www.maternityconsumernetwork.org.au

"Better outcomes for mothers and babies means better outcomes for the whole community."

Introduction:

Maternity Consumer Network is a consumer based organisation, with members across Australia. Our goal is for Australian families to have access to high quality maternity care, in a framework of informed choice. We particularly promote access to public available data on maternity care providers, community-based continuity of midwifery care as a primary care strategy, and bundled maternity payments.

In the current maternity care climate, it important the focus moves to improving a range of outcomes for mothers and babies, particularly around mother's experience of birth and emotional and mental well-being. Currently, almost one third are experiencing postnatal depression and over 14% experiencing PTSD because of birth (Boorman, Devilly, Gamble, Creedy, & Fenwich, 2014). The number 1 cause of perinatal mortality is suicide.

We believe the benefits to Victorian maternity consumers will only truly be seen if treatment and outcomes by clinicians is made publicly available, as recommended and practiced in other parts of the world. According to Miller (2008) 'Health care providers should be required to report publicly on the level and quality of services provided to patients, particularly to minority and disadvantaged populations'.

We have prepared the following, in collaboration with our Victorian members:

Currently, there are severe restrictions on the private midwifery profession, which ultimately affects maternity consumer access to choice in care providers. With only one private midwifery practice with visiting access to a public hospital in Victoria, it is difficult for women to access a service which is strongly supported by high quality evidence and is in demand by women. Private midwives collaborate appropriately with other care providers, as required by ACM Guidelines, to deliver safe, timely and supportive care to mothers and babies.

Many women reported traveling long distance to seek out continuity of midwifery care, with some even having to relocate their entire family for birth. For some women, this has been unachievable and they have been forced to birth with fragmented care, and report feeling unsatisfied with this model. Women enjoy building a relationship with a known midwife, without feeling rushed through appointments, uninformed and scared in traditional, fragmented maternity care models.

Private midwifery outcomes, albeit small populations studied, have shown better outcomes across all national maternity indicators including: 13% caesarean birth rate, compared to almost 33% nationally, almost 80% spontaneous vaginal birth rate, compared to 54% nationally, newborn intensive care admission was just over 5%, compared to 16% nationally (Fenwick et al. 2017). This is significant, as private midwifery models operate as an "all risk" model of carer, unlike most public models of continuity of midwifery care, which restrict any women who are deemed "high risk" from accessing continuity.

We believe allowing more visiting access by private midwives, which needs to come via strong leadership will enable safer maternity care, with better outcomes for mothers and babies. Most recently, women of

East Gippsland reported their local private midwife was “banned” from even entering hospital grounds, meaning women under her care could only receive antenatal and postnatal care with her, and had to birth in the hospital with unknown care providers.

Maternity consumers report a lack of public MGP (midwifery group practice) and restrictions placed on being “approved” for this model of care, result in further limitations on choice. Mostly, MGPs operate as “low risk” models of care, resulting in women with Gestational Diabetes, multiples, high blood pressure or high BMI ending up with highly fragmented care, contributing to low satisfaction and sometimes more intervention (anecdotal). These women need more access to continuity, to see improved outcomes across Victoria. 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 continuity of midwifery care groups were also more likely to have a normal birth, more likely to feel in control during labour and birth, feel more satisfied with their care, and commenced breastfeeding earlier than women who had other models of care (Sandall, Soltani, Gates, & Devane, 2016).

Medical lobbying would have us believe the high rates of intervention we see in the birthing population can be attributed to women’s health. However, The Lancet medical journal articles into national maternity care have identified 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).

We would recommend support for the midwifery profession to transition to continuity of care models in the public sector, directives to ensure hospitals collaborate and enable private midwives to support their mothers through the continuum of pregnancy, birth and postnatally, and “all risk” public MGPs, supported in the community. Clear definitions around continuity of care are imperative to ensure these models align with true continuity of care, and consumers are fully informed about continuity of care, continuity of carer and continuity of midwifery care.

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