

AMA Submission to the Maternity Services Review

“There is a big difference between the knowledge, skills and abilities of doctors and nurses...I trained as a state registered nurse/registered sick children’s nurse (SRN/RSCN) for four years and worked as staff nurse, research nurse, and ward sister for the following seven years... I then went to medical school and found I knew about 10% of the course already...As a GP I still believe that the knowledge and diagnostic skills I have now are not possessed by nurses”

Elaine R Carter, general practitioner principal, Bridge Road Medical Centre, Liverpool
BMJ 2008; 337:a1974

Background

Our current maternity services.

Currently in Australia we have high quality maternity services that deliver infant and maternal morbidity and mortality statistics that are the envy of many countries. Our mothers and neonates are safe, and our babies are given the best possible start in life.

There are particular areas of focus and concern. Our indigenous mothers and babies need urgent special attention, and we must always ensure rural and remote Australians can access high quality and safe care.

The AMA believes that some of the current proposals that are being flagged in the Review of Maternity Services in Australia will actually compromise the high standards and confidence that we have in mother and baby care in this country, and risk deterioration in health outcomes. This would mean a worsening of morbidity and mortality, and that means mothers and babies being harmed or dying.

We agree with the Chair of the Australian Health Ministers Conference, The Hon Stephen Robertson who said “All jurisdictions acknowledge the right of women to access safe high quality maternity services and believe that care is best provided by qualified health professionals who work collaboratively within a high quality health service to ensure women receive appropriate and timely care”¹

Further, the Chair says “Maternity services in Australia are high quality, with health care outcomes which compare favourably with international settings, and are able to continually improve and respond to needs of contemporary families”²

Australia has a mixed public/private provision of maternity services with the public sector providing the majority of deliveries. The overall maternity service in Australia has historically been medically led.

¹ Australian Health Ministers Advisory Council 2008, Primary Maternity Services in Australia - a framework for implementation, page 1

² *ibid*

64% of deliveries are public patients in public hospitals. 34% of deliveries are private patients mainly in the private hospital sector. The figure of 34% represents 88,000 women who choose to pay for a private delivery with an Obstetrician (or in some situations a GP Obstetrician) involving payment of private health insurance premiums and out of pocket payments. In assessing the public sector deliveries (167,000 deliveries), we largely already have shared care. Most deliveries are done by midwives if the pregnancy is normal under the supervision of an Obstetrician in a conventional Labour Ward or on referral from a Birthing Centre.

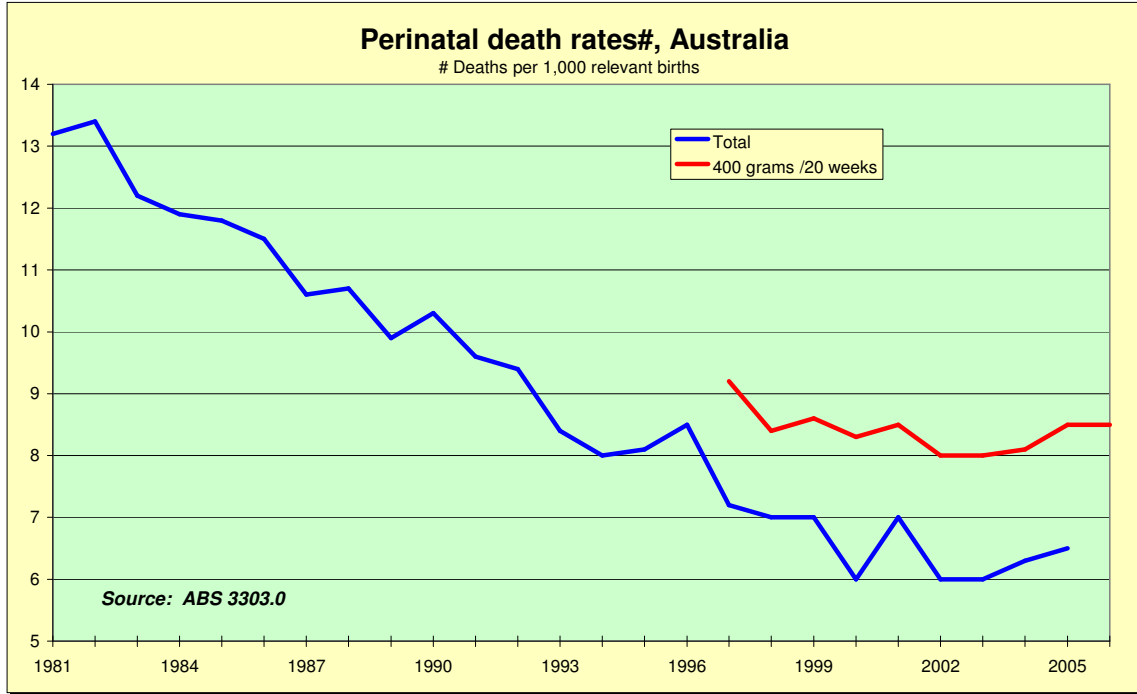
In addition, the majority of ante-natal care is provided by Obstetricians in the metropolitan area and GP obstetricians in rural and remote Australia.

