BACKGROUND:

Rebirthing review (QLD, 2006)

36 of the 84 maternity services in the state had closed in 1995- we've since had other closures. (Map on page 20 shows the maternity facilities) Safety has consistently been quoted as a factor- but the statistics from the Rural Doctors Association of Queensland would refute safety is an issue. A study from NSW last decade also showed a baby born outside metro areas was significantly less likely to die when born rurally, and even after risk adjustment, there was no significant different. Women in rural areas were less likely to have intervention such as induction, caesarean etc. so saving the health system money.

Women reported having to relocate for birth as the most difficult issue for women and their families.

(National Maternity Services Plan 2010-2016)

Priorities:

Priority 1: Access:

1.2 Increase access for Australian women and their families to local maternity care by expanding a range of services. 1.3 increase access for women and their families in rural Australia to high-quality maternity care.

Other recommendations of the QLD Rebirthing review:

- Care is safe and feels safe
- Care is open and honest
- 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 as much support as possible).
- Care is integrated (across a family's experience of new life rather than funding systems or across carers).
- Care belongs to consumers (women and families must decide how they birth and be involved in care decisions)
- Carers work together and communicate

LNP strategy (we will happy to support a pre-election campaign):

Local birthing options for women, including supporting reopening/permanency of birthing services at Nambour, Chinchilla, Biloela and other places in Queensland. There needs to be incentives for midwives to work in rural areas (just like doctors) are provided with incentives to work rurally)- such as relocation allowance, accommodation, upskilling. The HHS need to spend allocated money to staffing, and not siphon off to other areas. When there are local birthing options, hospitals are very functional and safe units to service the whole community.

Currently, we have far too much intervention and far too little access to evidence-based care. Primary maternity care, in the community with continuity of midwifery carer (a known midwife) is cost effective, has better outcomes- physically (higher vaginal birth weight, lower stillbirth rate, higher breastfeeding rates), cost wise, less intervention, women feel better about these models too. These do well, supported by local GP/OBs in rural areas. The Chief Nurses Office in Qld has just developed a tool to aide in HHSs moving to continuity of midwifery carer models, along with a small amount of funding to help set up. But there needs to be directive from the Health Minister to get

these up and running. Women are wanting continuity of midwifery care, yet the supply is dismal. There needs to be directive to move towards this model, whether financially or otherwise.

Federally, LNP has allocated $550 million to rural healthcare. This must include provisions for rural maternity units, rural workforce, including midwives to ensure the benefit to the whole community. To attract doctors to work in rural locations, we need well resourced maternity units, so all staff can work across their full skill set.

www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

https://www.health.gov.au/internet/main/publishing.nsf/Content/8AF951CE492C799FCA257BF0001C1A4E/$File/maternityplan.pdf

Prepared by:

Alecia Staines

Co-Director

management@maternityconsumernetwork.org.au

MATERNITY CONSUMER NETWORK