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AMA submission – draft National Maternity Services Framework

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The AMA is appalled that this opportunity for Australian governments to articulate a national vision to guide the future of public sector maternity services is being wasted.

The draft National Maternity Services Framework (the Framework) is so lacking in substance, so general and generic, that it ends up providing no 'framework' at all. State and Territory health services could provide any kind of maternity services of any standard and still meet the Framework 'requirements'.

Australia should be striving to have the best maternity services in the world – we are certainly capable of achieving this. Instead it appears that governments are ignoring the elephant in the room - the increase in recent years of infant mortality in some areas of Australia.

It is clear that the views of medical practitioners – the leaders of the provision of high quality maternity services in Australia – have been ignored. The AMA has already complained to the Queensland and Federal Health Ministers about the inadequate process for ensuring that the development of the Framework was informed by the full range of health care professionals involved in the provision of maternity services. Medical practitioners involved in 21st century best practice maternity care include specialist Obstetricians, General Practitioners, Anaesthetists, Psychiatrists, Obstetric Physicians, Pathologists and Haematologists. Not even the two key medical practitioners, obstetricians and general practitioners, were genuinely consulted.

The draft Framework does not explain how we will measure the success, or indeed failure, of maternity services in Australia. No quantifiable benchmarks have been provided for what constitutes success - no goals or standards are set. The key and obvious quantifiable measures – maternal and perinatal illness and death – are ignored in the proposed list of National Core Maternity Indicators.

The health of mothers and babies should be paramount, and yet this seems to be a secondary consideration in this Framework. Of course it is important that services are women-centred, recognise cultural differences and are equally accessible by all women. However, we should also recognise and be guided by the evidence and a much greater requirement to focus on the safety and needs of the other half of the equation in this care - the baby.

The fact is that obstetrician-led maternity services provide the best outcomes for mothers and babies. There is compelling recent Australian evidence that women accessing 'low risk' models of care delivered by midwife teams and birth centres in large public hospital units have a

significantly higher perinatal mortality rate (2.3/1000) when compared to that of women accessing obstetrician-led care (1.2/1000) (Permezel & Milne, *Pregnancy outcome at term in low risk population: study at a tertiary obstetric hospital*, J Obstet Gynaecol, Res. 2015 Aug; 41(8):1171-7). The practice of obstetrician-led care ensures risk is managed appropriately and any co-morbidity or extra precautions to improve patient safety are properly considered.

It is devastating for our obstetrician members to see mothers and babies suffer needlessly. All too often an obstetrician is only made aware of a labour problem once it has become acute or serious, sometimes many hours after it began to develop. The obstetrician is then expected to assume all responsibility for the care and outcome of the mother and baby.

The popular public hospital maternity services model tends to be midwife-led with obstetrician rescue. But sometimes it is too late for rescue.

An obstetrician has broad medical education in addition to their speciality training spanning 15 years, giving them the clinical and surgical skills to assist mothers and babies in all scenarios. Midwifery training is narrower in scope and much shorter, however midwives are often put in the position of managing a patient's entire pregnancy and labour. This is despite the AIHW 2016 report on National Core Maternity Indicators stage 3 and 4 results from 2010-13 showing that critical obstetrician assistance is required in almost half of all births amongst mothers from a 'low-risk' group.

The Framework does not discuss appropriate models of care, let alone the available evidence supporting (or not supporting) different models of care. It does not provide any guidance to governments about the appropriate mix of health practitioners making up a high quality maternity service. It is not acceptable to dodge this issue by saying that Australian environments and conditions are too diverse for this to be prescribed. Access to maternity services cannot be 'equitable' if some women – particularly those in rural and remote areas – are only offered substandard models of care.

Related to this is the lack of acknowledgement or discussion about the workforce issues which exist in several states and territories, and are especially in crisis in rural and remote areas. There is little point in proclaiming a 'vision, values and principles' if there are insufficient positions for health practitioners, a lack of training opportunities, and adequate infrastructure, to support maternity services in rural and remote Australia.

Women put their trust in the health practitioner managing their care. Not only must this health practitioner be able to fully assess, monitor and address problems as they arise, but they should fully inform women of the risks to themselves and their babies of the choices they make regarding their maternity care plan, whether this concerns the risks of smoking through pregnancy or the risks associated with home births. The AMA fully supports women making their own decisions based on their values and preferences – as long as they are fully informed of the risks and benefits.

Finally, in relation to the *Phase 1 Consultation Report for the National Maternity Services Framework* that was released at the same time as the consultation draft Framework, the AMA notes that stakeholders were not provided with the opportunity to verify its accuracy.

The AMA understood that this report would be published in order to increase transparency about the consultation process undertaken to inform the draft Framework.

Instead, the report makes no mention of the late one-on-one meeting that was required with the AMA after it had not been included in the stakeholders identified for consultation. Instead the AMA is listed as one of the stakeholder groups attending stakeholder workshops - which is not true. The AMA was not invited to participate in any workshops until it was too late to attend, and nor did it receive an on-line survey to complete. The views of the AMA provided at its one meeting with consultants are not reported.

The report also does not list which stakeholders were contacted, why they were chosen, or what lead time was provided to those stakeholders who were contacted to attend workshops. This is hardly an accurate report of the 'consultation' undertaken.

Conclusion

The AMA cannot support the draft National Maternity Services Framework in its current form. Our primary concerns are articulated above, and some specific comments on the draft Framework text are provided in an attachment.

The AMA instead supports the alternative framework being developed by the Royal Australian College of Obstetricians and Gynaecologists – *Maternity Care in Australia*. This document is evidence-based and provides considered, realistic, meaningful and systematic guidance for public sector maternity services aimed at improving outcomes for mothers and babies.

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AMA specific comments on draft Framework text

1. The NFMS should aim to improve health outcomes for women and their babies, not just women. (pg 4)

2. The 'Value' titled 'Respect' should say that a woman's choices, preference and values are respected – and that she is fully informed of the risks and/or benefits of her choices. (pg 4)

3. The 'maternity continuum of care' in the 21st C should also include obstetric physicians, pathologists, haematologists and psychiatrists in order to provide high quality maternity care. (pg 10)

4. The AMA assumes maternity services should encompass healthy and unhealthy women. (pg 10)

5. Women should also be encouraged to consider the advice of health care professionals about maternity service choices, not just be encouraged to 'self determine' and 'assess her unique needs'. (pg 10)

6. AIHW/WHO statistics section should also include national/state/territory trend data over the last 15 years on maternal and perinatal morbidity and mortality in order to illustrate the bottom-line outcomes of maternity services currently available. (pg 12)

7. The 15 safety and quality indicators should be listed here. (pg 13)

8. The workforce related statements in the section 'funding and infrastructure' should be strengthened to stress the importance of maintaining and improving rural hospital facilities and equipment generally (pg 32)

   The closure of more than 50% of small rural maternity units in the past two decades in Australia has had a significant negative impact on training and professional development opportunities for specialists, GP proceduralists and generalists, and also made it more difficult to encourage medical students and doctors in training to work in rural areas. Scope of practice is also limited for specialist and generalists in rural areas because of inadequate infrastructure and insufficient support staff such as midwives and theatre nurses at many rural hospitals. Doctors who have the skills but are unable to practise them must leave the area if they wish to maintain their skills. This has the knock-on effect of reduced services to the local community and patients must travel greater distances for medical services.