These real choices by women need to be taken into account in assessing the claims of organisations claiming to represent the views of women broadly.

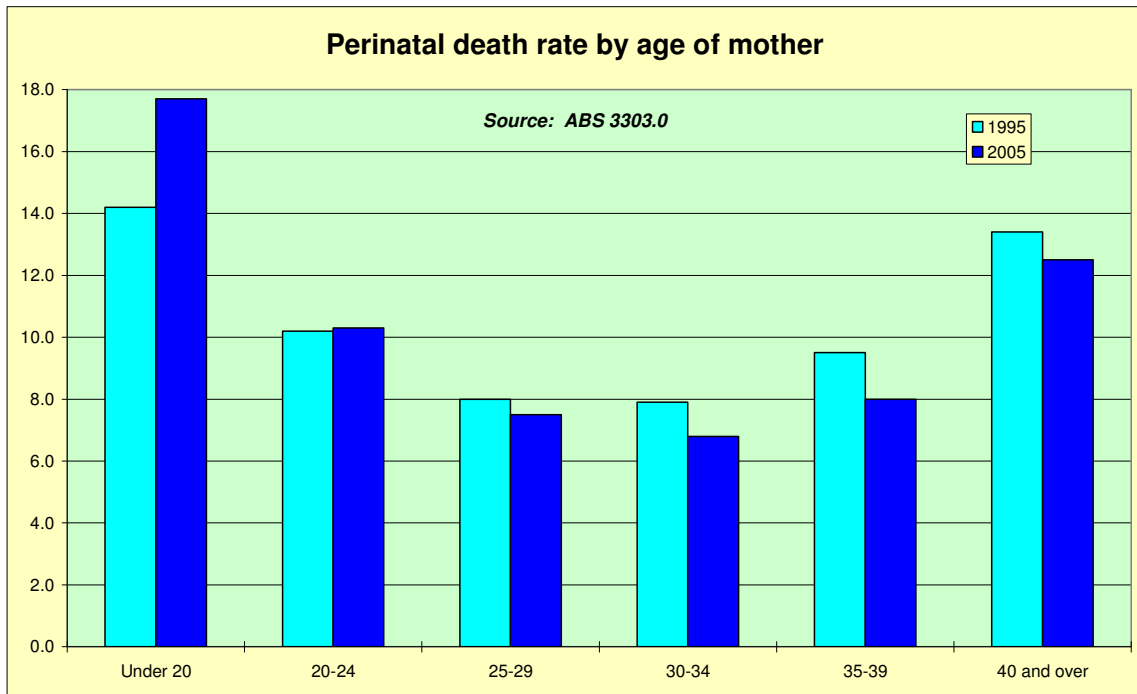
Our excellent outcomes

The Perinatal death rate is widely accepted as one of the cardinal indicators of population health in Australia. Perinatal death rates have declined very sharply over the past 35 years. Between 1973 and 1981, the perinatal death rate fell from 23 per 1,000 live births to 13.2, a 44% reduction. The following chart shows two different measures of the perinatal death rate between 1981 and 2005. The data define perinatal deaths as stillbirths and deaths of infants (in the first 28 days) weighing at least 500 grams or having a gestational period of 22 weeks. In 1997, to reflect advances in medical practice, the definition was made more challenging by dropping the weight to 400 grams and gestational age to 20 weeks.

