Maternity Care Australia 2017

Background

In 2009, a national review of maternity services was conducted (Australian Health Ministers Council, 2011). There has been little improvement in maternity care since this review.

The National Maternity Services Plan (2010-2016) was an attempt to implement recommended change and improvement in the maternity sector. The key priorities have merit in improving care, but lack of targets and accountability with the NMSP, have seen very little implementation. From a consumer perspective, one success has been Medicare eligibility for midwives, though accessibility is limited, due to lack of support within hospitals to allow visiting access for midwives (Queensland- since 2010 has approximately 12 hospitals with visiting access), (NSW and ACT have only just approved visiting access in 2 hospitals this year).

The Lancet medical journal articles into national maternity care have indentified Australia as falling into a situation where they provide “too much, too soon” (an over-medicalised model of care), leading to worse outcomes for mothers and babies (Miller, et al. 2016).

Less than 10% of Australian women can access midwifery continuity of care (known midwife for pregnancy, birth and postnatal care). Furthermore, almost 1/3 are experiencing postnatal depression and over 14% experiencing PTSD as a result of birth (Boorman, Devilly, Gamble, Creedy, & Fenwich, 2014). There are increasing rates of intervention, with our current caesarean rate of 33% (public) and 40% (private) one of the highest in the western world (Shaw, et al., 2016). The World Health Organisation recommends between 10-15%.

Maternity falls between the gaps of Commonwealth and State responsibility as care is funded by Medicare, and private health (with major Commonwealth contributions) and the State (via the Commonwealth) for inpatient care.

Medical lobbying states the issue is lack of medical control. However, the issue is clear. It’s due to a lack of reform to woman-centred, and best evidence based models of care due to funding models which priorities medical care and medical intervention. Priorities in all services are budget, the medical activity and only then are quality markers are considered.

Evidence based care is midwifery continuity of care, which has been widely studied, and is practiced countries such as New Zealand. A review of midwifery continuity of care models in the Cochrane Library included 16 trials involving over 17,000 women from around the world including trials from Australia. Women who had continuity of midwifery care were less likely to need epidurals or to use other drugs for pain relief in labour or have an instrumental birth. Women in the midwifery care groups were also more likely to have a normal birth, more likely to feel in control during labour and birth, and commenced breastfeeding earlier than women who had other models of care (Sandall, Soltani, Gates, & Devane, 2016).

Recommendations

1. National Maternity Service Plan – has recently been devolved to states, with Queensland taking a lead role. Has outsourced to private consulting firm for development – completely inappropriate process and completely inappropriate outcome. As of 23rd June, stakeholders unanimously decided to abandon the proposed NFMS (National Framework for Maternity Services). Issues included: no consultation with key stakeholders with regard to the scope of the framework, no evaluation of the NMSP (which was also raised during recent Federal Senate Estimates), no accountability nor reference to the previous advice from the Commonwealth Maternity Review in 2009.

   We request the Federal Health Department take over the NFMS development, and include an evaluation of the NMSP, with consumer engagement to ensure accountability and productivity. This plan must include provision for publicly reported data – both public and private hospitals must allow women the choice to access a facility that meets their needs and has the outcomes they desire.

2. Review of Commonwealth involvement in maternity care. The Commonwealth should take responsibility for maternity care in terms of policy, funding and direction. This may be achieved by a Senate inquiry into maternity care funding.

3. Followed by Commonwealth funding reform. Maternity needs to move to primary care and be funded appropriately and accordingly. Bundled payments for all women from public purse i.e. women are allocated an appropriate amount of funding which goes to the state if they are having state based care, or to their GP, or midwife, or obstetrician. This system operates well in New Zealand, which also has improved outcomes for women and babies.

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