- Ms Susan Stratigos
- Dr Roscoe Taylor
- Dr Paul Tofilau
- Ms Joan Webster
- Ms Vicki Assenheim (Secretariat)

Health/Report/ author /date	*Queensland Health (1998). Obstetric & Gynaecology Advisory Panel. Progress Report (2)* (continued)

Summary

This is the second Progress Report from the Obstetrics and Gynaecology Services Advisory Panel. It provides an up-date on the deliberations of the Panel since the last report in September 1997. (The Progress Report is based on the recommendations of a clinical advisory panel. The recommendations have not been endorsed by Queensland Health). In the 1997 Progress Report, the Panel identified several issues for future consideration by the Advisory Panel, a number of which are addressed in this report. These include: Workforce Planning particularly the provision and rationalisation of specialist obstetric and gynaecological services to rural and provincial areas and appropriate training programs; Midwifery training; Evaluation and impact of early post-natal discharge from hospital. Emerging issues discussed in this report include: Screening for diabetic conditions in pregnancy; the prevention and pre-natal detection of neural tube defect; 'Share Care' arrangements between public hospital antenatal clinics and general practitioners.

Early Discharge Program

- Members of the Advisory Panel have cautioned that early discharge programs should not be introduced without thorough evaluation of long term outcomes of this practice and have described the current move towards early post-natal discharge as a 'massive uncontrolled human experiment driven by economic rationalists without the normal safe guards for the introduction of such an intervention". This topic will remain on the agenda of the O&G Services Advisory Panel for further discussion

Screening for Gestational Diabetes in Queensland

- Currently, there is no agreed position on the need to screen for gestational diabetes. The Panel advised that at this point in time, no conclusive evidence exists to support universal screening of pregnant women for gestational diabetes and that the World Health Organisation criteria for population based screening are not met.
- Recommendation: Screening for gestational diabetes mellitus should be provided for pregnant women who are at high risk of developing the condition. Pregnant women who meet any of the following criteria should be regarded as being at high risk of developing GDM – glycosuria, aged over 30 years, obese, family history of diabetes, past history of gestational diabetes or impaired glucose tolerance, belong to an ethnic group which has high or moderately high prevalence of GD (Australian Aboriginal, Polynesian and South Asian/Indian, Middle Eastern and other Asian groups).

Rural Workforce and Training Issues

- A subgroup of the Panel was formed to discuss possible strategies to improve workforce supply and training in rural/remote and provincial areas of the state. To date this subgroup has…recommended vertical integration of rural obstetrics and gynaecology training between rural and urban programs and university programs. The work of this sub-group is still in progress with the provision and training of the midwifery, nursing and allied health workforce yet to be discussed. These discussion will be informed by the Midwifery Workforce Planning Project…which has indicated a growing shortage in the midwifery workforce state-wide and particularly in rural areas.
- Funding was being sought from the Commonwealth Department of Health and Ageing 'Rural Health Support Education and Training' scheme to cover the cost of enhancing the clinical skills of endorsed midwives who care for women and families in rural and remote areas of Queensland.

Neural Tube Defect – Prevention and Early Detection

- Advice was requested from the Panel regarding the prevention of neural tube defect (NTD) through pre-conception and antenatal folate supplementation and the early detection of NTD by obstetric ultrasound
- It has been noted that although almost all women have an ultra-sound at 18 weeks gestation, on national comparisons, Queensland ahs the second highest rate of neonates born with NTD. This could be due to: 1. an underlying higher occurrence of NTD in Queensland; 2. a failure to detect NTD prenatally by ultra-sound; 3. lack of access to termination of pregnancy for such malformation; or 4. parents in Queensland being less likely to choose the option of termination of pregnancy in the event of NTD being detected.
- There may be a need for improved quality control in obstetric ultra-sound.
- It has been suggested that lower birth rates of NTD in other states could be due to the active promotion of perinatal folate supplementation.
- Many questions regarding the relationship between dietary folate supplementation, the use of obstetric ultra=sound and the elevated birth incidence of NTD in Queensland cannot be addressed until data regarding the underlying occurrence of NTD are available.

Health/Report/ author /date	*Queensland Health (1998). Obstetric & Gynaecology Advisory Panel. Progress Report (2)* (continued)

Recommendations

Gynaecological Health: Female Urinary Incontinence

- A sub-group of the Panel has identified female urinary incontinence as an important health issue and has provided a number of recommendations for improved management of this condition. The sub-group has prepared a paper providing strategic direction for the management of female urinary incontinence which is attached in Appendix 2.
- Urinary incontinence is a widespread and largely unaddressed health problem which may affect between 25% and 35% of all women
- Major strategies: increasing public and professional awareness; professional curriculum development, opportunistic screening possibilities, state-wide network of specialist continence advisers; a state-wide phone service for incontinence advice.

Guidelines for Shared Maternity Care

- A maternity shared care program is one that provides comprehensive and holistic maternity care through the integration of various levels of care. In practice shared care arrangements exist between hospital obstetric units, obstetricians and general practitioners. A minority of hospitals have arrangements for shared care with midwives and other health practitioners, as appropriate
- Shared maternity care offers an opportunity to integrate the public tertiary health care sector with the often under utilised obstetric resources of the primary health care sector (Del Mar & O'Connor). For individual women shared care arrangements may offer more continuous personalised care, greater flexibility in appointment times and care provided closer to where women live (Webster, P et al 1995). Shared care arrangements involving GPs assist in building relationships between patients and their GP for the ongoing care of the child. (Del Mar & O'Connor)
- Some studies have reported possible disadvantages experience by women in maternity shared care arrangements. Webster et all (1996) reported that some women complain that their maternity care is fragmentation (sic) by shared care arrangements. Whilst Small et al (1998) cautions that shared care arrangements remove nmaternity care from the "well woman" context of the antenatal clinic to the "sick patient" context of the GP waiting room and query whether it is a reasonable assumption that GPs will have more time to spend with antenatal patients than maternity staff at antenatal clinics
- Recommendation:
    - o Queensland health should explore models of shared maternity care with GPs and midwives which reduce fragmentation of care
- Protocols and Guidelines
    - o Shared care arrangements, usually with GPs, are in operation through most public obstetric units in Queensland. In most of these units between 59 and 95% of patients are in shared care arrangements between their GPs and the antenatal clinic
    - o Arrangements for shared maternity care in Queensland are based on local agreements between the hospital and the primary health providers, usually GPs and occasionally midwives. Consequently, arrangements vary considerably across hospitals. Some hospitals have detailed, formal protocols for shared care, while others have none. Communication strategies vary, however, almost all hospitals utilise some form of patient-held record. Some hospitals have very specific requirements for practitioner's wishing to enter into shared care arrangements with the hospital, while others have no special requirements.
    - o The implementation of a formal protocol for shared maternity care establishes mutual objectives of care, clearly defines responsibilities and formalises links between hospital maternity services and primary health care providers for education and audit (Del mar et all 1991). However, it is acknowledged that in Queensland local circumstances may differ significantly, particularly between metropolitan/large provision areas and rural/remote areas. Therefore, the implementation of a uniform state-wide protocol or set of guidelines may not be useful. A clinical pathway, developed by a sub-group of the Panel (outlined in the document), describes share care arrangements at the operational level. It applies to the metropolitan and large provisional area context and the rural and remote context respectively. It is provided as a guideline to assist in the development of locally based agreements.

Health/Report/ author /date	*Queensland Health (1997). Obstetric & Gynaecology Advisory Panel. Progress Report.*

Informed by

Panel

- Ms Joy Vickerstaff (Chair)
- Dr John Menzies (Previous Chair)
- Dr Roger Brown
- Ms Kay Chapman
- Dr Deryck Charters
- Ms Leane Christie
- Dr John Evans
- Dr Kevin Forbes
- Dr Eric Green
- Prof Michael Humphrey
- Dr James King
- Dr John MacMillan
- Dr Jeremy Oats
- Ms Shirley Perkins
- Ms Jane Stanfield
- Ms Susan Stratigos
- Dr Roscoe Taylor
- Dr Paul Tofilau
- Ms Margaret Wall
- Ms Joan Webster
- Ms Vicki Assenheim (Secretariat)

Summary

The Obstetrics and Gynaecology Advisory Panel was formed to provide expert advice on issues including strategic approaches to service provision, specific clinical issues, benchmarking, planning of resources and workforce needs for obstetric and gynaecological services

Recommendations

Evidence-based care

- QH to develop a common data collection system across services, with standardised medical records and the adoption of validated practice guidelines, standards and models of care
- A statewide database management system…

Service provision

- Accommodation to be provided for those who need to stay close to a major centre during pregnancy and post-natally. Funding mechanism to be explored (NHMRC rec 5.8)
- Adequate and comprehensive post-natal support to be readily available (especially in climate of early discharge)… (breastfeeding, multiple births, post-natal depression. (NHMRC rec 9.2)
- The outcomes of early discharge programs to be monitored and assessed

Indigenous Issues

- QH to progress programs such as the Aboriginal Birthing on the Homelands project which develop appropriate models of maternity services involving Indigenous women in their planning and delivery

Models of Care

- QH to work towards increasing options for childbirth…
- Women to be informed of options for maternity care when they first contact their health care provider, hospital or community health centre (NHMRC rec 1.1)
- Public hospital antenatal clinics to be adapted to enable the development of links with GP, Obstetricians and Midwives to improve Share Care (NHMRC, rec 5.1)
- Statewide guidelines to be developed for Share Care arrangements with GPs and Private Practice Midwives in the rural and public hospital settings
- All major maternity units to incorporate the philosophy and practice of collaborative, comprehensive midwifery care in the delivery suite (NHMRC rec 6.1)
- Hospitals to be encouraged to maintain a list of accredited obstetric specialists, GPs and midwives in their local area. Team care should be encouraged and identified in these lists and the lists should be available to the women (NHMRC rec 8.1)

Specific Issues (recommendations outlined under each bullet point in the Progress Report, but not elaborated on here)

- Sexually Transmitted Infections
- Assisted Reproductive Technology
- Adolescent Pregnancy
- Termination of Abnormal Pregnancy
- Transfer In-Utero

Health/Report/ author /date	*Queensland Health (1997). Obstetric & Gynaecology Advisory Panel. Progress Report. (continued)*
Workforce	• Queensland Health to develop policy guidelines for accreditation of visiting midwives and these should be adopted by both public and private maternity units • The health standards of Aborigines and Torres Strait Islanders will be improved and maintained through the promotion of Primary Health Care Principles and evidence-based practice

Health/Report/ author /date	*ACIL (1996). The Birthing Services Program. An independent review of services funded under the Commonwealth Alternative Birthing Services Program and related services in Queensland.*
Informed by	Literature review, consultations
Summary	Services reviewed: • Cherbourg Community Midwifery Program • Cairns Outreach Midwifery Service • The Ngua Gundi Program • Community Outreach Midwifery Program in the Outer Islands of the Torres Strait • The Community Midwifery Service (ABSP/CMS) at the Mater Misericordiae Mothers' Hospital, Brisbane • Young Women's Outreach Midwifery Service, Inala • The Family Birthing Program – Bundaberg • Mackay Birth Centre • Birthing Services Funded Aboriginal and Torres Strait Islander Women's Health Promotion Resources • The Demand for Home Birth
Recommendations	54 recommendations are outlined, covering: **For action at the Commonwealth level:** • Commonwealth reviews of funding, private health insurance and Medicare Benefits Scheme in relation to birth centres and midwifery models of care. **For action by Queensland Health:** Ongoing evaluation • Qld Perinatal Data Set • funding for the analysis of existing external data sets (eg Mackay Birth Centre and Mater Mothers' Hospital Community Midwifery Service Research and development • funding to support ongoing monitoring and research of the clinical and economic aspects of midwifery models of care • R&D to support future program planning • R&D input into future implementation of midwifery models of care • Research into Aboriginal health • consider NZ legislation and UK House of Commons Select Committee on Health (1992) Policy Issues • BSP model as core service provision model • QH provide clarification for maternity service providers on midwifery indemnity • information and clarification to Aboriginal communities on policies and strategies for the introduction of birthing on Aboriginal and Torres Strait Islander Communities • QH should make a policy response to the demand for home birthing services Integration of Birthing Centres/Services • all maternity units in Qld should consider the incorporation of the philosophy and practice of birthing centre care in the delivery suite. The long term aim in QH should be for all women to have the option to access midwifery models of care • resources prioritised for new birth centres • team midwifery model of care be investigated (such as Westmead Hospital)

Health/Report/ author /date	*ACIL (1996). The Birthing Services Program. An independent review of services funded under the Commonwealth Alternative Birthing Services Program and related services in Queensland. (continued)*
Recommendations (continued)	Services for Indigenous Women • enhance culturally appropriate care, support education and information exchange • resources and strategies should target reproductive health education with menfolk • obbying by QH of training institutions for affirmative action policy in recruitment of Aboriginal and To rres Strait Islander women to midwifery and women's health courses • training in traditional and contemporary midwifery for Aboriginal and Torres Strait Islander Health Workers Health Promotion resources • Use pregnancy education videos. Health Promotion campaigns should be coordinated with existing treatment programs • interagency collaboration in the development of educational resources • funding for health promotion training of Health Workers • funding for trial and evaluation of variety of health promotion materials Service Agreements and Management • funding based on clinical and consumer outcome focussed service agreements • QH should to negotiate with recipient District services related to their anticipated potential to absorb the program into base funding • QH consider raising fees for the use of birth centres by private patients and independent midwives • with cost-effectiveness goal, procedures for costing service delivery should be established **Action by Peak/professional groups (in conjunction with Queensland Health)** • Midwives from the BSP programs to provide information/education sessions with medical and midwifery education programs. Students to work in BSP programs. ACMI provide opportunities for midwifery students to be provided with education into current midwifery models of care in QLD • professional and industrial support for midwives • Qld branch of RCO&G and ACMI continue dialogue to improve mutual understanding of midwifery practice in Qld • Birth Centre Program midwives participate in accreditation decision making process through ACMI and admission rights to Independently Practising Midwives **For Action by District Health Services** Consumer Input • service evaluation design, outcome and performance indicators developed and monitored by providers and consumers • services should actively inform Queensland women about midwifery-based options • consumer education in critical evaluation of maternity services to enhance consumer input. Change management • if implementing new model of care, funding for change management should be quarantined, including high level information sharing and consultation • education and orientation for all staff on philosophy and potential outcomes on the model. • develop awareness of special needs of particular groups, (young women, migrant women, Indigenous women). These women should have a representative on birth centre management committee.
Health/Report/ author /date	***Queensland Health (1995). Aboriginal Birthing on the Homelands Women's Health Unit.***
Informed by	Based on (Indigenous women's) ideas as expressed in previous reports, consultations, and the reference groups, committees and working parties which guided the program. The work in Corporate Office was carried out through the Aboriginal and Torres Strait Islander Health Branch and the Women's Health Unit. (based on reports: Some Good Long Talks 1992, Childbirth Business 1993, Options for Effective Care in Childbirth/NHMRC)

Health/Report/ author /date	*Queensland Health (1995). Aboriginal Birthing on the Homelands Women's Health Unit. (continued)*
Summary	• This project aimed to achieve major health gains for indigenous mothers and babies by the development of safe, acceptable birthing services planned and implemented in partnership by the community, the District Health Service and Queensland Health's Corporate Office. • This report outlines an incremental approach to setting up appropriate maternity services in certain identified Aboriginal communities (Cherbourg, Doomadgee, Mornington Island, Palm Island, Yarrabah) • The report acknowledges the unacceptably high rates of morbidity and mortality among indigenous mothers and babies. Infant mortality rates for indigenous infants are 2.5 to 3 times higher than the non-indigenous population and maternal mortality rates for Aboriginal women are seven times higher than that for non-indigenous women. • In the current hospital setting Aboriginal women do not have opportunities to draw on their own heritage, use their customs or language or to choose other options. 'The Queensland Aboriginal and Torres Strait Islander Health Policy emphasises that effective approaches to maternal and child health must draw upon communities' own resources and traditional knowledge. • This project focuses on the five communities identified in the initial reports – Cherbourg, Yarrabah, Palm Island, Mornington Island and Doomadgee. It sets out the initial steps which will gradually, with careful concern for the health and well-being of indigenous families, promote safe birthing on homelands.
Recommendations	Phase 1: implementation of appropriate antenatal and postnatal care with a partnership of midwives and qualified Aboriginal health workers, as the primary care providers in collaboration with medical practitioners and others who will provide back up services and resources. Phase 2: piloting birthing programs at two sites, Cherbourg and Yarrabah, for women who are at low risk of complications in pregnancy and birthing. Community based midwifery model of care programs can reach relatively high risk groups and support women as they take greater responsibility for their own health and well-being.' The project will require the placement of a Level II or III midwife and an Aboriginal Health Worker in each of the five communities and appropriate professional training and skills development for them. Specific practices and attitudes that were identified as requiring change are: • cutting the umbilical cord according to the wishes of the mother; • the women's wishes in respect to the afterbirth; • women's access to smoking babies if that is their wish; • women's wish about bathing their baby; provision of a model of care that is culturally appropriate and provided where the Aboriginal women's law can be practised; • the employment of Aboriginal health workers in health service facilities, in particular maternity units in hospitals; • the employment of Aboriginal hospital liaison officers at Mt Isa, Cairns, and Kingaroy hospitals; • a support person of the mother's choice to accompany her if she must give birth away from the community; and • accommodation in regional centres. Implementation of the Project • a three-year project • implement recommendations from 'Some Good Long Talks' and 'Childbirth Business' Stage 1 • implementation of appropriate community based antenatal and postnatal care in designated communities Stage 2 • development of protocols and guidelines and the establishment of minimum standards and requirements relating to screening and assessment, recruitment and staffing levels, quality assurance, education and training, birthing facilities, appropriateness of services, data management, service management, and equipment and maintenance

Health/Report/ author /date	*Queensland Health (1995). Aboriginal Birthing on the Homelands Women's Health Unit. (continued)*
Recommendations (continued)	• development of a minimum essential services model for maternity services • clinical needs analysis of the communities conducted by a suitably qualified and experienced medical practitioner and midwife (MHSIAC 1998) Stage 3 • piloting of demonstration birthing models at Cherbourg and Yarrabah, subject to community acceptance and compliance with minimum standards and requirements for safe birthing Stage 4 • strengthening referral, support and medical back-up systems in North Queensland to enable birthing trials at Palm Island, Mornington Island and Doomadgee
Health/Report/ author /date	***Mater Misericordiae Mothers' Hospital (1996). Evaluation – Alternative Birthing Services Program (Community Midwifery Service). Report produced by Kate Ramsay.***
Informed by	The evaluation consultation process sought to capture the view of a broad range of community members and service providers from both government and non government organisations. Data collection involved interviews, focus groups and a workshop to include views of both staff and consumers.
Summary	The data collected revealed seven themes, which went to inform the recommendations. Themes: 1. Choice for women and recognition of birth as a normal event. 2. Structural issues 3. Issues of professional practise and professional development 4. Relationships between health professionals 5. Role definition and clarification 6. Attitudinal change 7. Relationships between clients and Alternative Birthing Service Program (CMS)
Recommendations	• The promotion of greater choice through midwifery models of care for more women birthing at the mater Misericordiae Mothers' Hospital, Brisbane, Queensland • That a midwifery model of care be available as a choice for women birthing at the Mater Misericordiae Mothers' Hospital, Brisbane, Queensland • That a team midwifery approach be adopted at the Mater Misericordiae Mothers' Hospital, Brisbane, Queensland • That a team midwifery approach be adopted at the Mater Misericordiae Mothers' Hospital, Brisbane, Queensland and the team midwifery program at Westmead Hospital, Sydney, New South Wales be investigated as a model. • That a program Coordinator with a background of midwifery and women's health be employed to further develop a midwifery model of care and implement strategies to ensure integration of that model into the Mater Misericordiae Mothers' Hospital setting, Brisbane, Queensland, • That a research and evaluation component be built into future implementation of midwifery models of care. • That future planning development and implementation of a midwifery model of care be inclusive of all health care professionals involved in the care of birthing women to meet local conditions • That student midwives have the opportunity to complete a supervised clinical placement within a midwifery model of care. That within that clinical placement contribution of continuity of care by caring for a woman through her pregnancy and delivery be expected. • That selection criteria be developed to promote a home visiting antenatal service for women who for physiological, emotional and social reasons be benefit from that service • That the home visiting component of the current midwifery model of care be phased out immediately except for those with a demonstrated need. • That an education and orientation program be developed to raise awareness about the midwifery model of care amongst staff. That sustainability of innovative models of care be informed by inclusion and education of all staff.