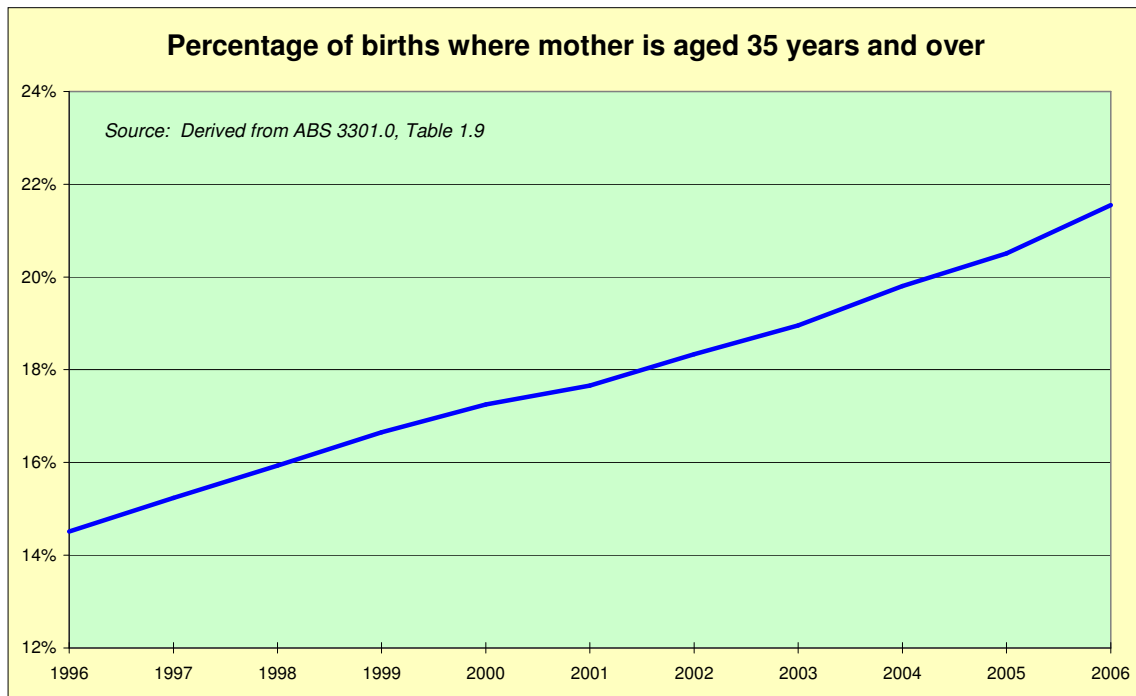
The graph shows that for babies who achieve birth at or greater than 500grms or gestation of 22 weeks or more, mortality has continued to drop from 13.2 per thousand births in 1981 to 6.5 per 1,000 live births in 2005, a 51% reduction. Under the more challenging definition since 1997, the rate has dropped from 9.2 per 1,000 live births to 8.5, an 8% reduction. These statistics compare extremely favorably with other OECD countries and are attributable to current maternity services that exist in Australia. These numbers encompass the poorer outcomes in Indigenous Australians.



Relative risk for perinatal death has many contributing factors but it is highest with very young mothers, lowest for mothers aged 25 to 34, and then rises with age. For mothers aged 40 and over, the perinatal death rate in 2005 was almost double that for mothers aged 30 to 34.



From this information we can understand that the rising age of mothers is highly relevant to understanding the relative “plateau” in the perinatal death rate under the new more challenging definition introduced in 1997. The median age of mothers at first birth rose from 27.2 years in 1997 to 28 in 2001 through 2005. The median age does not, however, reveal the extent of the growth in the number of mothers whose first birth occurs when they are 35 years and over. The following chart illustrates the trend growth in their relative importance.



Juxtaposing the perinatal death rate with the increasing risk associated with older mothers at first birth, the improvement in the rate over time is substantial.

Were the perinatal death rate standardised to the age of mothers, then the rate would be continuing to fall.

This is the result of a lot of hard work and dedication by the medical profession and close to perfect results are now an expectation of the Australian community.

The trends in increasing age at first birth and the increased risk in this group must be taken into account in any proposal to attempt to shift these women into lower levels of care.

In the young age group it is evident that risk to mother and baby is high, and in particular with young indigenous mothers. Similarly shifting them into maternity services that increases their risk will jeopardize outcomes.

The maternal mortality rate has dropped to 8.5 (direct and indirect) per 100,000 births in Australia compared to an average for the developed countries of 20 per 100,000. It

would be disastrous if these strong results for Australia were turned around because of poorly considered reforms.

Overseas experiments and results

Of the countries which are comparable to Australia, New Zealand is the one which has made the most significant intervention relevant to the Australian situation. Their reforms in 1995-96 provided for the concept of a Lead Maternity Carer. These reforms were instituted despite the strong opposition of the New Zealand medical profession which had and maintains a strong concern for the safety and quality of care for mothers and babies.

The scheme had the following key features:

- Primary maternity care would continue to be delivered without cost to the women and baby. Specialists could continue to charge for their services
- Each woman would have a Lead Maternity Carer (LMC) to provide and/or coordinate care throughout her pregnancy. This could be a midwife, GP Obstetrician or a specialist obstetrician.
- It became compulsory for a midwife to be present at each delivery, but not for a doctor to be present ie midwives could deliver on their own but a doctor could not.
- There was a more or less standard fee arrangement for LMCs, except that a doctor LMC had to pay an extra fee to have the midwife present. The fees were considered inadequate by most GPs
- A set of (weak) guidelines governed handover to medical care in cases where the birth was not proceeding normally.

This model was fiercely resisted by the NZMA, who warned the Government that GPs would cease to provide maternity care, but it was finally introduced by regulation.

Some of the adverse outcomes include:

- Most GPs no longer provide intra-partum care, so almost all maternity care is delivered by midwife LMCs. Services are provided via a mix of community-based independent midwives and hospital-based midwives. Patients have lost the choice to have a GP obstetrician which has had an enormous negative impact in rural communities.
- Referral by midwives for medical care tend to go to a specialist obstetrician, so there is a growing gulf between maternity care and general practice care. Once again this has significant negative impact in rural areas and the concerns about maternity services being delivered closer to home.

- There are substantial workforce issues facing maternity services. Many women find it hard to obtain an LMC. Rural women in particular find it increasingly difficult to get access to maternity services, particularly medical care. The reform in New Zealand has reduced maternity service access to women.
- There has been little or no formal assessment of the success or otherwise of the model, and the absence of good mortality and morbidity information has meant a lack of clarity in respect of the outcomes. The statistics in New Zealand for neonatal and maternal morbidity and mortality compare very poorly with Australian data in our current service delivery system.

There is emerging evidence of higher maternal death rates and perinatal death rates. Collection of data is essential and it is noted that there has been a failure of good data collection in this area in New Zealand which is currently being remedied.

Australia must continue to collect data in the area of maternity care, particularly if there is intervention and reform of maternity services. There can be no argument to not track outcomes for mothers and babies.

Also, importantly under the New Zealand model, the reforms seem to have disconnected families from General Practice leading to dramatic falls in immunisation rates and sharp rises in cases of late presenting post natal depression. These phenomena have been widely reported in New Zealand in direct correlation to the maternity services intervention.

The number of GP Obstetricians in New Zealand has dropped to less than 20 in the whole country. There has been an evaporation of experience and expertise in prenatal/ante-natal/ post-natal care, gynaecology, neonatal paediatrics, child development and maternal mental health in a system that offers women no choice of care giver when “increasing the choices available to women” was the stated objective.

Edward W Weaver et al have noted that in relation to the New Zealand reforms “...negative changes have also occurred, such as the effective loss of the option for women to have a GP involved in their maternity care, and an initial exodus of midwives out of the public hospital system.”³

There are significant lessons to be learnt from the New Zealand experience and the AMA believes that any pursuit of this model is a retrograde step for mothers and babies in Australia.

³ Edward W Weaver, Kenneth F Clark and Barbara A Vernon, Obstetricians and midwives modus vivendi for current times, MJA 2005;182(9): 436-437

Where we need to improve

Building on the high standards and quality that exists in Australia we must specifically focus on areas of need for improvement. In rural and regional Australia there are gaps and difficulties in offering access to high quality and safe services to rural mothers.

State Governments across Australia have progressively shut down rural and regional hospitals and rural maternity services have had their infrastructure removed.

Where GP Obstetricians and visiting Obstetricians working with midwives to provide care closer to home for rural mothers once existed, they are no longer able to provide these services.

State, Territory and Federal Governments must reinvest in rural and regional hospitals to provide the infrastructure required to enable safe and high standards of maternity services to be made available.

Patient transport services must also be supported to assist mothers and babies to access care either in the rural location if services available or transport to metropolitan services.

Lack of rural hospital and service infrastructure and locum relief are some of the key reasons why GPs do not stay in the bush. These were key findings of an AMA Rural Health Issues Survey in May 2007.⁴

Workforce issues contribute to the gap in rural maternity services. We have an increase in Australian trained graduates coming through our Medical Schools and this must be matched with an increase number of training positions for GPs. Rural General Practice must be rewarded for rurality and service with incentives to encourage GPs to work and experience rural Australia. The AMA and the RDAA have put forward a plan to incentivise and reward doctors who provide procedural care and obstetrics in rural Australia.⁵ These are positive high quality solutions to improving maternity services in rural Australia.

The other area of significant concern is mother and baby care in our Indigenous communities. This is multi factorial and includes social determinants of health as well as the coal face access to care. Indigenous children are more likely than non-Indigenous children to be still-born, to be born pre-term, to have low birth weight, or to die in the first month of life. Low access to appropriate health and medical services is a major factor in this, especially in remote locations.