Health/Report/ author /date	*Mater Misericordiae Mothers' Hospital (1996). Evaluation – Alternative Birthing Services Program (Community Midwifery Service). Report produced by Kate Ramsay. (continued)*
Recommendations	• That a specific component of a community based midwifery model of care be appropriate for non-english speaking background women, new settlers to Australia, women and their partners considered to be socially disadvantaged, indigenous women and young women.. • That education addressing the cultural diversity of clients and needs of those in their care be provided appropriately to birthing services staff. • That any future implementation of this model considers the role of the ABSP (CMS) co-ordinator and is to be managed and administered by a designated department or individual within the Mater Misericordiae Mothers' Hospital Executive, Brisbane, Queensland
Health/Report/ author /date	***Queensland Health (1992). Some Good Long Talks. About Birthing for Aboriginal Women in Remote Areas of Queensland. The Aboriginal and Torres Strait Islander Health Policy Unit & The Women's Health Policy Unit.***
Informed by	Community consultations
Summary	This report is the outcome of a series of talks with the women of Palm Island, Mornington Island, Doomadgee, Cherbourg and Yarrabah on their own communities and is the beginning of a project being developed by Queensland Health(see Birthing on the Homelands).
Recommendations	Birthing Issues • a program be established which builds towards a birthing on the land and communities through improvement in antenatal and postnatal care and education and the improvement of women's primary health status. It is recognised that this ultimate objective requires a number of carefully planned steps designed to enhance the primary health status of women and to increase the number of women with low risk pregnancies. This will involve addressing the basic health issues including nutrition and the quality and availability of antenatal and postnatal care and education. • All major urban centres to which women are transferred from remote areas for the purpose of awaiting the birth of their baby have suitable community based accommodation for Aboriginal women and Torres Strait Islander women (such as Mukai Rosie-Bi-Bayan in Cairns) Midwifery • Registered Midwives and especially trained Aboriginal health Workers be appointed to begin antenatal care and education programs in selected communities. In addition, they will develop appropriate postnatal programs for parents and children in conjunction with other health providers. These midwives should be experienced in self-reliant practice situations and be culturally sensitised through experience and specific training. Appropriate Aboriginal Registered Midwives should be given preference and the community should be represented on the selection panels for these positions. • culturally appropriate antenatal care be available in all communities • nursing faculties be encouraged to actively recruit Aboriginal students with a view to increasing the numbers of Aboriginal registered midwives. This process should also include provision of social, cultural and educational support to students throughout the courses. • All midwifery courses include, in a structured, formal manner, Aboriginal cultural, social and environmental awareness within the curriculum • an exchange of information about traditional and non-traditional midwifery practice take place as part of both the process of gathering the information for a cultural orientation and awareness module as well as enhancing Aboriginal community awareness and education. This would involve invitations to a small group of women from one community where motivation and commitment were well established, to visit another community and talk about their approach and success. The process should include face to face sharing of knowledge, followed by the production of a Remote Midwifery Manual which includes both traditional and contemporary practices. • A module providing information about traditional and contemporary midwifery be included in the training of Aboriginal Women's Health Workers

Health/Report/ author /date	*Queensland Health (1992). Some Good Long Talks. About Birthing for Aboriginal Women in Remote Areas of Queensland. The Aboriginal and Torres Strait Islander Health Policy Unit & The Women's Health Policy Unit. (continued)*
Recommendations (continued)	• Aboriginal Women's Health Workers be given the opportunity to work with community-based Registered Midwives so that they may learn antenatal, labour support and postnatal skills • Health workers offer continuity of carers for women during their pregnancy, birth and postnatal period. • Work begin immediately on recording traditional Aboriginal methods and practices of midwifery still remembered by numerous older women. • At least one female Aboriginal liaison officer should be appointed to all hospitals where Aboriginal women give birth Education • the Education Department be approached to make cultural programs available at primary school level in Aboriginal communities. These programs should include information about traditional birthing and its significance in Aboriginal culture. The teaching of these programs should utilise the traditional teachers in Aboriginal culture- elders appointed by the community Educational Resources • Educational video tape recordings be produced for use during antenatal and postnatal care and education programs. All educational resources are to feature Aboriginal women, be culturally and environmentally appropriate as well as gender sensitive. The main focus should be: a. about birth and pregnancy related issues, including traditional knowledge (see rec 5) and b. elders demonstrating bush food use and preparation (see rec 16) • posters and booklets using traditional and contemporary themes about birthing, nutrition and ceremonies be developed by Aboriginal writers and artists Nutrition • Communities be supported to develop and introduce specially designed nutrition programs in conjunction with the store in the community • ATSIC be approached, through the Aboriginal Organisational Training Program, to conduct training in traditional cooking for community members. Elders in the community should be engaged to teach cooking of traditional foods on an open fire.

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Health/Report/ author /date	*The Maternity Coalition Inc, AIMS, Australian Society of Independent Midwives, Community Midwifery WA Inc (2002). National Maternity Action Plan. For the Introduction of Community Midwifery Services in Urban and Regional Australia.*
Informed by	Literature review, provider and community consultations
Summary	NMAP outlines the rational behind the need for major reform in maternity services and proposes a strategy for Federal and State/Territory governments to enable comprehensive implementation of community midwifery services in both urban and regional/rural Australia within the public health system.
Recommendations	8 recommendations are set out, which include: • access for all pregnant women to primary care from a community midwife; • introduction of appropriate policy and implementation frameworks, consumer representation and participation in decision and policy making; • commitment to expand community midwifery services; • the WA Community Midwifery Program to be used as a template for future services; • identification and elimination of barriers to community midwifery; • review of the Medicare Schedule as it relates to midwives; • legislative change in relation to midwives ordering tests and prescribe drug therapy in pregnancy, labour and birth.

Health/Report/ author /date	*NSW Health (2000). The NSW Framework for Maternity Services.*
Informed by	The NSW Health Department convened a Maternity Services Advisory Committee (MSAC) to consider a range of issues regarding the provision of maternity services in NSW and to develop a five year plan for maternity services in NSW
Summary	The principle objective for contemporary maternity services is to ensure choice, control, continuity of care and safety for all women in all phases of pregnancy and childbirth **Terms of Reference:** 1. to develop a framework for implementing collaborative obstetric and midwifery practice across the continuum of maternity care, addressing issues relating to: models of care; cultural awareness and sensitivity; public and private sector collaboration; consumer needs and choices. 2. to assess, evaluate and formulate options for improved management of human resources in delivering maternity services, addressing issues relating to: education and training; professional indemnity; independent midwifery accreditation/ privileges; collaboration between professional and collegiate groups; rural and remote issues • Area Health Services need to use this framework to plan their individual services. • The Framework has been forwarded to the Clinical Implementation Working Groups who will develop the Metropolitan and Rural health Plans. **Goals:** • Consumer choice and access to culturally sensitive maternity care; • Safety & Quality • Continuity of Care; • Collaboration; • Recognition of birth as a normal process • Availability of a range of models of care; • A competent and flexible workforce.
Recommendations	• NSW Health adopt the five year goals, objectives and strategies of The NSW Framework for Maternity Services and implement these through the Area Maternity Services Plans; • NSW Health adopt the following philosophy statement for developing maternity services: - NSW Health recognises pregnancy, labour, birth and parenting as significant and meaningful life events and acknowledges the right of consumers to access safe maternity care and quality maternity services - Continuity of care and consistent information is essential to the provision of care that is culturally sensitive and appropriate - Collaboration between health workers at all levels plus the development of a competent and flexible workforce are critical factors in ensuring safe services and the availability of a range of models of care. • The NSW Health Department allocate designated resources within the Department to coordinate and oversee the implementation of The NSW Framework for Maternity Services. • The NSW Health Department review early discharge programs across NSW to determine their effectiveness and appropriateness, as well as the consistency of service guidelines, policies, terminology and reporting mechanisms. This should include evaluating the needs and priorities of women in accessing early discharge programs and the effectiveness of referral and follow-up procedures, particularly for women from marginalised or disadvantaged groups. • The NSW Health Department evaluate women's views of maternity care, including those of women from Aboriginal and Torres Strait Islander groups and non-English speaking backgrounds, with particular attention to addressing the specific needs of women from marginalised or disadvantaged groups A 'Five Year Goals, Objectives and Strategies for Maternity Services in NSW' plan is outlined in detail. The strategy was to be implemented 2000-2004. (initially in three Areas, South Western Sydney, the Far North Coast and the Mid North Coast in 1998-1999) SG do search and see implementation strategy in these areas

Health/Report/ author /date	*Commonwealth of Australia (1999). Senate Community Affairs Reference Committee. Rocking the Cradle Report on Childbirth Procedures. Canberra.*
Informed by	Senate Inquiry – submissions and hearings with providers and consumers
Summary	Evidence to the Committee indicated that Australian women value safety during childbirth for their babies and themselves above all other considerations. While recognising that the medical approach may be justified for women considered at risk, they (women) believe it inappropriate for the majority of women. The Committee is particularly concerned by the high rate of elective caesarean section in Australia for which, the evidence suggests, there is no medical justification.
Recommendations	35 recommendations are outlined, covering: • continuity of care; • shared care; • maternity records; • funding issues; • provision of antenatal services to Aboriginal and Torres Strait Islander women, non English speaking background women, and adolescent mothers; • availability of comprehensive information about antenatal and birth options; • establishment of guidelines for antenatal screening tests; • guidelines for counselling and information on various forms of intervention which may be required during birth; • training in safe and appropriate use of obstetrical ultrasound equipment; • conduct of a trial of the efficacy of nuchal fold screening; • expansion of birthing centres; • funding of midwives who assist at homebirths for women at low risk; • funding for support person for Aboriginal and Torres Strait Islander women who have to give birth outside their communities; • development of best practice guidelines for elective caesarean sections; • target rates for caesarean sections; • research and guidelines on the use of ultrasound in pregnancy; • enhancement of the Joint Committee on Maternity Services; • the annual publication of a list of all hospitals where births take place, with statistics on birth-related interventions and the insurance status on whom they are performed; mother and baby postnatal care arrangements; • research into postnatal depression; • Medicare rebate monitoring; definition of neonates as patients; • AIHW to establish comprehensive data on medical defence organizations; • independent inquiry into medical indemnity and litigations;
Health/Report/ author /date	***Australian Council of Healthcare Standards. (1999). Guidelines for Maternal and Infant Care Services***
Informed by	The Project to develop these guidelines was achieved through consultation with a consortium. The Consortium consisted of the Quality Improvement Council, The Australian Council on Healthcare Standards, and the Australian College of Midwives. A Project Management Group were responsible for the development of the content of the Guidelines. The PMG were also supported by a National Reference Committee. Consultations were held with service providers in NSW, ACT, VIC, WA, QLD, TAS and SA.
Summary	These Guidelines address quality care issues specific to maternal care services and infant care services up to 12 months of age. The intention of this document is to provide guidance and support to maternal and infant services to implement systems that support the delivery of care. The information provided in these Guidelines is framed in the context of the ACHS standards and criteria and will assist services to apply the ACHS Evaluation and Quality Improvement Program (EquIP). These Guidelines should not be considered as standards or criteria.

Health/Report/ author /date	*Australian Council of Healthcare Standards. (1999). Guidelines for Maternal and Infant Care Services (continued)*
Recommendations	The standards are divided into six functions: Patient/consumer function: - Continuum of Care (access, entry, assessment, care planning, implementation of care, separation, evaluation and community management). Infrastructure functions: - Leadership and management; - Human Resources Management; - Information Management; - Safe Practice and Environment; - Improving Performance
Health/Report/ author /date	***NHMRC (1998). Review of services offered by midwives. Canberra. Australian Government Publishing Service***
Informed by	In 1995, the NHMRC endorsed the report Options for Effective Care in Childbirth. In 1996, the Working Party to Review the Services Offered by Midwives in Australia was established to advise on measures that should be put in place to authorise midwives to order and interpret a limited range of tests, and to prescribe specified drugs as part of the care of healthy women during uncomplicated pregnancy and childbirth.
Summary	The Working Party chose to concentrate on midwives employed by public maternity services, where midwifery models of care are being increasingly introduced in response to community request. These midwives may work in maternity units at a public hospital or in an outreach or community setting…It is acknowledged that the recommendations contained in this report could be extended to midwives employed in other settings, providing issues relating to cost implications, indemnity and legislation are addressed.
Recommendations	Recommendations to allow midwives to safely assume responsibility for ordering and interpreting a limited range of tests and initiating, under agreed protocols, the use of a limited range of pharmacological substances for which there is evidence of benefit, as part of routine midwifery practice for the care of women and babies during uncomplicated pregnancy, labour, birth and the postnatal period. State/Territory authorities, in collaboration with relevant professional and educational bodies, should identify the educational preparation and assessment required on a national basis. Public maternity services, including birth centres and community and outreach settings, should confirm that professional indemnity insurance covers midwives Institutions that incorporate midwifery models of care into mainstream maternity services should include audit mechanisms (as for other models of care) to evaluate the health outcomes of mothers and babies
Health/Report/ author /date	***NHMRC (1996). Options for effective care in childbirth. Canberra. Australian Government Publishing Service***
Informed by	**Membership of the Expert Panel** • Professor Jeffrey Robinson (Chairperson), Department of Obstetrics and Gynaecology University of Adelaide • Dr Ross Haslam, Director of Neonatal Medicine, Queen Victoria Hospital • Ms Denyse Olds, Midwife, Queen Elizabeth Hospital • Dr John O'Loughlin, Royal Australian College of Obstetricians and Gynaecologists • Ms Maggie Oors-L'Estrange, Consumer's Health Forum • Dr Margie Ripper, Women's Studies Department, University of Adelaide • Ms Georgie Stamp, Independent Midwife • Ms Denise Troon, Aboriginal Health Council of South Australia

Health/Report/ author /date	*NHMRC (1996). Options for effective care in childbirth. Canberra. Australian Government Publishing Service (continued)*
Informed by (continued)	**Co-opted members** • Dr David Gill, Rural Practice Training Unit, Modbury Hospital • Dr Geoffrey Martin, Chairman, Council, Royal Australian College of General Practitioners In 1991, the Women's Health Committee suggested that a working party should examine the rates of obstetric intervention in Australia, and that this group should be based in South Australia. After initial discussions it was agreed that the topic should be changed to 'Options for Effective Care in Childbirth'. The membership of the working party, including co-opted and corresponding members. Since there have been a number of recent surveys of consumers' attitudes and concerns, it was decided that the group would use this information rather than attempt to obtain additional views on the options for effective care in childbirth. The publication, 'Having a Baby in Victoria' (1990), provided a clear message that, 'although the majority were satisfied with the present provision of maternity services, there is also a desire in the community for new options for the provision of maternity care in Australia'. Many similar views were expressed after the release of 'Maternity Services in New South Wales' ('Shearman Report', 1989) and the Western Australian Report on Obstetric, Neonatal and Gynaecological Services (1990). At the same time there is an increasing desire for midwives to provide a greater input into maternity services. Furthermore, the current practice of obstetrics is not compatible with an adequate quality of life, cover or remuneration for the obstetrician and often leads to litigation stress.
Summary	**Terms of Reference** Terms of reference for the Expert Panel on Options for Effective Care in Childbirth were to - i) Provide an overview of current practice issues in childbirth care in Australia, patterns of intervention in labour and the puerperium, and current knowledge about clinical and social outcomes, having reference to the cultural aspects of birthing practices for Aboriginal women and migrant women. ii) Describe the areas where the current practice is at variance with the aim of optimising outcomes for the mother, baby and family, and to identify methods of improving care. iii) Propose a national minimum data base of perinatal outcomes. iv) Identify methods of improving care.
Recommendations	15 recommendations, covering: informed choice, access to information, Aboriginal and Torres Strait Islander needs, the needs of new and established migrant groups, antenatal care, birthing centre options, midwifery care guidelines, access to registered providers list, postnatal care, practitioner indemnity, practitioner membership and training, tertiary centres, national data sets, funding. **Recommendation 1:** 1.1 Women should be informed of the options for maternity care in their region when they first contact their health care provider, hospital or community health centre. 1.2 The NHMRC should publish a leaflet outlining these options. Each State/Region/Area/Hospital should publish its own brochure relating to local conditions. **Recommendation 2:** 2.1 The membership of the Joint Committee on Maternity Services should be expanded to include representatives of the major relevant professional organisations. This Committee should explore the development of an integrated service, which offers an expanded range of options for maternity care. **Recommendation 3:** 3.1 Improving Aboriginal and Torres Strait Islander health generally should be recognised as a crucial step in improving the outcomes of childbirth for Aboriginal and Torres Strait Islander women. 3.2 Providers of maternity services should be cognisant of the needs and expectations of Aboriginal and Torres Strait Islander women. 3.3 To achieve this Aboriginal and Torres Strait Islander women leaders in each region should be involved in planning maternity services. In some regions it may be appropriate to provide birthing centres. 3.4 Aboriginal and Torres Strait Islander women representatives should be appointed to liaison committees representing the consumers of major obstetric hospitals.