A range of other social, economic and educational factors also play a persistent role in sustaining these poor health outcomes. For example, children of uneducated Indigenous mothers experience higher mortality than those of educated ones; 23% of Indigenous females who gave birth between 2001 and 2004 were under 20 years old compared to 4%

⁴ <http://www.ama.com.au/web.nsf/doc/WEEN-72S4P5>

⁵ <http://www.ama.com.au/web.nsf/doc/WEEN-784528>

of non-Indigenous females; a significant proportion of Indigenous mothers smoked and drank alcohol during pregnancy; and, malnutrition and access to a healthy diet continue to be problems for Indigenous children and adults, as does adequate housing and living conditions. These issues will be canvassed in an AMA Aboriginal and Torres Strait Islander Report Card 2008: "Ending the Cycle of Vulnerability - The Health of Indigenous Children" to be issued shortly.

The Government has drawn attention to high intervention rates in its Discussion Paper with differences in the rates between the public and the private sectors and between States and Territories and internationally. We accept that this is an issue which needs to be examined and we comment on this later in this paper. We note however that most studies show no appreciable difference in the intervention rates between mixed models of care and traditional Obstetrician led care and intervention rates would not respond to the other measures canvassed in this paper.

Issues

AMA position generally

"Don't throw the baby out with the bathwater"

Australia is one of the safest places in the world in which to give birth. Australia's maternal and perinatal death rates are lower than the majority of comparable countries. Any reforms to maternity services must not lose sight of or jeopardise this excellent record.

AMA supports a team based model of care where obstetricians, GPs, GP Obstetricians, nurses and midwives work in collaboration with each other.

An increasingly older maternal patient group is leading to more medical and obstetric complications in pregnancy, not less. Our maternity services must respond appropriately to this need.

Given the challenges we identify, reduced access to maternity care in rural Australia, specific concerns around the needs of indigenous women, and the concern raised over intervention rates, the AMA supports measures which will be beneficial to patients in these areas, and not compromise the safety and quality of care and maternal and neonatal outcomes.

The issue raised by government and other parties with regard to women having choice is also acknowledged and the AMA supports fully informed choice.

The AMA would support expanded funding arrangements for midwives provided this is available within a medically supervised model. In this model, there is a team based approach but the highest trained practitioner, the medical practitioner, supervises the overall care of the patient and can delegate aspects of a patient's care to a midwife.

The assessment of the patient by a medical practitioner and delegation to midwife care, if the patient desires, provides the patient with the scope for making secure and safe choices for herself and her baby.

In combination with this principle, at the time of delivery, there must be on site (or in the immediate vicinity for timely transfer) the availability of obstetric, anaesthetic and paediatric care to deal with unpredictable complications.

The absence of access to these services means that mothers will not have the choice of epidural anaesthesia if required, will not have the choice of emergency caesarean section if required, and will not have the choice of their baby being assisted by a paediatrician if required.

We believe medical practitioners and midwives have good relationships on the ground and are capable of evolving arrangements which would have the effect of extending maternity access and responding to reasonable patient demands if they are left alone to do so. The Government's role is to support and fund arrangements and infrastructure which provide patients with quality care.

Highly interventionist government agendas to advance an ideological cause are likely to create problems in the delivery of maternity services and exacerbate tensions in inter-professional relationships, not improve them. Actions by the government which favour one particular new model of care over another will generally not be in the interests of patients, will restrict real choice and will be inequitable.

The Government should not introduce any publicly funded arrangement which is based on independent midwife care for mothers and babies in Australia or use public funds to encourage separate streams of midwife led maternal care on the one hand and medical maternal care on the other. This will create two separate streams of care and the gulf between these will be detrimental to good patient care. The gulf cannot be addressed through protocols and other ameliorating initiatives and will ultimately lead to less safe care for mothers and babies.

There are many risks for Australian mothers and babies in the current proposals being put forward.

Apart from the real risks in morbidity and mortality outcomes, the real loss of choice of obstetric, anaesthetic and paediatric care, there is a risk that Australian women will be made to feel that they are "lesser" women if they choose to have medical specialist and hospital care for their pregnancies and delivery.

The push for the "normality of pregnancy" and women's right to choose must not create class distinctions between mothers. The right to choose must work both ways.

Further, shifts in funding models may mean that only those who can afford it will have access to obstetrician and hospital care. Those who cannot afford it may be pushed to midwife only care with the risks and outcomes described above.

This is not the case in Australia now with Public and Private access to health care. This would create discrimination based on affordability, and abrogates the government's responsibility to deliver equity of access.