Health/Report/ author /date	*NHMRC (1996). Options for effective care in childbirth. Canberra. Australian Government Publishing Service (continued)*
Recommendations (continued)	3.5 Priority needs to be given to increasing the number of Aboriginal and Torres Strait Islander birth attendants, midwives and obstetricians. However, an initial step may have to be undertaken first to encourage more Aboriginals and Torres Strait Islanders to train as nurses and medical practitioners. 3.6 The role and function of birth attendants needs to be agreed between local Aboriginal and Torres Strait Islander groups and health care providers. be a considered option for all women. **Recommendation 4** 4.1 The providers of maternity services need to be informed of and implement maternity services in keeping with the cultural and religious requirements for childbirth amongst new and established migrant groups. This should be part of the function of hospital liaison committees representing consumer groups. 4.2 Interpreter services need to be readily available to provide cover for obstetric care including emergencies. 4.3 All documents made available to pregnant women need to be in their language of first choice. 4.4 Special services within maternity units and elsewhere need to be provided for adolescent women who are pregnant. These, where possible, should include 'drop-in' services with staff who are cognisant of the needs of this special group. **Recommendation 5** 5.1 Public hospital antenatal clinics should be adapted to enable links to be developed with general practitioner obstetricians and midwives to improve shared care. 5.2 Public antenatal clinics should take all steps necessary to enable most women to have continuity of care and carer, in hospital or with a medical practitioner. 5.3 Shared care involving small teams of general practitioner obstetricians and midwives should be encouraged. This should promote satisfaction for both the woman and the service providers. 5.4 Guidelines for shared care should be drawn up locally having regard to State and National guidelines. 5.5 The hospital may provide screening and special tests. Timing and the number of these should be determined by a local maternity services committee comprising hospital specialist staff, general practitioners, midwives and representatives from liaison committees, including local divisions of general practice. 5.6 All pregnant women should be asked to carry a maternity record providing a summary of their health, their pregnancy and test results. Duplicate maternity records should be held by a service provider responsible for care. In the patient-held maternity record, check lists should be initialled by the care-giver on completion of a task to assist continuity of care. 5.7 Evaluation of patient-held maternity and infant records should be undertaken in Australia. 5.8 Hostel or other accommodation should be provided for those who need to stay close to a tertiary centre. New mechanisms for funding this accommodation will need to be devised. **Recommendation 6** 6.1 All major maternity units should incorporate the philosophy and practice of birthing centre care in the delivery suite. 6.2 The Panel does not support, other than in exceptional circumstances, free standing birthing centres remote from a maternity unit. 6.3 Birthing Centres should be a considered option for all women. The Centres should contain separate midwifery units which have supporting medical staff but with direct links to a traditional obstetric and midwifery unit. 6.4 Criteria for eligibility for care in birthing centres and for transfers-out need to be developed, evaluated and regularly revised. **Recommendation 7** 7.1 States/Regions and health units should develop guidelines for development of policies for accreditation ofvvisiting midwives. 7.2 These guidelines should recognise the need for an integrated maternity service with appropriatebcon sultations with other professionals, in particular with obstetricians and other medical practitioners. 7.3 The guidelines should also make recommendations about the provision of supporting specialist services and access for visiting midwives to maternity units.

Health/Report/ author /date	*NHMRC (1996). Options for effective care in childbirth. Canberra. Australian Government Publishing Service (continued)*
Recommendations (continued)	7.4 Public and private maternity units should adopt policies for accreditation of visiting midwives in line with the above recommendations. The Panel recommends that the JCMS facilitate this process. 7.5 Visiting midwives should be encouraged to provide their services in both birthing centres and hospital labour wards. **Recommendation 8** 8.1 The Panel would encourage hospitals to maintain a list of accredited specialists, general practitioners and midwives for their local area. Team care should be encouraged and identified in these lists. This list should be made available to women. **Recommendation 9** 9.1 It should be the woman's choice as to whether or not she participates in an early discharge program. Adequate support for such programs should be encouraged. 9.2 Maternity services should include programs for support of women with problems in the postnatal period, including difficulties with lactation, multiple births, and postnatal depression. 9.3 Training programs should increase awareness of psychological changes and postnatal depression in the postnatal period. 9.4 Professionals and voluntary groups should facilitate successful breastfeeding. 9.5 Providers of services need to be cognizant of the special needs of parents whose baby has died before or after birth. Special services are required to assist these parents. 9.6 All women should be offered advice on family planning. Special steps may be required in the context of early discharge programs. **Recommendation 10** 10.1 There should be a further examination of the complexity and costs of indemnity and their effects on current maternity services. The review should also examine their implications for an effective range of options for future maternity care. **Recommendation 11** 11.1 RACOG, the RACGP (particularly the Faculty of Rural Medicine), and others, should continue their dialogue to improve training in obstetrics for general practitioners for both metropolitan and country practice in obstetrics, and also in paediatrics and anaesthetics relevant to maternity services. 11.2 There should be continuing training in the care of the newborn for all those providing maternity services. **Recommendation 12** 12.1 There should be a review of the membership of the Australian Nursing Council (ANC) to ensure adequate midwifery representation. 12.2 Further consultation should take place with the ANC to recognise midwifery as a discrete practise. 12.3 The ACMI should maintain its register of independently practising midwives. 12.4 Re-accreditation of qualifications of independently practising midwives should be supervised by the ACMI. **Recommendation 13** 13.1 Funding and support of tertiary centres should be maintained so that they can continue to serve their regional functions. 13.2 State health authorities should recognise the role of obstetric and neonatal retrieval and transfer facilities of tertiary centres. Specific funding for this activity and its coordination should be provided. **Recommendation 14** 14.1 The National Perinatal Data Advisory Group should continue its periodic review of the National Minimum Data Set for maternity services. 14.2 This data set should contain items required for monitoring maternal and perinatal mortality and morbidity. 14.3 The data set should also contain a number of demographic and social measures. 14.4 The data set should also provide a method for assessing Diagnosis Related Groups for different maternity units and other components of maternity services.

Health/Report/ author /date	*NHMRC (1996). Options for effective care in childbirth. Canberra. Australian Government Publishing Service (continued)*
Recommendations (continued)	14.5 The obstetric indicators as produced by RACOG should be included in the National Minimum Data Set. For these indicators, benchmarks should be developed and regularly updated. 14.6 A new indicator reflecting a need for re-admission of the mother and/or baby after early discharge should be introduced. 14.7 New indicators reflecting neonatal health should be determined by the Australian College of Paediatrics and the Australian Council of Healthcare Standards. These should include re-admission rates of babies after early discharge from a maternity unit. 14.8 A new set of indicators of consumers' views of maternity services needs to be developed and added to the set of clinical indicators. **Recommendation 15** 15.1 Funds should be made available for evaluation and research into recent initiatives and new strategies for care in childbirth. Disbursement of these funds should be through recognised channels eg Medical Research Committee or Public Health Research and Development Committee. 15.2 These funds should be used to evaluate, by randomized controlled trials and other forms of research, new options for care in childbirth to assess the effectiveness of these options. 15.3 Research into the principal causes of maternal and perinatal mortality and morbidity needs to be continued and not reduced to fund evaluative research into maternity services. 15.4 Further research is needed to reduce the continuing high morbidity and mortality rates of Aboriginal and Torres Strait Islander people. These programs must be designed in consultation with Aboriginal and Torres Strait Islander people themselves.
Health/Report/ author /date	***Health Department of Victoria. (1990). Having a Baby in Victoria. Final Report of the Ministerial Review of Birthing Services in Victoria. Health Department of Victoria: Melbourne.***
Informed by	A call for public comment on the terms of reference, establishment of a Consultative Body (with provider associations and consumer organisations representatives), a consumer survey, small projects, Working Groups, submissions, literature review.
Summary	In 1998 the then Minister for health, the Honourable David White, announced the establishment of a major study of birthing services in Victoria. The aim of the Study was to review all aspects of birthing services with outcomes aimed at giving women greater freedom and range of choice in deciding how they wanted to have children. The Terms of Reference addressed current service provision in Victoria, models of service delivery and education and training of health practitioners. Central to the Study Group's deliberations was an extensive consultative process. This process incorporated four models, and aimed to provide service providers, consumer organisations and a diverse range of women and families with the opportunity to have input into the Review. The Report outlines the Review process, the statistical overview of birthing in Victoria at that time and lists 95 recommendations (topics listed in 'Recommendations' below)
Recommendations	**Recommendations covered the areas of:** *Models of care:* • Birth Plans and Personal Antenatal Care Card; • Hospital Based Models of Care • Community Based Models of Care • Childbirth Education and Information Needs • Childbirth Educators • Childbirth Education Programs • Information Needs

Health/Report/ author /date	*Health Department of Victoria. (1990). Having a Baby in Victoria. Final Report of the Ministerial Review of Birthing Services in Victoria. Health Department of Victoria: Melbourne. (continued)*
Recommendations (continued)	*Women with Additional Needs* • Women from NESBs • Aboriginal Women • Young Women • Women with Disabilities • Families experiencing a Perinatal Death • Families experiencing a Premature Birth *Intervention* *The Postnatal Period* • Guidelines for Hospital Discharge prior to Day 5 after Birth • Postnatal Issues/ Breastfeeding, PND, Postnatal Information *Midwifery Education* • Scope and Sphere of Midwifery Practice • Direct Entry Midwifery • Continuing Midwifery Education *Midwifery Registration* • Training and accreditation for Independent Practice • Hospital Visiting Rights for Independent Practising Midwives *Medical Education* • Undergraduate Education • Post Graduate Education • Continuing Education *Implementation*

Health/Report/ author /date	*Human Services Victoria (1999) WUDWAW. "Who Usually Delivers Whom and Where". Report on Models of Antenatal Care. (Halliday, J, Ellis, I, Stone, C)*
Informed by	A statewide population-based study was undertaken over a four-month period in 1998 by the Perinatal Data Collection, using the form completed for every birth of at least 20 weeks gestation in Victoria. Objectives: - to obtain a greater understanding of the types and use of different models of antenatal and intrapartum care and the personnel involved at different stages of pregnancy and labour, throughout Victoria. - to support planning of health services by obtaining information on the utilisation by women with different profiles (for example, Mother's country of birth, age, parity, region of residence) of the various models of care - to examine some pregnancy outcomes for comparisons between models of care, only where numbers in the comparison groups were large enough for meaningful statistical analysis - to provide feedback to individual hospitals, allowing for policy development.
Summary	Information was gathered from more than 23,000 pregnancies in a four-month period. The information sought and collected from more than 109 hospitals was: the gestation at the first visit to a doctor or midwife after the pregnancy was confirmed; the model of care at 20 weeks gestation; the model of care at birth; the accoucheur at birth. This report summarises the models of care component of the project. More than 18 models of care were identified by the project: 1. Public Hospital Outpatient: Standard Care 2. Public Hospital: High Risk Clinic Specialist Obstetrician 3. Public Hospital: Midwife Clinic 4. Team Midwifery in Public Hospital 5. Shared Care: Public Hospital with GP 6. Shared Care: Public Hospital with Midwife in Private Practice

Health/Report/ author /date	*Human Services Victoria (1999) WUDWAW. "Who Usually Delivers Whom and Where". Report on Models of Antenatal Care. (Halliday, J, Ellis, I, Stone, C) (continued)*
Summary (continued)	7. Shared Care: GP with Midwife 8. Shared Care: Public Hospital with Community Health Centre 9. Private Obstetrician and Private GP 10. GP Private 11. GP/Obstetrician/Public Patient 12. Private Obstetrician 13. Midwife in Private Practice 14. Hospital Birth Centre 15. No Care 16. Shared Care: Hospital Birth Centre with Obstetrician, GP or Midwife in Private Practice 17. Community-Based Public Hospital Care 18. Other Models of Care - Care shared between a private obstetrician and a midwife in private practice - Care shared between a private obstetrician and a midwife - Midwife managed care - Variations on team midwifery (HSV, 1999).
Recommendations	Gestation at the first visit to a doctor or midwife after the pregnancy was confirmed: • Approximately 80% of women first visit a doctor or midwife after knowing they are pregnant … for antenatal care, in the first trimester of pregnancy Model of care at 20 weeks gestation • there is little movement between models of care at 20 weeks, although the actual carer may change. • Region of residence of the woman is a very important predictor of which model of care is used, because of the location of certain types of hospitals in those regions. Overall, the highlights are the lack of availability of certain models in rural regions .. and the increased use of the 'shifted' model of care. [shifted care when a public hospital does not provide any outpatient antenatal care, women attending as public patients are required to obtain this care privately, from either an obstetrician or a GP. During the intrapartum period the woman's care is provided by the hospital medical and midwifery staff working or on call for that day]: • At 20 weeks gestation, single women are in public hospital standard care, shared care or not receiving antenatal care, but they are seldom accessing private obstetricians. Married women show a disproportionately high use of private obstetricians. A higher percentage of single, defacto, divorced, widowed and separated women use shared and shifted care when compared to married women. • 67% of women giving birth in Victoria are admitted as public patients The Accoucher • the accoucheur.. is a hospital midwife in 38% of cases and an obstetrician in another 38%
Health/Report/ author /date	***Thorogood, C, Thiele, B & Hyde, K. (2003). Community Midwifery Program (Western Australia). Evaluation. November 1997-December 2001. Prepared for Community Midwives Western Australia Inc. Centre for Research for Women***
Informed by	Community Midwifery Program women, questionnaires, survey forms
Summary	The CMP started as a pilot project in the Southern Metropolitan Region of Perth in 1996. Conclusions: Numerous studies have demonstrated that community-based maternity services such as that provided by the CMP are effective, safe and extremely well received by women. Programs such as this are focused on women rather than on services or clinicians… In partnership with their midwife, the childbearing woman and her family are encouraged to make informed choices that meet their needs and, irrespective of their choice of the place of their birth, feel that they are in control of the birthing process.
Recommendations	This evaluation demonstrates… that this model of care should be made available to all appropriately screened women.

Health/Report/ author /date	*Territory Health Services. (1999). And the women said…Reporting on Birthing Services for Aboriginal Women from Remote Top End Communities. (Sue Kildea, Women's Health Strategy Unit)*
Informed by	
Summary	The aim of the Remote Area Birthing Project is to develop an approach to birthing in the Top End which will improve birth outcomes and experiences for Aboriginal people and improve the quality of hospital and remote community based services. Improvements will be gained through integrating practices proposed by non urban Aboriginal women and service providers into the existing service delivery structure. This report documents the strategies community based Aboriginal women suggest will improve birth outcomes and their experiences as Territory Health Services clients.
Recommendations	Recommendations are based on the Key Findings (listed below): • Safety – birthing in the community and in personal safety in the regional centre; • Choice – the lack of choice for women and the unattractiveness of available options • Escorts – support in labour often leads to shorter labour with less intervention, less caesarean sections and less complications following birth; • Hostels – two major problems were identified with hostels: - the lack of security in many of the hostels for both the women and their personal property; and - the lack of food in some hostels. • Human Resources – all communities need a skilled, experienced midwife; • Infrastructure and Equipment – there is no standardisation of basic equipment; • Antenatal Women – culturally appropriate educational material and models of care are lacking in both the regional and remote area settings; • Continuing Education – needed for both Aboriginal health Workers and nurses, and rotation of staff from remote areas for updating clinical midwifery skills; • Regional Hospitals – the main issues relate to inappropriate and ineffective communication between staff and patients, including the absence of interpreters; • Birth Centre in Darwin – unanimous support for a birth centre in Darwin; and • Community Birthing – the majority of people consulted felt that community birthing should be available for low risk multiparous women, providing a number of conditions are met.

Health/Report/ author /date	*Tasmanian Department of Health and Human Service (2002). Maternity Options Assessment and Review. Consultation Report (Draft October 2002). (Elizabeth Carroll)*
Informed by	Consultation with Consumers, Government and Non-Government Service Providers.
Summary	Key Issues: 1. Models of care/birthing options 2. Access and equity of maternity services for Aboriginal consumers, consumers with special needs, and consumers in rural and remote areas 3. Service providers' attitudes towards consumers and philosophy towards birth and health 4. Effectiveness, safety and appropriateness of care 5. Staffing availability, education, training 6. Roles and responsibilities of service providers

Dimension of Quality	Key issues
1. Accessibility / Equitability: Ability of people to obtain services at the right place and right time irrespective of income, cultural background or geography	• access for consumers living in rural or remote areas • equity of midwifery support • access to services for consumers from marginalised groups • equity of multidisciplinary input • equity of provision of models of care • aspects of equity

Health/Report/ author /date	*Tasmanian Department of Health and Human Service (2002). Maternity Options Assessment and Review. Consultation Report (Draft October 2002). (Elizabeth Carroll) (continued)*	
Summary (continued)	Dimension of Quality	Key issues
	2. Effectiveness: care, support, intervention or action achieves desired result	• the effectiveness of maternity services for consumers with special needs • the effectiveness of physiotherapy services in relation to childbearing women • the effectiveness of breastfeeding support
	3. Appropriateness/ sustainability: services that are relevant to needs, based on best practice and offer a range of service options	• the range of models of care available • appropriateness of current service provision for consumers with special needs • appropriateness of information available to consumers • appropriateness of clinical intervention
	4. Responsiveness: services that meet the expectations of the community, provide respect for persons and are consumer orientated.	• attitudes of service providers towards consumers • continuity of carer • choice of type of care and choice of carer • control • midwifery-based care • philosophy towards health and birth • flexibility of services • physical amenities
	5. Sustainability: developing and maintaining responsive, innovative and affordable services and programs in collaboration with key stakeholders	• professional indemnity insurance • retention and recruitment of staff • resources for staff education and training • ongoing allocation of physical resources.
	6. Capability: the ability to provide services based on appropriate infrastructure, including skills, knowledge, facilities and systems	• the capacity of service providers to offer general support • the capacity of services to care for consumers with special needs
	7. Integration/ continuity: ability to provide coordinated and linked services through the service continuum and across settings	• collaboration between professionals within maternity services • liaison between maternity services, community support services and other health service providers
	8. Efficiency: achieving desired results through optimal use and allocation of financial, human, physical and technical resources.	• efficiency of service through optimal use of physical resources • efficiency of services through optimal use of human resources
	9. Safety: the potential risks of an intervention or the environment are systematically identified, avoided or minimised.	• the safety of birthing in rural and remote areas • the safety of birthing in hospitals.
Recommendations	• n/a report on consultations only	

Health/Report/ author /date	*South Australia Department of Human Services (1999). Healthy Start Implementation Plan 2000-2011*
Informed by	The directions have been informed by a number of reviews that have been undertaken in order to ensure that a model of service provision was developed which provides flexible and affordable arrangements for the delivery of services for women in South Australia. Two major components identified in this document are Health Start: A Primary Care Approach to Services Supporting Women, Children and Families in the Transition to Parenthood and The Implementation Plan for Obstetric, Neonatal and Gynaecology Services in South Australia. The framework recognises the need for a holistic approach for policy and service development.
Summary	The Statewide Division has prime responsibility for improving the health and well-being of people through improved planning, contracting and co-ordination of services provided by metropolitan hospitals, domiciliary care and mental health services. 2. Clinical service delivery, structure and resources **Key Directions:** A Statewide Planning Framework will provide the direction for the provision of acute Obstetric, Neonatal and Gynaecology Services for South Australia…Changes in clinical practice, technology advancements and consumer preferences in care requirements are influencing the development of service options and models of care. **Key Issues**: The proposed changes are based on the principles of: • concentration of expensive, highly complex and specialised services at tertiary centres, with the provision of primary and follow-up services within the local area • networking with service providers to promote and retain locally accessible services for the majority of consumers • support the networking of service providers in order to facilitate a process whereby staff have the opportunity to provide continuity of care through joint appointments • the provision of obstetric neonatal and gynaecology services reflecting a continuum of care that would incorporate elements of community services to the provision of high-risk services • the revision of the 'Operational Policy, Guidelines and Standards of Maternal and Neonatal Service in South Australia', endorsed and published in January 2000. *2.1 The Statewide Division in conjunction with the major health units will implement an agreed integrated clinical service model by December 2000.* *2.2 Statewide Division will facilitate the changed service roles during the period of 2000/01-2005/6 financial years* *2.3 Statewide Division identifies the current resources allocated for acute Obstetric, Neonatal and Gynaecology services – 2000/01* *2.4 Statewide Division develop revised service specifications which describe the changed service levels, mix and volume of services and perfomance criteria and discuss with individual Chief Executive Officers the transitional funding arrangements 2000/01* *2.5 CEOs of individual health units prepare a Business Plan by December 2000* *2.6 Statewide Division in conjunction with Asset Services identifies the current approved capital works programs that will support the implementation of the recommendations within the plan* *2.7 Statewide Division will continue to review medical and midwifery workforce requirements taking into account: projected reductions in demand for birthing services; the proposed restructuring of services; the recommended changes to models of care* *2.8 Statewide Division develops a 5-year funding allocation program in line with the proposed medium to long term service changes.* 3. Clinical standards, quality and monitoring – research and development **Key Directions**: To develop a coordinated approach to achieve quality obstetric, neonatal and gynaecology service delivery systems that demonstrate a commitment to evidence based practice, evaluation and continuous improvement through collaborative models of teaching, research and development.