The "ideal" maternity unit would include medical obstetric care (including foetal monitoring facilities), anaesthetic and paediatric services, and the infrastructure to deal with an emergency caesarean section if necessary. We support RANZCOG's view that even where women have been carefully assessed for delivery in low technology primary care units, such units should be located within or immediately adjacent to a 24 hour obstetric facility.

Our efforts should be to encourage and support all that is good in the current system and look for win- win solutions to expand and improve our existing service.

Quality and safety

There is strong evidence that we should not be considering publicly funded midwife led home birth. A 1998 Australian Study published in the BMJ showed that in-home birthing by midwives is three times more likely to lead to perinatal mortality than conventional options even with the lowest risk pregnancies.

The conclusions of the study were that Australian home births carried a high death rate compared with both all Australian births and home births elsewhere. The two largest contributors to the excess mortality were underestimation of the risks associated with the pregnancy and a lack of response to fetal distress.⁶

The evidence for increased perinatal death rates is compelling and the difference is so substantial that the Federal Government could not reasonably nor responsibly introduce payment arrangements which encourage and sanction such activities. If the Government did sanction such practices, it is likely that independent midwives would be encouraged by this action to extend their practice into riskier patient selection areas and this could well see an escalation of an already very significant risk differential.

Whenever a new medical item into the MBS is sought, it must meet strict clinical and cost effectiveness criteria and be thoroughly assessed by the Medical Services Advisory Committee (MSAC). No less should be expected of any proposed new substitute item for midwives. It is already clear to us that no new medical item would pass MSAC with the level of increased risk associated with home-birth, no matter what the fee.

⁶ Hilda Bastian, Marc N J Keirse and Paul A L Lancaster, Perinatal death associated with planned home birth in Australia: population based study, BMJ 1998;317:384-388

In relation to birth centres, the best evidence is a 2004 Cochrane Study. Main findings were:

1. For birth centres, there was a trend to higher perinatal mortality, with an 83% higher risk of perinatal mortality overall. This figure just failed to reach a level of statistical significance but led the authors to conclude that caregivers and clients “should be vigilant for signs of complications”
2. A small increase in the likelihood of spontaneous vaginal birth, small decreases in intrapartum medical interventions and increased maternal satisfaction. Maternal satisfaction is a function of one on one care which is a luxury which cannot be afforded in most clinical situations.

The authors also observed “the trend towards higher rates of perinatal mortality in the home-like settings raises important questions. A focus on normality may have a negative impact on the ability of caregivers and childbearing women to detect, act upon, and/or receive assistance with complications.”⁷

Other studies have found that there was a statistically significant 4 fold overall increased risk of a baby dying during labour in a birth centre group overall and a 7 fold increased risk of dying in labour for babies of first time mothers in the birth centre group.⁸

Informed choice

We support choice but it should be a choice between equally effective and safe models of care. The AMA supports the provision of greater information to patients on the choices available to them and the clinical outcomes which follow from those choices. Obviously this information needs to be presented to the woman in an objective and scientific form and should not be ideologically driven.

We find it disappointing that although the New Zealand Government intervened in the provision of maternity services in 1995-96, it is still not able to establish clear outcomes from this intervention or to evaluate the consequences of the intervention. We understand there may be recent attempts to evaluate the care outcomes in NZ but these are unlikely to emerge in an election environment.

If there is an intervention in the provision of Australian maternity services, there must be appropriate and immediate prospective data collection, evaluation and publication of outcomes data.

⁷ Hodnett ED, Downe S, Edwards N, Walsh D, Home-like versus conventional institutional settings for birth 2005, The Cochrane Collaboration, John Wiley and Sons

⁸ Gottvall K, Grunewald C, Waldenstrom U, Safety of birth centre care: perinatal mortality over a ten year period, British journal of Obstetrics and Gynaecology 2004;111;71-8

Collaborative care

Collaborative care models are already available in the public system. Although there are systemic differences in style, philosophy and resource intensity, the different models have evolved to meet the changing needs of women through consultation with patient groups, the medical profession and public hospitals. These models continue to evolve to meet the needs of women with poorer birth outcomes, women from marginalised groups for example.

These public maternity services are provided across the interface between community and acute facilities and offer such services as:

- ante-natal booking and regular ante-natal visits
- ante-natal inpatient and emergency care
- pregnancy and parenting education
- labour and birthing care
- newborn nursery care
- acute post-natal and community based post-natal care

A range of different health and allied health practitioners are involved in the provision of these services including:

- Obstetricians
- General Practitioners
- Paediatricians
- Anaesthetists
- Pathologists
- Midwives
- Neonatal nurses
- Social workers

There does not seem to be a need for central planning in the evolution of these services. The services have mostly evolved to meet the needs of women and are provided in a safe environment within a traditional unit or in a birthing unit adjacent to a 24 hour obstetric unit.