Health/Report/ author /date	*South Australia Department of Human Services (1999). Healthy Start Implementation Plan 2000-2011 (continued)*
Summary (continued)	**Key Issues:** The development of a networked service that provides opportunities for: • the provision of continuity of care and carer • consolidate consistent quality clinical standards and accreditation • enhancement of teaching, research and development opportunities • enhancement of linkages with other services eg Child and Youth Health, SHine SA and Helen Mayo House **Key Deliverables** 3.1 Statewide Division establishes a reference group inclusive of all key stakeholders, to identify strategies to achieve consistent approaches to clinical standards, quality and monitoring by December 2000. The practice standards developed shall be regularly reviewed in accordance with international and national evidence based best practice guidelines. They should ensure quality and maintenance of services by including: • consistent access protocols, standards of care and treatment guidelines • uniform protocols in relation to GP Shared Care and Domiciliary Midwifery Services • development of the Midwife Practitioner role • development of continuity of midwifery carer models for all women regardless of risk • use of patient held records • monitoring of clinical indicators by service providers • uniform access protocols for Birth Centres • adoption of the NH&MRC recommendations *3.2 Statewide Division ensures that Teaching and Research opportunities are maximised to support the development of continuous improviment through collaboration with the universities andservice networks* *3.3 Statewide Division will establish a 'single point' of access for rural and metropolitan medical and midwifery personnel to gain perinatal advice and information by 2000/01* *3.4 Statewide Division is committed to the establishment of the Nurse Practitioner/Midwife role through the provision of a Project Office to pursue the recommendations of the Nurse Practitioner Report (NUPRAC) completed in November 1999* DHS is supporting the following initiatives to promote consumer awareness, evaluate models of care and promote healthy living and improved perinatal outcomes. • Development and production of a promotional pamphlet/booklet to inform women as to their choices for childbirth, in terms of care providers and places of care. Project Manager: Project Officer, Strategy & Operations Service • Development, implementation and evaluation of a midwifery led model of care at TQEH and evaluation of the outcomes of care at the LMHS in relation to the midwifery led model. Project Manager: NWAHS, Nursing Director, Division of Obstetrics, Gynaecology and Paediatrics • Aboriginal Services Division is currently developing a two (2) year program to reduce smoking and improve the nutrition of Aboriginal children, young women and mothers in the far north and west of SA. This program is currently being evaluated for funding. 4. Support for rural areas **Key Directions** A Statewide Planning Framework will assist Country and Disability Dvisions's ongoing commitment to its key priorities of ensuring safe clinical practice. In particular, strategies will be explored to ensure that services are provided in an integrated and flexible manner and are sensitive to the needs of women from rural and remote communities **Key Deliverables** *4.1 Country & Disability Division in conjunction with the Statewide Division – Nursing Unit will implement an agreed training and development program for midwives in 2000/2001* *4.2 Country & Disability Division, in collaboration with major metropolitan health units and Aboriginal Services Division, will develop a strategy that explores the opportunities for appropriate accommodation arrangements and support options for rural and remote women and their families by 2000/01*

Health/Report/ author /date	*Western Australian Statewide Obstetrics Services Review, Report Of the Project Working Group. Discussion Paper April 2003*
Informed by	The Terms of Reference of the review were; *to address issues relating to provision of public hospital birth services; to ensure optimum safety and efficiencies of services, review current and five year predictions for human resources requirements; review birth practices and procedures and identify and recommend areas for improvement with specific regard to adoption of standard protocols; indications for secondary and tertiary referral and training of staff and to review and recommend a system of clinical governance committees for birth.* A literature review was conducted to help formulate a balanced set of principles that would support quality and safety principles, whilst acknowledging the unique circumstance of Western Australia. The literature review suggests that clinical safety, quality, efficiency and effectiveness guidelines require determination of clear indicators of minimum births numbers where capacity to service exists and determination of travel time when a practitioner is recalled for urgent duty. These definitions can then be used as a basis for planning and the capacity of hospitals to provide safe services, optimal numbers of deliveries; resultant equipment needs, teaching capacity, professional development and staff coverage.
Summary	• The aim of the review has been to develop an 'in principle' approach, based upon a quality and safety framework, which can be used when implementing the recommendations contained in this report. • A number of relevant reports such as the Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia (1990) were considered. It was evident that there were recurrent themes that emerged, that remain of relevance today. This indicates a significant commitment of resource and time needs to be invested into Obstetrics Services, to allow adoption of world's best practice. Additionally, the group has had access to material sourced from interstate and overseas. A list of references is appended. • The last decade has seen significant changes in the way obstetric care is delivered in Western Australia. The changing needs and expectations of Western Australian women during the antenatal, labour, birth and post natal periods, has highlighted the need for an integrated approach, based on clearly defined and monitored best practice guidelines and quality improvement initiatives. • The myriad of issues relating to staffing levels, recruitment and retention strategies, indemnity, accountability and responsibility demands, capacity of work conditions to match service requirements and the need to effectively and efficiently integrate services on a state wide basis, were raised by health care professionals.
Recommendations	***Recommendation 1: Endorsement Of Service Models*** That the proposed integrated obstetric services model and the metropolitan obstetric services model, that are both based upon minimum safety and quality requirements, are established and implemented. ***Recommendation 2: Chief Medical Officer Classification*** That the chief medical officer endorses the models and directs that the recommendations are applied to all facilities and beds offering public obstetrics services which are then classified accordingly and that services not meeting minimum standards or numbers of births may be withdrawn. ***Recommendation 3: Clinical Governance*** That each obstetric unit must be involved in and linked to, a functioning clinical governance committee, that meets standards set by the chief medical officer. ***Recommendation 4: Statewide Obstetric Service*** That a statewide obstetric service is established, supported and funded as a matter of priority. ***Recommendation 5: Consumer Education*** That education regarding the choices and associated risks in obstetric service provision to childbearing women, is promoted in a culturally sensitive way, in the community by publication, internet and information handouts. ***Recommendation 6: Consumer Linkage*** That an information service is explored and linked to a telephone service and an internet web page, is established to enable the woman and her family to 'check the facts' and information they may have heard, or been given regarding pregnancy, labour, birth and the postnatal period.

Health/Report/ author /date	*Western Australian Statewide Obstetrics Services Review, Report Of the Project Working Group. Discussion Paper April 2003 (continued)*
Recommendations (continued)	***Recommendation 7: Workforce Issues Working Group*** That the health department and statewide obstetric service analyse workforce issues and recommend options for solutions to the state health management team. ***Recommendation 8: Enhanced Role Of The Midwife*** That the 'enhanced role of the midwife' is implemented as a priority. ***Recommendation 9: Midwifery*** There is an urgent need for the statewide obstetric service to conduct a review of training, support and develop methods of attracting and retaining midwives in the speciality of midwifery, in conjunction with the relevant colleges. ***Recommendation 10: Oobstetricians*** There is an urgent need for the statewide obstetric service to conduct a review of training, support and methods of attraction to bring and retain doctors in the speciality of obstetrics, in conjunction with the relevant colleges. ***Recommendation 11: Anaesthetists And General Practitioner Anaesthetists*** There is an urgent need for the statewide obstetric service to review incentives, availability and methods of attracting anaesthetists and gp anaesthetists to provide obstetric anaesthetic services. ***Recommendation 12: Allied Health*** That the statewide obstetric service undertakes an analysis to determine the quality guidelines and obstetric credentialling requirements and service demand for allied health staff. ***Recommendation 13: Mother And Baby Unit Integrated*** That the mother and baby unit is transferred from Graylands hospital to King Edward memorial hospital as soon as possible. ***Recommendation 14: General Practice Obstetricians*** That the statewide obstetric service formulates and implements a plan to ensure that general practitioners are encouraged to pursue the speciality of obstetrics and support general practitioner obstetricians to maintain involvement, training and credentialling. ***Recommendation 15: Practitioner Education & Training*** That a comprehensive education and training program is developed by a working group, to fully describe the requirements and identify the linkages across disciplines. ***Recommendation 16: Clinical Academic Titles*** That clinical academic titles are appointed and located at secondary and regional hospitals. This would include the establishment of a professor of midwifery. ***Recommendation 17: Academic Education And Research Centre*** That a master service-plan is completed to facilitate the establishment of a new academic and research centre in close proximity to the tertiary services. ***Recommendation 18: Business Case For Funding*** That business cases that identify the costs in relation to a statewide obstetric service, an education and research facility and hospital and staff accommodation upgrades are prepared for the budgetary consideration of the state health management team, as soon as possible.
Suggested Models	Following the review of current models of care, the literature and consideration of practitioner input, based on many years of collective clinical experience, the following model was arrived at. The model takes into account safety, staffing, efficiencies and economies of scale. The capacity of a hospital to deliver services to a predetermined level was then defined. This model is conceptual and based upon quality and safety principles in the first instance. **6.1 Critical Assumptions** • Care should be provided as close to home as possible consistent with the risk assessment contained in the model. • Hospitals will only deliver services consistent with a Secondary or Tertiary hospital role. • The Tertiary Hospital also incorporates a Secondary hospital role to service the local catchment population. • Risk is described as low (uncomplicated), medium (intervention maybe required) and high (potential for significant complication) and relates to transfer guidelines.

Health/Report/ author /date	*Western Australian Statewide Obstetrics Services Review, Report Of the Project Working Group. Discussion Paper April 2003 (continued)*
Suggested Models (continued)	**6.2 Proposed Models** • Integrated Obstetric Service Model: The proposed Integrated Obstetric Service Model … presents the key service capacities of each level of hospital facility and provides a whole of state focus. The Integrated Obstetric Service Model is then applied based upon the numbers of births, staffing levels and economies of scale to the public system in a Perth Metropolitan Model context. (In Section 6.2.2) • Metropolitan Obstetrics Services Model: The model … for the Perth metropolitan area applies the criteria described previously for Secondary and Tertiary Hospitals. It is apparent when applying minimum numbers required to sustain a safe, quality, efficient and effective service, that Perth should only sustain a maximum of five Secondary Obstetric units (more than 1,000 births) and one Tertiary hospital (more than 5,000 births). To achieve optimum safety, economies of scale and critical mass, it is advised that four Secondary units delivering 1,500 births per annum provide for better birth per practitioner ratios.
Model Advantages	1) Better access to a range of childbirth services by; a) An increased number of Birth Centres. b) Midwifery led care in Birth Centres. c) Traditional Obstetrician led care with enhanced access to consultants. d) 24 hour specialist services. e) Access to Obstetric Allied Health services as required. 2) Improved monitoring of adherence to Best Practice Guidelines resulting in increased quality of care and clinical governance. 3) Increased birth numbers at the Tertiary and Secondary hospitals will enhance collegiate team development, education and research opportunities, clinical governance, opportunities for training, professional support and development. 4) Service realignment will allow enhanced local community opportunities for other health needs such as aged care or rehabilitation. 5) Recruitment and retention ability will be enhanced with an increase in critical mass at centres. This will reduce agency nursing requirements and costs, redistribute the existing staff pools across fewer centres, whilst training and recruitment packages address the medium and long-term deficits. 6) Practitioner lifestyle improvements due to more predictable rosters will enhance recruitment and retention ability and decrease staff burnout. Larger teams also provide better opportunity for peer support. 7) The proposed model takes into account the international and national growing shortage of General Practice Obstetricians, Obstetricians, Midwives, Anaesthetists, Paediatricians and Allied Health professionals. 8) The proposed model provides increased opportunities for the development of the role of midwives as independent and interdependent professionals in the provision of childbirth services 9) The proposed model supports the enhancement of the General Practitioner Obstetrician role by increased involvement and further development of a collegiate partnership. The opportunity to maintain and develop skills of General Practitioner Obstetricians linked to effective public system credentialling, increases with staff availability needs being met. This will result in greater opportunities for public sector professional development. 10) On site provision of essential support services at Secondary/Regional Centres such as Pathology, Diagnostic Imaging, Physiotherapy, Social Work, Dietetics and Psychological Medicine support as required, will be improved. 11) Increased efficiency in capital works, equipment, staff rosters, support services, consumables and transport/transfer of patients will reduce costs by reducing number of duplicated centres. This will facilitate redirection of funds to improve quality of services and facilities such as the birth centres. 12) Facilities and services that better reflect changing population demographics, aligned to transport links and indicators of current and future growth in Perth, would be created.

Health/Report/ author /date	*Western Australian Statewide Obstetrics Services Review, Report Of the Project Working Group. Discussion Paper April 2003 (continued)*
Model Advantages (continued)	Challenge to Implementation 1) Lobbying may result in community distress over changes to local facilities, such as perceived lack of access in local areas with prior service delivery history. These issues need to be addressed by wide consultation and community education. 2) Patch protection at some hospitals and by some clinicians may divert the attention from the real issues as described above. 3) Change management issues such as staff movements, service rationalisation and claims that service will decline, need to be managed effectively and in a timely manner. 4) Possible loss of remuneration to some current service providers may result in a public campaign to discredit the model, despite the clinical imperative provided. 5) Capital works requirements and service funding required may not be allocated in a timely manner resulting in delays and negatively affecting morale. 6) Early acceptance of the model by users and consumers is desirable. Therefore consultation with the following groups needs to be planned and undertaken and will help to resolve some of the challenges identified above. Relevant and important suggestions may arise from this process. a) Australian College Midwives (ACMI); b) Australian Nursing Federation (ANF); c) Australian Medical Association (AMA); d) Royal Australian College of General Practitioners (RACGP); e) Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG); f) Australian and New Zealand College of Anaesthetists (ANZCA) ; g) Royal Australasian College of Physicians (Paediatricians) (RACP); h) Division of General Practitioners (Div.GPs); i) Western Australian General Practice Education and Training (WAGPET); j) Rural Doctors Association (RDA); k) Western Australian College of Rural and Remote Medicine (WACRRM); l) Health Consumers Council (HCC); m) Department of Health Western Australia (Other task forces/key stakeholders); n) Australian Physiotherapy Association (APA); o) Aboriginal Medical Services (AMS); p) Royal Flying Doctors Service (RFDS); q) Medical Defence Australia (MDA); r) Hospital Salaried Officers Association (HSOA); s) Miscellaneous Workers Union (MWA); t) Other Professional, Federal, State, Local Government and community groups as indicated
Health/Report/ author /date	***Victorian Department of Human Services (2004). Rural Birthing Services. Rural & Regional Health Services Branch. Planning Framework. August 2004 Final Draft***
Informed by	Rural Birthing Services Discussion Paper (2003), feedback from an Expert Reference Group.
Summary	The Victorian Government is committed to the continued provision of safe and high quality birthing services throughout the state, as this is an essential component of a comprehensive health system designed to meet the needs of all communities. The desired outcome is ultimately the safe management of pregnancy, labour, birth and postnatal care, with the minimisation of avoidable adverse events. To support this objective, a planning framework has been developed which defines levels of service, with the minimum standards required to achieve each level. The focus of the planning framework is on the designated levels of care and roles for rural and regional health services. The objective of the planing framework is to outline a fair, equitable and transparent planning approach for service providers, consumers and the Department of Human Services. The framework is intended to address the basic issue facing health services in rural areas, which is what level of birthing service is sustainable both now and in the future, with four service levels described. To assist health services to make an informed decision the framework defines the minimum standards in terms of structures, protocols and service arrangements that need to be formally put in place to ensure service continuity at each level.
Recommendations	

Health/Report/ author /date	*Victorian Department of Human Services (2004). Future Directions for Victoria's Maternity Services*
Informed by	Consumer surveys, literature reviews, (NHMRC 1998, ED Hodnett 1996), review of existing services, analysis of current intervention rates in maternity services in Victoria.
Summary	The purpose in initiating this statement is to offer a leadership role in setting an agenda for future direction win birthing services throughout Victoria. The statement sets out a framework for gradual but strategic changes that will guide service developments over the next 5-10 years. The aim of the document is to work towards high quality birthing services where providers work with a collaborative approach and where women are informed and have choices, with women the focus of maternity care. The statement was developed in the context of community and Government concern about services closing and issues being raised by consumers. The statement recognises that pregnancy and childbirth, while requiring quick and highly specialised responses to complications, are a normal physiological process. It acknowledges that obstetricians and general practitioners are fundamental to high quality care but the average woman experiencing an uncomplicated pregnancy does not required ongoing speciality supervision. The focus of the document is on women rather than health services, with three levels of care defined for women. The three levels of maternity cervices defined are: • Primary (Provided by midwives and/or GPs for low risk women) • Secondary (involving specialist medical care) • Tertiary (for complex care to be provided from the Royal Women's Hospital, Mercy Hospital for Women and Monash Medical Centre) In this context rural and regional services would be expected of offer a mix of either primary or secondary care, depending on patient need and choice and service provider availability. Benefits of the service framework: • Increased options for women: The development of mainstream primary care services will provide choice and encourage consumer involvement in decisions about care. The new service framework will achieve the right balance in providing women with (1) greater choice and control of their birthing experience and (2) access to appropriate and needed levels of medical expertise. • Support for rural services: The new service framework will support the provision of maternity services in rural communities to ensure women continue to have access to quality maternity care. • A workforce working together for the benefit of women: This model will make the best use of the complementary skills of midwives, general practitioners and obstetricians, while promoting multidisciplinary learning, respect and trust among these different disciplines. • Safety and quality of care: Studies and experiences from within Australia and overseas suggest maternity services that adopt a continuity of care approach to service provision can expect lower rates of intervention, without jeopardising safety. The Maternity Services Advisory Committee is working with health services to support analysis of intervention rate data, to ensure interventions such as caesarean section are used appropriately.
Recommendations	• Providing continuity of carer through a teamwork approach. • Focusing on primary maternity services Implementation strategy – 6 point plan 1. Establishing primary maternity services in metropolitan Melbourne 2. Supporting the provision of maternity services in rural Victoria 3. Undertaking workforce training and support 4. Investing in the tertiary maternity services: 5. Providing emergency consultation and co-ordination: An integrated maternity service requires excellent coordination to provide access to specialist workers and its tertirary hospitals when required. 6. Calling on the Australian Government: We call on the Australian Government to work with us by agreeing to fund antenatal care more flexibly.
Outcomes	n/a as this is a planning document

Health/Report/ author /date	*Three Centres Consensus Guidelines on Antenatal Care Project, Mercy Hospital for Women, Southern Health and Women's & Children's Health 2001.*
Informed by	The evidence for intervention questions presented in these guidelines was systematically assessed and classified according to the NHMRC's A Guide to the Development,Implementation and Evaluation of Clinical Practice Guidelines (1998) Evidence for other questions was generally given the equivalent of Level IV status by consensus of the steering group and clinical epidemiologist.
Summary	The guidelines were developed for a 'normal healthy woman in her first singleton pregnancy'. Such a woman may be easily imagined but is more difficult to define. (Valid until December 2003 unless otherwise indicated) The aim of these guidelines is to provide information to midwives and doctors regarding: 1. the number and timing of routine antenatal visits for low risk women; 2. to advise women on models of care that are safe and satisfactory; 3. to reduce the risk of poor health outcomes for babies caused by exposure to maternal smoking (also to reduce the long-term health risks for mothers associated with tobacco use); 4. to counsel women enabling them to make informed choices regarding prenatal testing for Down's Syndrome; 5. in the detection of asymptomatic bacteriuria in pregnant women and decrease associated outcomes of urinary tract infections, pre-term birth and low birth weight in infants; 6. to detect hepatitis B virus (HBV) in pregnant women in order to prevent transmission to newborns, to detect hepatitis C virus (HCV) in pregnant women; 7. in the detection of mothers who are Human Immunodeficiency Virus (HIV) positive to decrease the incidence of vertical transmission; 8. to detect syphilis in pregnant women in order to treat mothers and prevent transmission to infants; 9. in accurate measurement of blood pressure to identify the likely onset of hypertensive disorders of pregnancy; 10. in their decisions about weighing pregnant women to detect foetal growth restriction, macrosomia and hypertensive disorders of pregnancy; 11. in accurate measurement of uterine size in order to identify foetuses that are either small or large for gestational age so as to improve outcomes for those foetuses; 12. in their decisions about methods to detect pre-eclampsia, chronic renal disease and urinary tract infections; regarding auscultation of the foetal heart during pregnancy; 13. regarding screening pregnant women for gestational diabetes mellitus (GDM); 14. in the prevention of early onset group B streptococcal disease (GBS) in newborns; 15. on antenatal discharge planning for women assessed as low obstetric risk in order to reduce maternal anxiety, maternal and neonatal morbidities and increase satisfaction with care.
Key Findings/ Recommendations	2. Models of Antenatal Care Guidelines: • At, or prior to, their first antenatal visit all women should be provided with appropriate written information about the models of pregnancy care available to them (in terms of cost to women, continuity and transition from hospital to home and other information as women identify it). • A description of the roles of the various carers may assist their decisions. • At each antenatal visit midwives and doctors should offer information, consistent advice, clear explanations, and provide women an opportunity to ask questions. • Women are more likely to be satisfied with antenatal care when they perceive midwives and doctors are kind, supportive, courteous, respectful and recognise their individual needs. Women should not be kept waiting for long periods or feel rushed through visits and investigations. • Wherever possible, women should be offered continuity of care, including continuity of carer. • Midwifery and GP- led models of care are safe for low risk women.

Health/Report/ author /date	*Three Centres Consensus Guidelines on Antenatal Care Project, Mercy Hospital for Women, Southern Health and Women's & Children's Health 2001. (continued)*
Key Findings/ Recommendations (continued)	Good Practice Notes • Routinely involving obstetricians in the care of low risk women at scheduled times does not appear to improve perinatal outcomes compared with involving obstetricians when complications arise. Where possible, women should be sent or given written information on models of care prior to their first visit. This is due to the high volume of information that women are required to process and the decisions required at their first and second visits. Individual preferences regarding models of care should be established and discussed in the first two antenatal visits. • Women should be offered the option of carrying a copy of their antenatal record.
Health/Report/ author /date	***Barclay, L, Brodie, P, Lane, K, Leap, N, Reiger, K, Tracy, S (2002). The AMAP Report - Volume 1 & Volume 2.***
Informed by	An action oriented research process facilitated the collaboration of Industry Partners (Australian College of Midwives Inc, Women's Hospitals Australasia, South East Sydney Area Health Service, SA Dept of Human Services, NSW Health Department), researchers, relevant organisations and the wider community in active collaboration throughout the project…Important research participants included health services and agencies who provide maternity care; professional organisations for midwifery, nursing and obstetrics,; educators and institutions involved with midwifery education; statutory authorities responsible for the regulation of midwives; and consumer groups. These stakeholders collaborated in the research to generate the outcomes needed to inform: maternity service policy and service provision; the education of midwives; and the workforce and the regulation of midwives within the maternity sector.
Summary	The project investigated maternity service provision, midwifery education, policy and regulation and analysed the barriers to safe and cost effective midwifery care. It also examined the problems of communication and co-ordination across these sectors. Terms of Reference: The contract between UTS and the Industry partner… stated that a national research project entitled 'The improvement of midwifery care', would 'provide information what [would] assist Industry Partners, health departments, health services, universities and regulatory bodies to co-ordinate planning and improve the implementation of maternity care.' The two main aims of the research project were: • To investigate the service delivery, educational, policy and regulatory environments affecting midwifery in Australia; • To analyse and facilitate collaboration, planning and communication across these sectors. Research Questions: • What are the barriers to the provision of safe, efficient and economic midwifery care within maternity services? • What are the strategies to overcome these barriers?
Key Findings/ Recommendations	Volume 1 **SERVICE PROVISION** **Recommendation 1** That an evidence-based, woman centred approach to the provision of public sector maternity care be adopted. This would involve the mainstreaming of models of continuity of midwifery care that have been demonstrated to be effective in the Australian setting. **Recommendation 2** That models of maternity care be implemented to provide hight quality, safe, appropriate and cost effective care: • To enable midwives to practise according to the full potential of their role, providing continuity of care to women across the interface of community and acute services • To ensure that midwives practise within a framework that is supportive, collaborative and interdisciplinary.

Health/Report/ author /date	*Barclay, L, Brodie, P, Lane, K, Leap, N, Reiger, K, Tracy, S (2002). The AMAP Report - Volume 1 & Volume 2. (continued)*
Key Findings/ Recommendations (continued)	**Recommendation 3** That both Commonwealth and State governments review the funding mechanisms that govern the provision of matnerity care in Australia in order to support community orientated maternity services and midwifery care as an option for women. **Recommendation 4** That midwives be authorised to order and interpret a limited range of tests and to prescribe specified drugs as part of the care of healthy women during uncomplicated pregnancy and childbirth, as already recommended by the 1998 'NHMRC Review of Services offered by Midwives'. This should be implemented immediately. **Recommendation 5** That, in order to support enhanced midwifery practice through the development of national standards, leadership and a cohesive political voice, the Australian College of Midwives Incorporated develop further strategies to increase its profile within health services. **WORKFORCE** **Recommendation 6** That a national database of the midwifery workforce be developed to allow for rational planning of the future midwifery workforce. **Recommendation 7** That research identifying issues related to recruitment, retention, attrition and the employment profile of new midwifery graduates to be funded by the Commonwealth government. **Recommendation 8** That the current midwifery workforce shortages be addressed through national recruitment and retention strategies targeted to areas of critical need. This may require collaboration and involvement by the Commonwealth government, the state and territory governments, the professions and/or industry. **Recommendation 9** That workforce development and maintenance of midwifery practice standards be identified in the overall planning and provision of safe and supportive maternity care in any setting. **EDUCATION** **Recommendation 10** That the Commonwealth DEST increases its allocation of funded positions for students (EFSTU) in midwifery education programs. **Recommendation 11** That dedicated funding be identified to promote collaboration between industry and universities to guarantee adequate clinical placements in hospitals, birth centre, midwifery models and community midwifery settings in order to achieve minimum clinical practice standards in midwifery education. **Recommendation 12** That the interface between universities and the health system be strengthened in midwifery education, emphasising the importance of clinical placements and the engagement and investment of clinicians and health services in the teaching and assessment of students. **Recommendation 13** That the amount and nature of supernumerary content of programs be reviewed to ensure: • Students 'belong' to a clinical workforce and benefit from becoming part of a clinical team; • An appropriate system of funding by jurisdictional health authorities support and resources from industry enables this to happen. **Recommendation 14** That active support and incentives are funded and implemented for rural students and Aboriginal and Torres Strait Islander students to enter programs that meet their learning and cultural requirements. **Recommendation 15** That the cost for students undertaking midwifery education be subsidised in the light of workforce shortages.

Health/Report/ author /date	*Barclay, L, Brodie, P, Lane, K, Leap, N, Reiger, K, Tracy, S (2002). The AMAP Report - Volume 1 & Volume 2. (continued)*
Key Findings/ Recommendations (continued)	**Recommendation 16** That the Commonwealth Government funds the evaluation of the introduction of the three-year Bachelor of Midwifery and the double degree in Nursing and Midwifery. **REGULATION** **Recommendation 17** That the ACMI standards for midwifery education and practice be adopted by all regulatory authorities as the national standards for midwifery education and practice, and that the AMCI and service providers become key participants in the accreditation of all courses leading to authorisation to practise midwifery. **Recommendation 18** That the renewal of registration for midwifery practice be tied to continuing education and recency of practice. **Recommendation 19** That all industrial, legislative and regulatory frameworks give recognition to the safety and cost effectiveness of midwifery care recognising and licensing the midwife as a practitioner in her or his own right. **Recommendation 20** That the current state and Territory Nurses Regulations be strengthened to improve standards in the accreditation of midwifery education programs and national comparability through a national organisation such as National Nursing and Midwifery Council of Australia. **CONSUMERS** **Recommendation 21** That providers initiate coherent policies at regional, state and national levels to encourage the participation by consumers in planning, reviewing and monitoring maternity services and that jurisdictional health authorities fund these initiatives. **Recommendation 22** That attention be directed towards philosophies and models of care that recognise the importance of placing women at the centre of decision-making about their own care.
Health/Report/ author /date	***WA Department of Health (2003). Western Australian Statewide Obstetrics Service Review. The Report of the Project Working Group***
Informed by	The Obstetric Services Working Group was commenced as part of a broad review of clinical services established in late 2001, for the Western Australian Department of Health's State Health Management Team.
Summary	The immediate goal was to provide a vision of a new way forward that reaffirmed the important role of obstetrics in the community. A way forward that considers the rights, diversity and cultural dignity of the consumer to be paramount. The aim of the Working Group was to develop a model that defines best practice principles of quality, clinical safety, efficiency and effectiveness and recommend future strategic initiatives. The purpose of the review group was to ascertain the current status of Obstetric services in Western Australia and to make recommendations for future strategic initiatives. This innovative approach was aimed at gaining consensus and key support from clinicians to own a model that they will support. **TERMS OF REFERENCE** i. To review the current provision of Metropolitan (and country public) hospital birth services (antenatal, delivery and postnatal) with a view to ensuring optimum safety and efficiencies of services. ii. To review the current staffing requirements for birth services and make recommendations to address any current or future deficiencies. iii. To review current birth practices and procedures. Identify and recommend areas for improvement with specific regard to adoption of standard protocols, indications for secondary and tertiary referral and training of staff. iv. To review and recommend a system of clinical governance committees for births.

Health/Report/ author /date	*WA Department of Health (2003). Western Australian Statewide Obstetrics Service Review. The Report of the Project Working Group (contiinued)*
Recommendations	**RECOMMENDATION 1: ENDORSEMENT OF SERVICE MODELS** That the proposed Integrated Obstetric Services Model and the Metropolitan Obstetric Services Model, that are both based upon minimum safety and quality requirements, are established and implemented. **RECOMMENDATION 2: CHIEF MEDICAL OFFICER CLASSIFICATION** That the Chief Medical Officer endorses the models and directs that the recommendations are applied to all facilities and beds offering public Obstetrics Services which are then classified accordingly and that services not meeting minimum standards or numbers of births may be withdrawn. **RECOMMENDATION 3: CLINICAL GOVERNANCE** That each obstetric unit must be involved in and linked to, a functioning clinical governance committee, that meets standards set by the Chief Medical Officer. **RECOMMENDATION 4: STATEWIDE OBSTETRIC SERVICE** That a Statewide Obstetric Service is established, supported and funded as a matter of priority. **RECOMMENDATION 5: CONSUMER EDUCATION** That education regarding the choices and associated risks in obstetric service provision to childbearing women, is promoted in a culturally sensitive way, in the community by publication, Internet and information handouts. **RECOMMENDATION 6: CONSUMER LINKAGE** That an information service is explored and linked to a telephone service and an Internet Web page, is established to enable the woman and her family to 'check the facts' and information they may have heard, or been given regarding pregnancy, labour, birth and the postnatal period. **RECOMMENDATION 7: WORKFORCE ISSUES WORKING GROUP** That the Health Department and Statewide Obstetric Service analyse workforce issues and recommend options for solutions to the State Health Management Team. **RECOMMENDATION 8: ENHANCED ROLE OF THE MIDWIFE** That the 'Enhanced Role of the Midwife' is implemented as a priority. **RECOMMENDATION 9: MIDWIFERY** There is an urgent need for the Statewide Obstetric Service to conduct a review of training, support and develop methods of attracting and retaining Midwives in the speciality of Midwifery, in conjunction with the relevant colleges. **RECOMMENDATION 10: OBSTETRICIANS** There is an urgent need for the Statewide Obstetric Service to conduct a review of training, support and methods of attraction to bring and retain doctors in the speciality of Obstetrics, in conjunction with the relevant colleges. **RECOMMENDATION 11: ANAESTHETISTS AND GENERAL PRACTITIONER ANAESTHETISTS** There is an urgent need for the Statewide Obstetric Service to review incentives, availability and methods of attracting Anaesthetists and GP Anaesthetists to provide Obstetric Anaesthetic services. **RECOMMENDATION 12: ALLIED HEALTH** That the Statewide Obstetric Service undertakes an analysis to determine the quality guidelines and obstetric credentialling requirements and service demand for Allied Health staff. **RECOMMENDATION 13: MOTHER AND BABY UNIT INTEGRATED** That the mother and baby unit is transferred from Graylands Hospital to King Edward Memorial Hospital as soon as possible. **RECOMMENDATION 14: GENERAL PRACTICE OBSTETRICIANS** That the Statewide Obstetric Service formulates and implements a plan to ensure that General Practitioners are encouraged to pursue the speciality of Obstetrics and support General Practitioner Obstetricians to maintain involvement, training and credentialling. **RECOMMENDATION 15: PRACTITIONER EDUCATION & TRAINING** That a comprehensive education and training program is developed by a Working Group, to fully describe the requirements and identify the linkages across disciplines.

Health/Report/ author /date	*WA Department of Health (2003). Western Australian Statewide Obstetrics Service Review. The Report of the Project Working Group (contiinued)*
Recommendations (continued)	**RECOMMENDATION 16: CLINICAL ACADEMIC TITLES** That Clinical Academic titles are appointed and located at Secondary and Regional Hospitals. This would include the establishment of a Professor of Midwifery. **RECOMMENDATION 17: ACADEMIC EDUCATION AND RESEARCH CENTRE** That a master service-plan is completed to facilitate the establishment of a new Academic and Research centre in close proximity to the Tertiary services. **RECOMMENDATION 18: BUSINESS CASE FOR FUNDING** That business cases that identify the costs in relation to a Statewide Obstetric Service, an Education and Research facility and hospital and staff accommodation upgrades are prepared for the budgetary consideration of the State Health Management Team, as soon as possible.

Appendix 8
Consumer Issues

The experience of pregnant women in Queensland: Issues emerging from submissions

As its first task, the Review of Maternity Services called for community submissions in general and specialist media and through posters circulated to places offering maternity care. Over a four-month period, a total 447 submissions were received, with over half (229) of these from maternity services consumers, almost all women. An additional 18 submissions were received from organisations representing well over 500 consumers as members, including the Maternity Coalition (Queensland), Friends of the Birth Centre Queensland Association Inc. Kyabra Community Association, the Gold Coast Homebirth Support Group, Birthtalk, the Childbirth Education Association, Consumers for Choices in Childbirth, the Ethnic Communities Council of Queensland, Women with Disabilities Australia, Birth Trauma, Women in Agriculture, and Mums in Touch. In addition, 44 of the health care professionals who wrote to the Review reported on consumer experiences as well as carer experiences.

Including those who identified also as consumers, the Review received 102 submissions from health care professionals (75 midwives, 27 obstetricians, 7 general practitioners, and 9 other health care professionals). The remaining 116 submissions were from maternity care hospitals (12 submissions), support organisations (18 submissions), Local and State Government bodies (23 submissions), universities (10 submissions), professional organisations (7) and other interested individuals.