We do note that there are some instances where State Governments and Area Health Services have been prepared to allow standalone birth centre models to operate. We do not support this model.

88,000 women, noting these public services are available, choose to have a private birth mostly in the private hospital sector where many of the same services are available. The Government could take initiatives to increase the involvement of midwives in the provision of ante-natal and post-natal care in a team environment supervised by Obstetricians, GPs and GP Obstetricians. This could be done through the introduction of “for and on behalf of items” into the Medicare Benefits Schedule.

This would have the effect of expanding the reach of medical obstetric care, expanding the role of the midwife, continuing the provision of safe obstetric services to women and providing greater choices for women at a reasonable cost. In rural Australia, it would accelerate an existing trend to collaborative care and similarly expand the reach of rural maternity care without diminishing quality.

We need to be certain that the midwifery workforce is not a limiting factor and that increases in the utilisation of midwives in the private sector is not offset by reductions in an already stretched public sector. A recent story in the media concerning Maternity Services in Royal Prince Alfred Hospital is an example of how current public services are stretched.

In all other respects, it is a win-win-win solution for patients, midwives and medical practitioners. Doctors and nurses have been working these issues out on the ground amicably for years.

Indemnity

The only new and unassessed indemnity situation which would arise is if the Government considered giving independent midwives public subsidies along with control over any aspect of ante-natal, post-natal or birthing services in specified situations. We have previously said this is not wise given the available evidence concerning safety and that such a decision would not meet the clinical and cost effectiveness considerations which are applied to new medical services for example through MSAC.

It would be our expectation that the indemnity premium for a midwife practising independently and bearing the full legal risk associated with her/his clinical decisions would be assessed on purely commercial grounds at a much higher annual premium than an Obstetrician or GP Obstetrician. This difference would reflect differences in training and experience but also higher risk factors in alternative birthing settings away from medical assistance and support.

We need to avoid a situation where any proposed reforms impact on the indemnity premiums of the existing medical indemnity premiums (particularly Obstetricians and Anaesthetists) by increasing the quantity of “fire brigade” or “emergency response” obstetrics in the system. This would arise when doctors are called in at the last minute for an obstetric complication without any prior engagement in assessment or management of the patient.

Our informal advice is that the indemnity premium for an independent Midwife could be as high as \$200,000 per annum. This premium represents the differences in training but also the higher risks assessed by the industry to flow from such decisions. It is clear that at this level, midwives could not provide the service at a lower cost to patients than a medical practitioner. If the Government chose to fully or substantially subsidise the

medical indemnity premiums for independent midwives, it would need to provide a level playing field for the other providers.

Equity

Any public subsidy available to an independent midwife should also be available to a midwife working in a team based care model in a medical practice. The Government should not use this review to promote what are, in our view, inferior choices at the expense of safer choices.

Rural

Health care in rural areas depends on a strong primary health care workforce and a viable public hospital system. We cannot have one without the other. One of the reasons nominated by the Australian Institute of Health and Welfare for the poorer health status of people living in rural and remote Australia is the lack of access to facilities and services.

This is a key barrier to improving the health and well-being of rural communities. In addition, without access to decent public hospital facilities, doctors cannot maintain their procedural skill levels and the opportunity to train new doctors in rural areas is greatly diminished.

These basic principles apply equally to the maintenance of high quality maternity services in rural Australia. Yet, since 1995 the Rural Doctors Association of Australia estimate that more than 130 maternity units have been closed in rural Australia. The delivery of high quality maternity services in rural Australia requires a well-trained local workforce – backed by adequate local facilities and the option for timely transfer to more specialised maternity services based on a proper risk assessment.

Initiatives to improve the delivery of rural maternity services must recognise the important role played by GP obstetricians. One of the attractions of working rural Australia is that it can offer GPs greater exposure to this type of clinical practice. Moving to models of care that diminish the role of GP obstetricians will result not only in significant deskilling but also remove a key attraction of working in a rural community.