Consumer submissions offer a unique picture of maternity experiences in Queensland. They differ from a systematic study of consumer opinion (which has not yet been done in the State) in that the views expressed do not necessarily represent those of the whole community. For example, homebirth care and birth centre care experiences are over-represented in consumer submissions compared with actual experience of care. While less than one per cent of women access these approaches to care, homebirth care is the subject of almost a quarter of consumer submissions and birth centre care is the subject of over a third of the consumer submissions (many submissions addressed more than one subject).

Consumer submissions provide valuable feedback from people motivated to write and the over-representation highlights issues that people are motivated to write about. The submissions raise issues about urban/metropolitan and rural/remote maternity experiences in Queensland, many of which echo the issues raised in other consumer studies. Several consumers compare different experiences within the State. Some compare a Queensland experience with an experience elsewhere in Australia or internationally. Individuals making submissions have experienced between zero (currently pregnant with a first baby) and nine births.

Many submissions from consumers welcome the Review of Maternity Services and express a view that change is needed in maternity care in Queensland. Many share a belief that pregnancy and birth are vital to the life of a community and that their own pregnancy and birth experiences were among the most important of their lives. 'The real reasons for our passion about birth are hard to describe. They are to do with how we feel. Not only is it hard to find the right words, we have adapted to a maternity system which devalues how people feel.'

Many consumers provide valuable feedback on specific approaches to care. Submissions about homebirth or birth centre care are almost invariably positive, and 63 submissions were received from women whose pregnancy and birth experiences included Mackay Birth Centre experiences. The vast majority of submissions about other approaches to care, in both public and private sector environments, recount negative experiences, particularly in terms of labour and birth care and post-birth care and support. Consumers suggest some interesting strategies which might improve care while achieving economies for the system.

The Review is privileged to have been provided with this rich data on the experience of mothers and families in Queensland and appreciates the time taken especially by new mothers to contribute in this way. The Review's recommendations would be much poorer without this input.

This paper includes consumer issues raised by

- Individuals with experience of maternity care
- Health care professionals who raise consumer issues (from their own experiences as consumers of maternity care or from surveys of consumers)
- Organisations providing support to consumers that identify their clients' issues (generally from surveys)
- Health care organisations that raise consumer issues (from surveys).

The paper does not include workforce issues which are dealt with in a separate paper.

Themes which emerge consistently in submissions can be summarised under broad headings

- Choice and Access
- Information
- Participation and Respect
- Continuity of Care/Carer
- Safety.

Choice and Access

A key issue that emerges from consumer submissions is the importance of choice in maternity services which is related to access to services. For many women, lack of choice is the primary reason for their making a submission to the Review. They report having had little or no choice and/or having been unable to access the kind of care they wanted. When they mention choice, many women specifically want birth centre care, homebirth care, care with a known midwife or care in local communities.

The lack of choice about approaches to care leaves women uncomfortable when they make a choice they feel is the best they can in the circumstances. Submissions that raise homebirth care point to the lack of independent midwives, the cost of homebirth care which must be met entirely by the consumer and the lack of acceptance of homebirth care as normal.

Choice and access for Indigenous women

The Review received no submissions from women who identified as being Aboriginal or Torres Strait Islander.

Submissions from health providers raise a number of issues relating to choice and access for Indigenous women. The Queensland Aboriginal and Islander Health Forum (QAIHF) points to the need to 'invest effort to enhance the capacity of the Aboriginal Community Controlled Health Service to provide maternity health services.' The Royal Flying Doctor Service (RFDS) raises a number of issues including the need to recognise traditional birth attendants in maternity care.

Officers of the Department of Aboriginal and Torres Strait Islander Policy raise a number of key issues and suggest a multidisciplinary collaboration across national and Queensland agencies and private sector and community organisations is needed.

On birthing on homelands, QAIHF draws attention to issues of safety, duty of care and culturally appropriate service provision which need further consideration. Care must be tailored to respond to Aboriginal and Torres Strait Islander people's needs and to address/reduce '... low birthweight, nutrition and nutrition-infection interactions, enteric pathogens, and other conditions and pathologies contributing to infant health problems.'

QAIHF and other providers stress the need for community engagement and participation, specifically 'community based birthing services, traditional birthing attendants, social support strategies, and community and family escorts.'

Choice and access for women in rural and remote communities

Over 30 individuals from rural and remote communities wrote to the Review, and access to local pregnancy, birth and post-birth care was by far the most common issue they raised. This issue was also raised by a number of support organisations and professional bodies representing rural practitioners.

Women in rural and remote communities report having to travel for antenatal classes, antenatal care, labour and birth care and post-birth care. 'Antenatal classes were only available in Longreach (200 km away) and were held at night over a 12-week period. Attending these classes was out of the question...' Suggestions are made that some material might be provided in booklets, by video and that weekend courses would suit families better.

The lack of birthing places in many local communities is raised repeatedly in submissions. Women in many communities are required to relocate four to six weeks before their due date to a larger centre that has a maternity hospital. 'The most asked question was not "how is it all going?" or "how are you feeling?" but "when are you going away?".'

This issue has also emerged as a key issue in the many consultations undertaken with Aboriginal and Torres Strait Islander women in recent years. Aboriginal and Torres Strait Islander women may have cultural links that make birthing away an even greater personal cost they must bear.

Women required to relocate are often isolated from family and community for the last stages of their pregnancy, leaving other children with relatives and disrupting family life. Many are without a known support person or partner during labour and birth. In addition to the cultural and emotional issues relocation raises, financial cost is a factor for many women. Many women report having no Government support to assist relocation. 'There appear to be no facilities to allow a geographically isolated person to stay in another town while waiting to deliver a baby.'

While women are advised to relocate for the safety of themselves and their babies, a few submissions express a view that relocation for birth is less rather than more safe. One woman describes the risk she faces by not having maternity facilities in her town. 'When I go into labour I must immediately get in the car and drive to Theodore and hope I make it before the baby is born. If the doctor is not available in Theodore the day I am having the baby, it appears the hospital must ring around and find another hospital which will deliver. As far as the dash to the hospital is concerned, there are two women I know of, who, in the last twelve months, have delivered their babies on the side of the highway between Miles and Wandoan.'

There is also confusion among women about whether or not they are required to relocate.

One woman and her friend received conflicting advice from two GPs. After going to great lengths to try to clarify whether she had to relocate, 'I then rang Queensland Health and after

speaking to a fair few people who had no idea what I was talking about and never heard of such a thing I finally got onto the Director General's office. An assistant consulted with a doctor there and the official line I received was that it is a recommendation that you are near the delivery hospital at 38 weeks but it is still your choice.'

Carers writing to the Review raising consumer issues often raise access to care for women in rural and remote areas. More than one in four individual midwives who wrote to the Review wrote of the inequity, the personal and family distress, the social disruption and the financial stress of relocation. Every one of these submissions called for greater effort to be put into trying to provide birthing services for rural and remote women closer to home.

Medical staff in the Northern Zone raised the need to improve maternal fetal medicine (currently women must travel for scans). This is also raised by a hospital unit which suggested expansion of telemedicine.

Choice during labour and birth

A second aspect of choice is choice within various approaches to care which is raised particularly around labour and birth care in many submissions.

Women report not being supported in their choices about pain relief, particularly alternatives to analgesia. 'The lack of pain relief options... I spent some time in the shower... there was a huge big bath in the bathroom that I wasn't able to use.' Or, 'I wanted to try different types of pain relief such as acupuncture, but this was simply not available.' A number of submissions mention the fact that the use of baths for birthing or pain relief is not an option in some hospital maternity units. 'I was keen to have a water birth... Women can't even have a bath for pain relief – they have taken the plugs away.' Or, 'It seems strange that after spending my entire pregnancy avoiding alcohol and painkillers, that on the day I give birth, I'm limited in my choices of non-pharmaceutical pain-relief... the system makes it easier for me to get access to opiates (than a bath)...'

Women mention being encouraged to lie on a bed to labour and birth and even being prevented from moving around, by monitoring equipment or staff, '... trying various birthing positions during labour, none of which were recognised by this particular nurse.'

Access to pregnancy and post-birth care

Access to pregnancy care and education is raised in a number of submissions. While women who experience birth centre or homebirth care in the main feel their care was integrated, women in hospital care have some negative comments about their pregnancy care and education.

An inference that can be drawn from many of the comments made in submissions is that pregnancy, birth and post-birth care lacks integration in the both public and private sectors. Care is provided by a number of different agencies and carers, funded under different Commonwealth and State arrangements, and structured around these organisational and funding arrangements rather than around women's needs.

Women in rural and remote areas report having to travel long distances to access pregnancy education. A number of submissions make the point that pregnancy education classes do not help prepare people for parenting. 'I found the classes to be centred mostly on the pregnancy and birth – little on what happens when you take the baby home.' Pregnancy education was also seen as biased towards the kind of care offered in the relevant hospital (advocating pain relief options or labour and birth practices) and not particularly helpful. 'In hindsight, the information we received would have been easily and adequately accessible through printed handouts from the hospital...'

One suggestion is that parents with perhaps a year's experience could attend antenatal classes and give a perspective.

One submission from an organisation supporting women residing in marginalised circumstances points out that women are expected to wait up to four hours for antenatal appointments which leads women to give up and forego antenatal care. The submission made the point that these women were unaware of share care options.

At least one woman who wrote to the Review was unable to access any antenatal classes in a public hospital because they were full. Others had to wait until well into pregnancy. 'I found it difficult to get into classes at the ... Hospital. I was 6 months pregnant before attending the class on health during pregnancy.'

Many submissions point to the lack of adequate support from hospital staff in the immediate post-birth period. 'Wards seem to be very understaffed...The nurses were too busy to go over basics such as bathing a baby, an orientation around the ward. One nurse asked me why my feeding and nappy changing chart wasn't filled out. Well, I wasn't advised that I was required to do so.'

Many women report having had little or no post-birth support after they leave hospital, particularly in establishing and maintaining breastfeeding and learning to care for a baby.

A number of submissions raise the issue of early discharge from hospital, and going home without adequate preparation. 'I still cannot believe that new parents can take home a baby and nobody contacts them again to see how they are going and if they have any problems.'

Postnatal depression is raised. Access to help is one issue. 'I suffered from postnatal depression and there was no help available where I lived.' Many of the women who raise postnatal depression also relate it to negative care experiences.

'My son was born... I felt no connection... It seemed like a movie... I spiralled into depression and was admitted straight from the ...[hospital] into Belmont Private Hospital in the postnatal depression unit.' Or: 'After leaving the hospital I suffered from depression for a while. I felt like a failure as I couldn't birth my baby in the way I had wanted and at the time (during labour) had felt powerless to do anything else.'

Hospital protocols are perceived as unsupportive of women. One submission from a support group for women experiencing birth trauma makes a distinction between postnatal depression and post-traumatic stress disorder from trauma in labour and birth care.

Many submissions report difficulty accessing child health clinics. 'Community health centres seem to be rare and understaffed... At one time I was told that the next available appointment was 4 weeks away.'

Many women needed more support than the system provided, particularly with a first baby. 'I cried most days for the first few months and wondered if I would every feel better again. I didn't feel like I was really coping for quite some time. I do not think I am unique or alone in this experience... I really felt I was on my own during that time and had to just deal with it.'

Some submissions report better experiences of postnatal care, particularly in small communities. 'The local Community Health nurses provided an excellent service to me, visiting at home for the first couple of weeks and providing support weekly after that for some time. 'I received four consecutive at home day visits that enabled me to talk one on one about anything.'

The effect of good post-birth support is emphasised in one submission from a woman who was motivated to write to the Review solely because of the quality of the postnatal care she experienced 30 years ago. 'Sister Mac visited me in the hospital and made an appointment for me to see her at the infant welfare centre... She introduced me to 2 other Mothers who had given birth about the same time, lived in my neighbourhood and like me did not have relatives in Australia. We started a morning coffee group and found that our children weren't that different from others their age. We started a babysitting club where only Mothers took care of children. My friend went on to head the committee that built the local kindergarten...'

Many women report being unable to access community child health clinics. Many submissions give an impression of care ending at the hospital door with no community follow-up. 'I received no support or follow up phone call from the hospital after my discharge. Fortunately this was my third baby and I had some experience to draw from, however, I did feel quite bereft when I came home.' The writer of this submission also reported experiencing postnatal depression after an earlier pregnancy.

Information

Many women are disappointed with the level of **information** available to them, about approaches to care, providers and facilities. A lack of information is related to a lack of choice and participation. Women also report a lack of basic information about pregnancy health and care. Inconsistent information from carers, particularly about breastfeeding, is raised repeatedly in submissions. A number of submissions also point out that antenatal education, which is often only available on a user-pays basis, focuses almost exclusively on the birth process and could do much more to assist people to prepare for the job of parenting.

Women report being unable to get information about approaches to care and their costs. 'I phoned some obstetricians. I asked for fees and was told that it wasn't practice policy to give out fees.' A receptionist to one obstetrician told a woman who wanted to know the obstetrician's caesarean rate that '...it was not client privilege...' to know those sort of things.

Women often report finding out more for a second or subsequent pregnancy but regretting that information had not been easily available before. 'I only wish I had known the first time round what I knew the second time round... I still feel, and probably more so after the second birth, emotionally scarred from the first birthing experience and cannot stress enough to other pregnant women the importance of knowing all that you can about labour and birthing.'

Breastfeeding is raised in a number of submissions, mostly in terms of the lack of good, consistent advice and support to establish breastfeeding in hospital and to maintain it once home. It seems some hospital nurseries work against breastfeeding. 'My baby was placed in a special care unit for 6 days, given formula and a dummy.' One woman whose baby required nursery care expressly asked a midwife to wake her when the baby woke so she could breastfeed her baby. The midwife gave the baby bottles instead. One submission suggests milk banks be supported so that women can donate breastmilk for babies who for some reason cannot be breastfed by their mothers.

Most submissions that raise breastfeeding mention inconsistent or incorrect information or a lack of advice from staff. 'I was not given any instruction to breastfeed my baby until 6 hours later. I believe this contributed to feeding difficulties in the following weeks and months.' Many submissions mention inconsistent advice. 'I heard the midwives give the mothers some of the worst information regarding breastfeeding and general care of their babies.'

Early discharge combined with a perceived dearth of community-based care is contributing to a lack of

confidence about breastfeeding among women. One submission mentioned the work of the Australian Breastfeeding Association to encourage and support breastfeeding, particularly for women in rural and remote areas.

At the same time, some women report being pressured to breastfeed despite expressing a clear preference or requirement to know about bottle feeding. 'When back up in the ward – the midwives were breastfeeding nazis... They are wonderful and caring in every way – except when you ask for a bottle.'

Participation and Respect

An issue related to choice is the extent to which women participate and feel respected in the maternity care experience. A perceived lack of participation and control over what happens to them is central to most of the issues women raise about maternity care experiences. Some women express positive views about care, particularly in relation to birth centre and homebirth experiences, but many more feel disempowered in the maternity care system, in both public and private care environments. 'I feel strongly that for a woman to have a good birth, she needs to feel in control. The experience of having a baby in hospital often results in a woman giving up that control and feeling helpless and overwhelmed.'

Some women feel they are excluded from clinical care decisions, particularly about interventions during labour and birth. A number of submissions describe traumatic care experiences in which women disassociated from their experience in order to cope. 'During the examination I felt that I was not being included in what was happening... A hook was used to sweep without me knowing it was happening... After the examination the obstetrician told me that the baby was positioned such that labour would be longer and more painful than average and that unless labour started spontaneously by 11 pm, I would have to be induced by drip... There was no negotiation; that was the way things were. He offered me a caesarean...'

One woman was thankful her primary carer had not made it to the birth. 'I delivered, exhausted but comfortable, draped over a bean bag. The gynaecologist rolled through the door some time later... demanding to know "who let this woman give birth like this." I barked back at him, "I did." He was unimpressed. I felt invincible. His lack of presence was the best thing that could have happened for me.'

Women report being given little or no information about what is happening to them during labour and birth, and inadequate preparation beforehand. Some report that they did not give informed consent to clinical decisions. This is exacerbated for women who need and are not provided with an interpreter. 'I was asked to sign a document but I didn't know it was for a caesarean section.'

Many women recount a first negative maternity care experience that was completely unexpected. When it comes to a second or third experience, they are wary of the maternity care system. 'My third child came along and I knew so very much more... Only once during the short labour did the midwife tell me off, but my argument (that she could hear the baby's heartbeat while I was standing, I didn't need to be lying down for that) convinced her that I was ok...'

One woman who had two emergency caesareans reports very different outcomes for herself and her babies, which she relates to different attitudes of carers in the two situations and the extent to which she was able to feel some control over her experience. Her first emergency caesarean was carried out before she could contact her partner or he could get to the hospital. 'I think the doctor asked if I knew about what a caesarean was and I replied yes. I had read about it and done antenatal classes but when the moment was there it was like I forgot... Suddenly everything seemed to happen at once... Being a first time mum I must have looked terrified yet not one single person stopped to reassure me... I asked again where was my husband. They said he was on his way...' In the months that followed, the woman experienced relationship difficulties with her partner and eventually sought counselling. Two years later, after opting for a homebirth which resulted in a second emergency caesarean in hospital, the woman's experience was completely different, which she attributes to the doctors and midwives who happened to be on duty when she came in. 'I felt in control of what was happening to me. My husband was with me every step. My midwife informed me of what was happening, informed me of the risks and I got to choose what to do next. Of course I felt disappointed that I wasn't going to have my baby at home but... I felt calm and happy with the decision to transfer.'

A number of submissions from health care professionals relate women's experiences to the culture of care: 'An endemic professional culture (including midwives) which lacks respect and patience for the process of birth and which can be both patronising and disparaging towards women; a culture which purports to know best but which often coerces women to conform to procedures which are mainly for the convenience of the system rather than for the safety and satisfaction of the woman concerned.'

Perceptions of intervention

Many submissions mention interventions during labour and some question their necessity. 'Australia has one of the highest rates of intervention in birth in the world, including unnecessary caesareans and excessive drug use that lead to complications in both mother and baby.'

In private care, a number of women mention concerns they had during pregnancy that intervention might be forced upon them. '[I] wrote a "birth plan" but was disappointed with the doctor's reaction to my desire for a natural delivery as it seemed he preferred to perform caesarean sections and argued with each point of my plan.' Some women report waiting until labour is well established to go to hospital in the hope that this will help them to avoid interventions.

Increasing caesarean rates and fear of unnecessary intervention are mentioned repeatedly in women's decisions to opt for homebirth.

Caesarean births

When submissions from consumers mention caesarean births, it is often disappointment that a caesarean was deemed necessary or anger that consultation beforehand seemed inadequate. 'The obstetrician came back 6 hours later for about 1 minute and announced that I was still 3 cm and that I could either have a caesarean now or in 3 hours... There was no explanation...'

Some of the submissions on caesarean births make the point that the trauma of an emergency caesarean could be mitigated if handled differently by carers. One woman who had developed pre-eclampsia and had to have an emergency caesarean. '...my beautiful baby girl was born... she was taken away and I was wheeled off to intensive care... Finally, I was wheeled into Special Care to see my little baby... I started hyper-ventilating, panicking and wanted to know what was wrong. For hours, she had been in the care of strangers...'

A number of submissions point to the inadequacy of care following caesarean births in the public and private sectors. 'During the first night in the ward my son was crying all night because I was unable to get out of bed to pick him up and feed him. I had tried many times pushing the alarm for the nurse to come and help but every time it was hours before someone would come.' Or, 'As this was our first child we did not know what to expect and the staff were not at all helpful eg buzzed and it took half an hour for someone to attend... they were incredibly understaffed.'

One submission points out that vaginal birth after caesarean is not encouraged for women and that few hospitals offer this care. A number of consumers report having gone to a specific hospital because it is willing to support vaginal births after caesareans. Others have opted for homebirth care.

At least one submission suggests individual hospitals should publish their caesarean rates so that women can make choices.

Labour and birth support

'I felt like I had won the jackpot, we had done it by the skin of our teeth. It really felt like an adversarial experience, us against the hospital and obstetrician.'

'I was absolutely shattered. My vision of the birth that I wanted had been completely violated.'

'I have witnessed inappropriate swearing, yelling and threats to refuse care by a medical officer... when women do not comply with the request. This would intimidate me into complying as I would be scared the care would be compromised if I did not...'

Most consumer submissions mention labour and birth experiences and these more than anything else determine how women feel about their care experience. 'It is difficult to speak about hospital birth... My experiences left me victimised and abused with a hatred of doctors, nurses, midwives and hospitals and I was left traumatised and had to seek psychiatric help.'

Several women in the private sector report having arrived at hospital in labour and discovering that their obstetrician would not be there for the birth. They had never met the midwives who cared for them or the obstetrician who attended. 'At this moment my midwife who hadn't spoken with me at all during all this time announced she had to leave to attend a funeral... The new midwife finally appeared... So I said "I suppose I better have a caesarean now"... After about 5 minutes I said I wasn't sure about this decision. She said, "it's too late the operating room is being prepared."

Women report having been left in labour and frightened they will give birth alone. 'There was only one nurse rostered on the night of my labour and she had to leave me on several occasions to attend other mothers or answer the phone. This was very frightening for me as I never knew from one minute to the next if I would be left alone at a crucial moment.' At least two women reported having given birth unattended. In one private hospital experience, the midwife had walked out of the room: 'Our baby was born onto the bed without a medical attendant in the room and it was terrifying.'

The fear of being alone is exacerbated for women who relocate for birth as they will have no support person.

Some women mention the value of engaging a midwife or other support person to be with them in labour and birth, and the need for a known, trusted carer features in almost every submission reporting on the positive aspects of homebirth and birth centre care. A few submissions mention doulas, carers who provide pregnancy, birth and early parenting support to women. 'A doula is a short term solution to an existing long term problem. If women are to birth confidently with minimum intervention, they need to be offered continual support throughout their labour. Ideally a midwife could be this person and more. Under the present system this is not realistic.'

Carers writing to the Review express concern about the way consumers are treated. '... intimidation, bullying and

violence are rife in the Queensland hospitals...Individual women are receiving conflicting advice which is confusing in an already stressful care environment.'One doctor told a patient whose birth plan stated that she would prefer a tear to an episiotomy that if she tore she would' "...never use your vagina again." The same doctor later angrily threw scissors on the floor after four cuts and said they were blunt. He said to the patient's partner on his way out, "You'll be sorry." The patient suffered later urinal and faecal incontinence. A complaint to the hospital was not dealt with adequately.'

One submission from a carer and consumer makes the point that while emotional support is the most important aspect of labour and birth, hospitals cannot be expected to provide emotional support to women. 'Hospital staff may be too busy to attend to a woman's emotional needs but I also believe that it is too much to expect of them. Labour is not the time to be discussing your birth plan or forming a relationship with a stranger. This needs to happen over time... all women must be encouraged to find a support person to guide them through labour. Whether this is a private midwife or a doula or a best friend or their own mother – the point is that birthing women need the support of an experienced woman.'

Many woman believe their carers are overworked. 'I was left in the birthing suite for 6 hours waiting for staff to give me permission and help to shower, remove epidural and drip tubes...' Some consumers point out that hospitals are woefully understaffed while others are sure they received a higher level of care because the maternity unit they attended was so quiet at the time they were birthing. One submission, which is able to compare eight maternity experiences across the public and private sectors since 1988, reports early experiences with midwives as carers in the public system positively. '...Again in the public system I found wonderful staff...' although later experiences in both public and private care were that staff were overworked and wards were under-staffed. Another submission points out that changes in practice which now include routine rooming-in of mother and baby, have led to a situation where four or six women and their babies are trying to sleep in shared bed wards. Rooming-in is mentioned in two submissions, with a suggestion that tired women may need a break from their baby some nights.

Two submissions mention the term 'failure to progress' as unnecessarily derogatory and implying failure on the part of the labouring woman.

Women who may have special or additional needs for care

Submissions from a range of support organisations suggest the needs of young women, women with disabilities and women from some cultural or language backgrounds are not being met in maternity care environments. Many of these organisations say their members are not even accorded basic respect in systems which have little time or resources to deal with difference. 'There is the perception amongst many ethnic communities that service providers seldom offer patients the opportunity to understand the system and take health decisions concerning themselves and their babies.'

Support organisations for young families report their clients feel judged and are hesitant to seek pregnancy care in an environment in which they do not feel comfortable. 'Many young women commented that they had experienced discrimination due to their age. Many talked of automatic statutory involvement... They spoke of fear and uncertainty this evoked, and how it dissuaded them from returning for further appointments.'

According to one support organisation, women in marginalised circumstances feel judged, criticised and looked down upon in their interaction with the maternity care system. They find hospital booking-in procedures overwhelming and automated phone systems and extensive paperwork alienating. This issue is raised in other submissions to the Review.

The Review is indebted to the Ethnic Communities Council of Queensland Ltd which, through a Multicultural Reference Group representing 13 service organisations, commissioned survey, focus group and telephone research in order to gather data on the maternity care experiences of women from African, Cambodian, Sudanese, Afghanistani, Vietnamese and Spanish-speaking communities in Brisbane. Language and cultural differences exacerbate already considerable difficulties negotiating a maternity service environment. 'Ethnic women often feel intimidated by service providers as they are in a foreign environment and the medical environment is a daunting one for most people. For these reasons ethnic women generally are not able to advocate for themselves, especially when they're close to labour, and this places them in a particularly vulnerable position.'

Women from these communities can have cultural needs and life experiences which are very different from those of other women. 'I wanted to attend the antenatal lessons but there were men in the room, so I just turned back because in our culture we don't talk of health issues in front of man.' Refugee women may have experienced trauma or torture which makes any physical interaction traumatic. In some cultures, female genital mutilation has implications for childbirth and post-birth care of women. Parents of female children may not know that the practice is illegal in Australia.

One submission from an organisation providing support to women from non-English speaking backgrounds who experience domestic and sexual violence, stresses the importance of considering the issue of violence towards pregnant women. Another submission points

out that pregnancy and birth are life moments when intervention might be more possible. 'It can be the safety of unborn children, a pregnancy or children in the household, that triggers the need for women to seek safety and support for themselves and their children. It is in these situations that care provided by health staff during pregnancy and post pregnancy becomes critical.'

A number of submissions claim that women who need a language interpreter are not routinely offered or provided with one during consultations. 'I was guessing what the GP told me all the time. I asked for an interpreter but he say it wasn't necessary.' Or, 'When I asked for information in Spanish about breastfeeding they gave me a telephone number to call. They don't have available flyer or brochure...' Without interpreters during labour and birth care, women are much more likely to feel they have no control over what is happening to them.

One submission suggests maternity care for women with disabilities is complicated by public perceptions of disability. 'Lack of support, information, resources and training coupled with the negative stereotyping of women with disabilities as mothers leads to questions of parenting abilities and increased likelihood of removal of children.'

The lack of support and counselling for women who experience miscarriage is mentioned in at least two submissions.

At least two women who wrote to the Review had experienced a stillbirth and were subsequently cared for in the maternity ward of the hospital where women with their new babies were cared for. 'Because I was in the maternity ward people just assumed I had a baby that lived or that I was still pregnant... I had to explain over and over that I had had a baby boy and he had died.'

Continuity

Another issue emerging from submissions is the importance of **continuity** of care, which is expressed in a number of ways. Women are more positive about approaches that provide continuity of care, preferably with one carer or a small team of carers. Women with more than one kind of experience mostly tend to favour the approach that provides most continuity, and they mostly stress that what they value about the continuity is that the carer was known, trusted and responsive to their needs.

A number of submissions point to the difficulties associated with having many different carers during pregnancy, labour and birth. Women may have had to explain sensitive details of their personal histories repeatedly, because they saw so many different individuals. One woman reported having to explain details of female genital mutilation to the three different midwives who provided her labour care.

Many women, including most of those writing about homebirth or birth centre experiences, mention the importance of knowing beforehand the person or people who will be with them through the demanding and unknown experience of birth. Many women in public and private care make the point that they had not met their carers until they arrived at the hospital in labour.

For the women in rural and remote communities who are forced to travel long distances for maternity care, continuity can be especially difficult. 'As I was being cared for by a number of health professionals between three places (Mount Isa, Cloncurry and Toowoomba) I found it difficult to find continuity of care.'

A number of submissions stress the importance of continuity in the context of a close, trusting relationship. 'Midwives provide a very different level of care to an obstetrician. An obstetrician is quite distant in a woman's pregnancy and a close and trusting relationship is hard to establish. It is also very disconcerting to a woman to be in labour and find that her own obstetrician is not available to be at her birth, and she is also surrounded by a group of midwives she has never even met or perhaps does not feel relaxed around.'

Women often choose a particular care approach primarily to achieve continuity. Mostly this is associated with a midwife as primary carer but not exclusively. 'I chose a private obstetrician as continuity of care was important to me and I had not experienced such continuity when I was pregnant with my other children and had gone through a midwives program. I felt that the lack of consistency in the midwives program led to lack of choice to me and an increase in my general anxiety while I was pregnant. I subsequently suffered post natal depression and had difficulty in locating the support I needed as I had no one person coordinating my care.'

Some women who have gone to considerable effort to ensure continuity of care are bitterly disappointed or frightened when they discover the continuity they felt was assured will not eventuate. 'I chose a private obstetrician, because I wanted continuity of care and carer, and I thought that this was the way I would get this continuity. I would see the obstetrician regularly, we would develop an understanding of what I wanted and he would be there at the birth... When I got to the hospital I found that the obstetrician I had been seeing was not on call that weekend, and another of the obstetricians would be along to examine me. I was alarmed; the continuity of care I valued so highly had evaporated...'

Safety

Relatively few consumer submissions mention safety specifically as an issue but safety for themselves and their babies underpins many of the fears and

concerns expressed by women. 'I do not consider a 20 % chance of having a caesarean section safe.'

Safety is a major factor in contributing to decisions about approaches to care. Women who homebirth report doing so because concerns about the safety of hospital birth. 'I have chosen to birth at home because I feel it is safer and healthier for myself and my baby (given that I have been well informed and that I am healthy). Birth is a natural process with a degree of risk to mother and baby, but with high quality and holistic antenatal care and with a carer who is known intimately and trusted, I believe that the "risks" are drastically diminished even with so called "high-risk" pregnancies.'

Many women who choose homebirth do so because they decide it is the safest option. 'There will always be an element of risk in birth whatever the choice of birthplace. However, safety in childbirth is intrinsically related to the mother's emotional, psychological and physical well-being during labour. This, in turn, is influenced by the choices which are made during pregnancy, choices which should enable a woman to give birth at ease with her environment, her attendants and herself.'

A number of women who were able to access birth centre care felt they could have the aspects of care they wanted while being close to '...medical experts who could intervene instantly to save my baby or myself.'

Other submissions express views about the lack of safety in the current maternity system. One submission mentions the need for hospitals to publish information about their emergency care facilities so that consumers can make informed choices.

Safety is related to risk. One submission makes the point that women with 'high risk' pregnancies are often cared for differently from other women and that this is not always necessary.

One submission from a woman who had a home vaginal birth after a first caesarean birth: '...I researched my situation thoroughly and based on this information I knew that I would be able to have a natural birth if given the right circumstances.'

Women who opt for homebirth are aware of the risks of birth. 'I would like to have had the choice of a birthing centre, an obstetrician back-up my safely-managed birth at home or possibly my independent midwife attend me in a hospital of my choice.' One woman with homebirth experiences writes about her own responsibility for her care. 'I trust that my midwife is competent in assessing risks. I am aware that there is rarely a situation where there isn't adequate time for transfer to medical attention.'

Approaches to care

Consumer submissions have much to say about overall approaches to care. Women who have experienced more than one approach to care make comparisons. Almost universally, the approaches in which they feel in control of what happens to them are in the main the approaches they favour. 'I am one of the few women who has experienced virtually all types of antenatal and birth care in Australia... My caesarean birth taught me that to follow the masses when it came to having a baby such as having a private obstetrician and attending ante-natal classes, did not necessarily give me the best birthing outcome. My VBAC homebirth taught me that I am in control of my body and that the best way to give birth is to "let go". My hospital breech birth showed me that it is possible to have a great birthing experience in a hospital setting with no medical intervention even with what the obstetricians would class a "high risk" birth...'

Some women compare approaches to care in Queensland with care in other places. This from a father, comparing UK homebirth with Queensland hospital birth in the 1970s. 'At the time of the birth my wife was attended at home in our bedroom by one of the community midwives where the birth occurred. I was able to attend and assist... I formed a deep and life long bond with my wife and with our children, partly, I believe, because of the birth and post birth circumstances. This was very different from a previous birth in Australia that was in a hospital, where I could attend the birth as a distant observer but could not participate and where my wife stayed in hospital... with me only being able to see my child for much of that time through a glass window...'

Transfer from homebirth to hospital care is invariably traumatic. 'It was recommended that I transfer for failure to progress... I was taken to a labour room and was confronted with harshness, metal, loud blaring radio of Country n' Western, strangers, hospital smell, hard surfaces, bright lights, machines and boxes of plastic gloves.' A couple planning a homebirth but transferred with a baby born 10 weeks prematurely. 'We felt the hospital staff had problems accepting our right to make informed decisions as parents. We know and certainly felt that we were in their territory... It was a constant battle...'

Homebirth care

Homebirth care is raised in over a quarter of the submissions from consumers. These submissions are extremely valuable to the Review's work because they give an indication of the views of women who have made a decision, at a financial cost to themselves, for an option that they sometimes do not feel is medically supported or generally accepted. 'However when I remember my second pregnancy I remember much fear and frustration as I made choices that were outside the normal and made me feel like an exile from society.'

Women choose homebirth for a number of reasons. Some want continuity of care with a known and trusted carer and find this difficult to access in the current maternity care system. 'I was somewhat shocked when I became pregnant to discover that in Queensland, as a public patient, I would have a different carer at every appointment throughout my pregnancy and a stranger to deliver my baby. I cannot imagine a more important time in my life as a woman, nor a time when I have ever been so vulnerable and in need of a familiar face. Becoming a mother would be the most important moment in my life and it was devastating for me to imagine experiencing it with a doctor or midwife that I had never met, would never meet again, and who knew nothing about me or my medical history.'

Concern about levels of intervention in hospitals also contribute to decisions to homebirth. One woman opted for a homebirth after working as an neonatal intensive care nurse. 'I've seen a Doctor put his leg up on a bed for traction while they pulled the baby from the mother during a caesarean... I've looked after babies with black eyes and massive bruising from forceps. The simplest thing... I've walked into a labour room of a woman in full labour with her legs up in the air and everything exposed and said with a big smile "excuse me I just need this Pulse Oximetry Machine, I won't be a minute".'

Often the decision to homebirth is made after a traumatic hospital experience. Some of the women who have written to the Review are so traumatised by a first experience and frightened of maternity care in hospital, they have resolved to homebirth for a second or subsequent pregnancy, with no professional care as they live in a place where no homebirth care is provided. One woman who had one child in a public hospital opted for unassisted homebirths in her other five pregnancies. 'I chose this option for several reasons. The lack of personal care and respect throughout my first pregnancy/ birth... also my lack of choice. Interventions without consent or acknowledgement and feeling as if I were classed less than a human being... midwifery services were not an option due to expense...'

For some women, homebirth is the only option they would ever choose. 'I wanted to have my support people around me, but I also wanted the option to be alone. No time limits, no clock watching. I did not want strangers examining me. I wanted to use a warm bath for pain relief. I definitely did not want artificial pain relief. Based on what I had read about C-section rates in Australia I was afraid that I would be forced into "emergency" surgery without even being allowed to try to birth my child naturally. I was afraid that after birth my baby would be taken from me. I was afraid that in hospital his first food would be an antibiotic when it should be colostrum. I was adamant that should resuscitation be required, my baby would stay with me, on my body with the cord intact until after third stage. When I realised that in hospital these things would be beyond my control, I chose to birth at home.'

Homebirthing women report problems accessing the medical care when they do need it. 'My GP was also a bit of a letdown... after telling him of my decision to have a home birth he raised his eyebrows and said, "Ah going the hippy, alternative route are you?"... He then went on to state that he couldn't have anything to do with me after that and not to see him again until after the baby was born... This was a little bit scary at first...' This woman was unable to get any information from her GP about options for homebirth or how homebirth might integrate into the health care system.

Very occasionally, submissions report good integration of homebirth hospital transfer, and this is attributed to individual carers. 'God was on my side that day as on arrival to the hospital I was looked after by a midwife who had had a homebirth herself and the registrar had been involved in the Home Midwifery Association some years ago.'

Women who birth meet their own costs and many raise this as an issue. 'I so much love having my babies at home, where I feel safe...Baby five is on the way. The midwife is not longer able to practise. Who will help me this time? Why won't the government help us pay for births at home when I'm saving them so much money by not choosing to have elective Caesars... Do I have to deliver all on my own to have the birth I so desire?.'