Medically supervised, flexible, team based care arrangements that are designed to meet local needs will deliver the best outcomes for patients in rural areas. The delivery of effective maternity services in rural areas will ideally involve:

- continuity of care delivered locally during pregnancy, birth and the post-natal period
- professional job satisfaction
- appropriately trained and properly supported procedural GPs, midwives and multi-skilled nurses working in a collaboratively model of care
- access to specialised services where appropriate

- reliable 24 hour advisory and referral networks, ambulance services and retrieval systems

local hospitals and community based services that are adequately funded, staffed and equipped for safe birthing

Intervention rates

The Australian intervention rates for Caesarean section seem high by international standards. We do not know for certain but intervention rates in Australia are largely driven by safety and quality considerations and patient choice and by maternal ageing. Spontaneous vaginal delivery rates for women aged <20 yrs are 72.2% but for women aged >39yrs, the rate falls to 45.9%. The rate progressively falls at each age between 20yrs and 40yrs so a small part of the explanation for higher intervention rates lies in maternal age at delivery.⁹

While the overall rate of caesarean deliveries is 30.3%, 41% of these are performed after the onset of labour presumably reflecting some sort of emergency obstetric need. There are higher rates of caesarean delivery in the private sector than the public sector but there is evidence emerging that private care is associated with improved perinatal mortality and other improved health outcomes for babies.

It should also be noted that no appreciable difference in intervention rates shows up if delivery occurs in a collaborative care model such as a birthing centre versus a traditional model.

Sensible policy would be to ensure medical practitioners receive no additional financial incentives whether a baby is delivered via a normal vaginal delivery a delivery involving additional interventions particularly caesarean and that patients are given high quality information regarding the common interventions. This is the situation now where MBS based remuneration for pregnancy and delivery care is determined by level of complexity rather than mode of delivery.

There should be no financial disincentives either. Neutrality of financial incentives is the appropriate position and it is the position we have now.

It is important not to rush to judgement. The only sensible thing to do is do an independent scientific study into the reasons for interventions in Australia and why our rates are different to other OECD countries. This needs to be done removed from the political environment although given the Government's clear interest, it may want to support such a study.

⁹ AIHW, Australia's mothers and babies 2005

Post-natal depression

This is a serious issue and shows the importance of strong medical involvement in maternity care so there is every opportunity to assess this issue in advance of the delivery and every opportunity to identify it in the postnatal period.

While this is not a major focus of the AMA's submission, it is important to note the need for good health and psychological outcomes for the mothers. It was agreed that midwives could be trained to undertake first line screening for post natal depression (PND) which would assist in identification of those at risk. This screening would not negate the need for a medical practitioner to undertake proper assessment and diagnosis.

A need for investment in follow up support services is needed. Once a diagnosis had been made, it was very difficult to access the appropriate services for the patient.

Indigenous

In general terms, the AMA supports the submission from the Australian Human Rights Commission to the Maternity Services Review titled "Close the Gap (CTG) Maternity Services". In particular, we support better access to primary (GP) and specialist maternity services as a key part of the close the gap strategy. The AMA is proud to be associated with this submission and we urge the Government to continue its efforts in this area.

Recommendations

1. Australia has high quality maternity services which have historically been medically led and which broadly meet the needs of the population and there is no case for radical change.
2. The evidence that is available indicates that home birth and birth centre care is substantially less safe than 24 hour traditional obstetric care taking into account the most material considerations which are perinatal and maternal mortality and there is no case for public subsidy of home birth services, or stand-alone birthing centre services, and no case for encouraging these services to be provided more independently.
3. There is a need for better information on outcomes from the various options chosen by women to ensure their choice is informed by objective scientific data, collected prospectively, and not ideology
4. Any reform of the provision of maternity services in Australia needs to be accompanied by measures to collect data, assess outcomes and publish results free of political interference or ideological overlay.

5. Government should work with the profession to fund an independent scientific study to look at intervention rates in Australia and overseas to establish reasons for differences to inform future decisions in this area.
6. The Government should encourage greater collaborative care in the private medical sector by examining the establishment of “for and on behalf of” items in the Medicare Benefits Schedule for ante-natal and postnatal services by midwives within a team directed by an Obstetrician or GP as the case may be.
7. Rural issues need a comprehensive workforce solution. The rural medical workforce in relation to maternity services is delicately poised and there is reason for caution. There is an obvious need to look at more GP training overall and incentives for GPs and specialists to provide maternity services in rural locations. This needs to involve the States and Territories closely and provision of infrastructure is essential. Rural patients deserve the same access to high quality care, not some second tier service.
8. All Australian women have a right to high standard and safe maternity care and we must focus on areas of need. Reform proposals must not risk the principle of equity of access to medical and hospital care where it is now available, but work towards increasing its accessibility where there are gaps such as in indigenous maternity and rural services. Women must feel confident and safe, not be discriminated against on the basis of their desire to have medical care or their inability to afford medical care.