One submission expresses concern about the ostracism of homebirth from officially-sanctioned care. 'The powerful paradigm of the medical system means that the homebirth structure exists "on the fringes" or "underground". It relies, and on the whole successfully, on its own members/consumers for support and accountability. It battles a medical system that is unsupportive, and at times persecuting... On the flip side, I do have concerns that because the homebirth system has had to operate in such difficult circumstances that sometimes it can be just as narrow and one-eyed as the medical system. Both systems harbour an incredible fear in women about the other.'

Birth centre-style care

'I am having my first baby in January at the Birth Centre and I feel I am one of the luckiest women in Brisbane.'

Birth centre care is raised in over a third of the submissions from consumers, almost always positively.

Women mention not having to wait for antenatal care appointments, their partners and families being welcome at the birth and subsequently, and the importance of responsive care from a known midwife. Women feel they have choices about birth and feel confident going into labour that they know what to expect. Home visiting from a known

midwife combines well with early discharge (and discharge from birth centres is often within 24 hours of birth). Physical surroundings also play a part in the total experience (soft lighting, music, showers, baths for pain relief and/ or birthing).

Negative comments about birth centre care include feeling let down when intervention became necessary (when non-intervention had been promoted as a feature of the birth centre model of care). One highly negative submission about a birth centre experience was negative because of the attitude of an individual midwife.

Many women wrote to the Review primarily because they were unable to access a place in a birth centre. The birth centres themselves report unmet demand. 'I have recently fallen pregnant.. I rang to go on the Birth Centre ballot and am waiting on the draw... I am now stressed about where to go.'

Submissions question why more birth centre-style care is not available. One woman who had a 'physically and emotionally damaging' first birth at the ...[hospital] and experienced postnatal depression, no breastfeeding and years of reluctance to have another baby, gained a place in the ... Birth Centre.

While birth centre experiences are mostly positive, one submission from a woman who birthed 300 km from her home suggests local community access is at least as important as style of care. The woman relocated and accommodated herself two weeks before her due date to wait for labour. Because the birth centre she attended didn't provide post-birth care, she then had to accommodate herself for ten days before a three-hour trip home with the new baby. 'I believe that the ... Birth Centre provides a fantastic facility... I will be going there to have my second baby, but again will have the hassle of travel except this time with a toddler.'

A number of private and public hospitals offer care that shares some qualities in common with birth centre care. One woman who felt she had experienced 'women/family centred care' at ... Private Hospital, reported: 'They (obstetrician and midwives) listened, respected and involved my husband and I in all decisions relating to our care. We had a very empowered vaginal birth after caesarean and our only regret is that we had to travel some distance from our home to do so.'

A few submissions mention the community midwifery scheme offered from the ... Hospital where a team of midwives worked in community centres with women and accompanied them to hospital for the birth. This scheme was discontinued. 'We looked forward to accessing the Community Midwifery Scheme again. I was shocked and devastated when I discovered it no longer existed. What could we do? We couldn't access the birth centre... I wasn't confident about shared care with my GP, I didn't want to use an Obstetrician (the cost and the stories of intervention)...' Or: 'The midwives that cared for me and my baby were exceptional and I cannot speak highly enough of them.'

Other hospital care

Although most submissions report negative experiences of care in traditional public hospital sector, there are positive experiences of care, based on individual carers or particular care environments. 'My Midwife, J. Bayles was great. I felt awkward at first but she soon calmed me and had me on a birthing ball. She stayed back a couple of hours after her shift had finished to stay with me... She kept saying supportive words. I felt very strong with her support.' One woman who was transferred from a birth centre for a caesarean reported positively about postnatal care. 'I cannot express how grateful I am to the midwives (both young and old) that cared for me and provided invaluable information that facilitated my ability to take my baby home and care for him with confidence.' The same submission points to the fact that midwives' time was stretched 'to capacity.'

One woman who felt pressured into a caesarean for her first birth in a private hospital had a similar labour experience but different outcome for her second birth. The woman praises the doctors and midwives at the ...[hospital]. 'I am so grateful to the team. It was a very different world from the ...[hospital] where I was left alone and treated with annoyance... I found comfort in sharing a room with three other new mothers. It was grounding to have them around me and constant action going on rather than silence... In summary, the public system was so much better than the private system in so many ways.' Other submissions raise concerns about an overworked public system burgeoning under the load.

Women compare public and private hospitals and their views differ. 'Baby two was delivered in a public hospital. I felt I'd landed in a leper colony. I was asked to don a hospital gown... I was embarrassed... Again I didn't get to celebrate that first moment with my daughter, again her cord was cut and she was cleaned up. Again I had to wait to hold her. Again I felt cheated.'

Appendix 9
Carer Issues

Review of Maternity Services in Queensland
Issues Raised by Carers

The Review's initial call for submissions elicited responses from most of the key professional bodies and organisations involved in maternity care as well as from support organisations. Individual carers also made submissions, with 76 submissions from midwives, 27 from obstetricians, 16 from medical practitioners and community health providers, and 18 from support organisations. Queensland Health made a submission and a detailed response to a questionnaire from the Review. The Private Hospitals' Association of Queensland and some individual care providers responded to the questionnaire. In addition to the submissions received, the Review has met personally with hundreds of individual carers and with professional organisations and support groups everywhere it has visited, in Queensland and in other states.

Professional bodies and care organisations that made submissions included:

- The Australian College of Midwives Inc. (Qld Branch)
- The Australian College of Rural and Remote Medicine/Rural Doctors' Association Joint Submission (ACRRM/RDA)
- The Council of Remote Area Nurses (CRANA)
- The Doula Register
- The Private Hospitals' Association of Queensland (response to Review's request for information)
- Queensland Health
- The Queensland Nursing Council
- The Queensland Nurses Union (QNU)
- The Royal Australasian College of Physicians (RACP)
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- The Royal Flying Doctor Service of Australia (Queensland Section) (RFDS).

Education providers were also asked to make submissions. Submissions were received from:

- Central Queensland University
- Griffith University
- James Cook University School of Medicine
- James Cook University School of Nursing Sciences
- Queensland Midwifery Education Providers
- QUT Faculty of Health School of Nursing.

Submissions were received from Shire Councils, staff of individual hospitals, community health organisations and other support groups.

These organisations raise a range of issues with the Review. While there are differences of emphasis and view on a number of key matters, some issues of concern cross a number of organisations.

Care Issues

- The need for change in maternity services, with some differences of emphasis about the problems in the current system of maternity care but an agreement that care needs to be more focused on the needs of women.
- Outcomes for babies of Aboriginal and Torres Strait Islander women and the need to make this a priority for reform.
- A lack of local community-based pregnancy, birth and post-birth care for women in rural and remote areas of the State (with ACMI and ACCRM/RDAQ pointing to evidence that outcomes are no worse in small hospitals for women with low-risk pregnancies).
- Access to post-birth care (early discharge combining with little community support) is raised by all professional organisations and in many submissions from individual carers and support organisations.

Workforce Issues

- Concerns about workplace tension and the lack of collaboration between midwives and doctors (RANZCOG), stress and fear of bullying in work environments (individual midwives).
- Concern that fewer GP obstetricians are practising in rural and remote areas (RANZCOG,ACRRM/RDA) and that there are too few incentives and training and development opportunities for those who do. For GPs, lifestyle, fear of litigation and professional indemnity insurance issues discourage practice. According to RANZCOG, the gap in rural and remote areas is currently being filled by second year medical graduates who are ill-prepared for obstetric emergencies in these settings.
- Concern about current and predicted shortages in the midwifery workforce in rural and remote areas (ACMI, ACRRM/RDA, AARN, QNU, RANZCOG), with suggestions for incentives that might attract and retain staff. For midwives in rural or remote areas, Queensland Health's Remote Area Nurse Incentive Program (RANIP) is welcomed, but more may be needed. For midwives, the requirement that they also work in nursing roles can be a disincentive (or occasionally an incentive).
- Shortages in the midwifery workforce and attrition from the profession (ACMI, QNU, QNC, CQU, GU, RANZCOG, individual midwives). Contributing factors include high attrition, an aging workforce with few younger people entering the profession, the experience of a profession in transition and current education requirements. In Queensland over 80 per cent of midwives licensed to practise are 40 or over.
- A lack of recognition of midwifery by the health system and the community (ACMI, individual midwives,

RANZCOG) linked to frustration and disappointment around career pathways, work satisfaction and morale, with many individual midwives leaving the profession.

- The lack of skilled midwives ready to take on needed roles (ACMI, RANZCOG, individual midwives).
- A suggestion that private practice could be covered to employ midwives along the line of practice nurses.
- Medicare-funded services for midwives in private practice (ACMI).
- Professional indemnity insurance issues. Midwives cannot access professional indemnity insurance.
- Midwifery education and the move to direct-entry undergraduate midwifery programs. University providers point out that there are inconsistencies among providers regarding current course levels and structures. The current postgraduate midwifery programs that follow nursing are not in high demand (fees and lost income while studying are barriers) and will be unable to meet workforce needs. The registered nurse requirement for entry is a barrier to access (particularly for Indigenous applicants). The courses produce 90 graduates a year, compared with 200 – 300 graduates from the former hospital programs. Proposals have been made for direct-entry undergraduate degrees that will not require nurse registration (raised by ACMI, supported by QNF and university providers). QNC raises regulatory implications (the possible need for separate regulatory authorities and legislation for midwifery), the implications for direct-entry midwifery graduates who wish to study other postgraduate nursing programs such as child health, graduate employability (in remote areas for example where midwife-nurses are needed) and indemnity for students who are not nurses.
- Clinical placements for midwifery students in terms of inconsistencies, some paid, others supernumerary, inconsistencies in hospital agreements, student experience different from workplace environment (ACMI, university providers, individual midwives).
- The lack of reskilling education programs for midwives wishing to return to the workforce after a number of years' absence.
- The lack of a formalised ongoing professional accreditation and development system for midwives (ACMI, QNC, RANZCOG). The QNC's annual licence renewal for nurses and midwives provides for self-assessment for continuing competence to practise but this relates to nursing or midwifery. The licence to practise as a nurse is renewed along with the midwifery endorsement regardless of practice. The QNC is currently considering continuing competence for practice standards that might also apply to endorsements such as midwifery (which will further reduce available workforce).
- The lack of financial support for continuing professional education for midwives.
- The need for more midwives to be trained in lactation.
- The need for training for emergencies (preferably joint training) for all carers, including neonatal resuscitation and the Advanced Life Support in Obstetrics (ALSO) program.
- Shortages in the obstetric workforce (ACMI, GU, RANZCOG). Likely problems with future provision of obstetric services nationally. Contributing factors include the aging obstetric workforce, difficulties in attracting trainees, unusually high attrition among current trainees, high attrition from obstetric practice (retirement or ceasing obstetric practice for lifestyle/ indemnity concerns), and the impact of a higher number of female trainees.
- Clinical teaching places for obstetrics (individual obstetricians).

Issues Relating to Approaches to Care

- Support for collaborative care and working together (ACMI, RANZCOG, individual midwives and obstetricians, consumers).
- Moderate or extreme resistance to midwifery-led care (RANZCOG, individual obstetricians) 'We strongly feel that adopting any new model will undermine the already struggling training programs in Queensland and further damage the support of the general practitioner. We feel that this could be either a golden opportunity to bring Queensland maternity services into the 21st century or it could lead to the road to disaster.'
- Strong support for midwifery-led care (ACMI, individual midwives, RFDS), with an underpinning philosophy that birth is a natural process and should be managed as such by society, with a stress from individual midwives on continuity of care (23%), choice (27%), one-on one care in labour (10%), importance of information provision and empowerment during antenatal care as well as early parenting preparation.
- Support for community midwifery with links to general practices which provide an early and seamless link between midwives and general practitioner care.
- Safety and risk management, with attention drawn by ACMI to the 2004 *National Midwifery Guidelines for Consultation and Referral* and by RANZCOG to the need to develop for Australia jointly with midwives a minimum standards document for maternity services. RANZCOG is currently reviewing the ACMI Guidelines at national level.

- More comprehensive lactation advice and support (individual midwives).
- Maternal fetal medicine – women having to travel for scans, the need for a Statewide service.
- The benefit of folate and the need for mandatory fortification of flour.
- The efficacy of water for pain relief during labour or birth.
- GP shared care and the importance of the integration of care for consumers (hand-held records do not work as the only records, GPs not receiving timely advice from hospital post-birth, lack of communication, duplication of services).
- *The National Midwifery Guidelines for Consultation and Referral* developed by the Australian College of Midwives (ACMI, RANZCOG and the ACRMM/RDA).

Appendix 10
Maternity carers

Midwives in Queensland work predominantly in hospitals, with community midwifery mostly limited to post-birth care or communities with special needs. In other states midwives attached to hospitals work in community settings to provide some or all pregnancy, birth and post-birth care.

Different hospitals have different arrangements for the way midwives provide care (one-on-one, in a small team, or through standard rostered shifts) and the kinds of care midwives provide. Award restrictions may prevent midwives from working caseloads.

In hospitals, midwives work under the supervision of doctors although discrepancies between formal responsibilities and practice have been noted in the Review's consultation. A lack of clarity about roles and responsibilities is a source of tension.

Until recently in Queensland only midwives have been allowed to care for women in labour but recent legislation allows nurses without midwifery qualifications to work under midwife supervision. This raises considerable concern about the critical nature of midwifery specialist training and credentialing and to some extent undervalues their specific expertise.

Midwives are not empowered to prescribe drugs or order routine tests, although there may be discrepancies between legislation, regulation and practice in some care environments.

Very few midwives provide independent care. This care is not funded by Medicare nor currently supported by private health funds. Midwives have been unable to access indemnity insurance to cover them for any independent services. The decision about whether midwives have admitting rights in hospitals is made by District Managers. The Review is not aware of any Districts in which midwives currently have admitting rights in Queensland.

There are current shortages in midwives in rural and remote areas of Queensland, with predicted increased shortages.

Midwives in Queensland are currently trained in university graduate diploma or masters degree courses which follow nursing degree courses. Other states offer direct-entry undergraduate midwifery courses.

The Australian Nursing and Midwifery Council and the Australian College of Midwives Inc. are working on a series of requirements for ongoing professional development and national competency standards, although these requirements are yet to be endorsed and put in place. This means that currently, practising midwives have no ongoing professional accreditation requirements.

Obstetricians work in private practice and hospitals to provide pregnancy, birth and post-birth care. This care is funded by Medicare and private health funds. Obstetricians are insured by private insurance companies. In addition to their hospital work, a few obstetricians in the public sector work in community settings to provide pregnancy and post-birth care, mainly in Aboriginal and Torres Strait Islander communities.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) does not support its members attending homebirths and insurance companies do not cover practitioners for homebirths.

There are current and predicted increased shortages in the obstetric profession which have been reported nationally.

Obstetricians train as medical doctors in universities and complete their training with RANZCOG. They participate in an ongoing professional accreditation system.

Obstetricians in training, some GPs in training for postgraduate qualifications, as well as senior house officers in hospitals, work alongside obstetricians.

General practitioners work in private practice and in hospitals and provide pregnancy and post-birth care. Some general practitioners work in formal shared care arrangements with hospitals to provide pregnancy care. In some rural communities, general practitioners with qualifications in obstetrics also provide birth care but this is becoming rarer as indemnity insurance premiums and low remuneration make the associated risk unacceptable to many.

There are current chronic shortages of obstetric general practitioners in rural and remote areas of Queensland. Lack of staff is the most common reason given for closure of maternity services in rural and remote areas.

General practitioners train as medical doctors in universities and complete their training with the Royal Australian College of General Practitioners (RACGP). They may also complete a six-month diploma program in obstetrics and if they wish to practise birthing must complete a 12 month Advanced Diploma of Obstetrics. They participate in an ongoing professional accreditation system as GPs but ongoing professional education in obstetric care is difficult to achieve.

Indigenous health workers in Aboriginal and Torres Strait Islander communities provide some pregnancy and post-birth care in community health centres. Vocational Education, Training and Employment Commission (VETEC) providers run accredited training for Indigenous health workers through primary health courses. In 1997 James Cook University opened a National Centre for Maternal Health Education for Aboriginal and Torres

Strait Islander health workers and offered short courses in maternal health education which included a clinical placement at five sites across Australia. The intention was to train 100 students per year and by end 2000 when the course was discontinued, 176 students had completed the course nationally (69 from Qld). Just over half of the total students were from rural and remote communities. Currently maternal health is integrated into existing Health Worker programs, and Aboriginal and Torres Strait Islander health services report demand for Health Workers with maternity care skills.

Aboriginal and Torres Strait Islander liaison officers are employed in some hospitals to provide linkages between communities and hospitals.

Child health nurses provide post-birth care to babies and mothers. Child health nurses undertake graduate diploma courses in universities. Child health nurses operate at the transition from maternity care to child health care.

Doulas are support people who assist women in pregnancy, birth and post-birth care. Some undergo training although this is not accredited. Their role should not be confused with that of nurses or midwives – they come with the birthing woman and are not part of the hospital system. In some Aboriginal and Torres Strait Islander communities, traditional birth attendants continue to work in a doula role to support Aboriginal and Torres Strait Islander health workers. These women may be part of the workforce in dedicated facilities either as volunteers or paid workers.

Depending on the kind of pregnancy and birth, **other health care professionals** become involved in care of women and babies, including maternal foetal doctors (obstetricians who specialise in babies in the womb), obstetric physicians, anaesthetists (who provide anaesthetics for caesarean births and pain relief during labour), paediatricians (who care for newborn babies) and neonatologists (who care for premature or sick newborn babies).

Many allied professionals also contribute to pregnancy and post-birth care, including lactation consultants, social workers, community workers, interpreters, physiotherapists, psychologists, genetic counsellors, psychiatrists, mental health nurses and dieticians. The attention of the Review has been drawn to the lack of integration of these services in many places and situations and the difficulty women may have in accessing them in both public and private sectors.

The **Royal Flying Doctor Service** of Australia (Queensland Section) is a not-for-profit organisation that provides and supports primary health care in rural and remote areas and provides aeromedical services throughout Queensland. The RFDS has eight bases (Brisbane, Bundaberg, Cairns, Charleville, Longreach, Mount Isa, Rockhampton and Townsville). The RFDS provides remote telephone consultations, emergency retrieval and evacuation services and primary health care services including general practice, child and family health, mental health, health promotion and women's health. From all its bases except Longreach, the RFDS provides a 24-hour a day, seven days a week emergency retrieval services. RFDS intersects with other organisations: Queensland Health remote area nurses who rely on remote clinic and retrieval services, Indigenous health workers who work in primary health care centres in communities, traditional birth attendants in Indigenous communities, visiting obstetric and gynaecology services (eg FROGS which is a QH services operating from Cairns Base Hospital), QH medical officers and neonatal retrieval teams from Townsville and Brisbane tertiary hospitals travel with the RFDS on emergency retrieval).

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