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AMA submission: National Strategic Approach to Maternity Services

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The Australian Medical Association (AMA) welcomes this opportunity to contribute to the development of a national approach to maternity services in Australia.

The AMA's detailed responses to the questions posed in the consultation paper *Developing a National Strategic Approach to Maternity Services* are attached.

However, the essential points are as follows.

- The primary objective of all maternity services should be healthy mothers and babies.
- Ideology and practitioner-specific agendas should not determine maternity policies and services.
- Policies and services should be evidence-based.
- Policies and services should consider the 'whole' woman, her baby and family, not just labour and delivery.
- Funding should follow models of care which improve the health of mothers and babies; is cost-effective; and improves women's experiences.

The AMA defers to the Royal Australian College of Obstetricians and Gynaecologists and its 2017 framework for maternity services - *Maternity Care in Australia* – to provide further detail of public sector maternity services and requirements.

The AMA assumes the responses to these very broad questions and the other consultations undertaken so far will lead to the development of a draft strategic plan for maternity services for further public consultation.

1. Overarching key outcome statement for the NSAMS

The primary outcome for any national maternity services strategy should be healthy mothers and babies.

2. Values underpinning the NSAMS

The safety and health care needs of the mother and baby are paramount.

Maternity services should be women-centred, recognise cultural differences and be equally accessible by all women.

Maternity policies and services should be evidence-based and not driven by ideology, practitioner-specific agendas or purely cost.

Quality of care should not be dependent on where a woman lives.

Maternity services should provide a continuum of care – not start and stop at a hospital – and be delivered in the context of the whole person, family and community. General practitioners must be involved as the long-term clinician in the healthcare needs of the family.

3. Positive aspects of maternity services in Australia

Nationally, maternal and perinatal statistics illustrate that our health care services are providing high quality care and achieving positive outcomes.

However, it should be recognised that Australia is different from many countries with which it is often compared, due to its vast geography and the distances to health care services, even in metropolitan areas. This reality must inform the availability of various models of care due to the different risks involved.

Shared care models, led by obstetricians or GP obstetricians, are effective and flexible models of care that can be adapted to a range of health care service environments and women's preferences and needs. They should continue to be supported and expanded as the model of care with optimal outcomes for mother and baby.

4. Gaps/Issues for maternity services in Australia

Multidisciplinary, comprehensive care

Best practice maternity care in the 21st century is provided by a multi-disciplinary team of health professionals. Obstetricians and midwives are key, but the team also includes general practitioners, anaesthetists, psychiatrists, obstetric physicians, pathologists, haematologists and paediatricians.

A national maternity services strategy should provide 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. Obstetrician/general practitioner obstetrician led care is the optimal model.

Fully informed maternity care choices

Women put their trust in the medical practitioners and midwives managing their care. Not only must the lead 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, including an honest appraisal of current outcome data.

Continuity of care with general practitioners

There is little recognition of the depth and breadth of the contribution general practitioners make to maternity care, as illustrated by general practitioners' role largely being ignored in the consultation paper. State-based funding of maternity care through the public hospital system fails to take advantage of the opportunities – and savings – to be made by strengthening and supporting continuity of care with general practitioners.

The role of general practitioners in maternity care is expanded below under question 5.

5. Where improvement is needed on a national basis

Obstetrician-led, collaborative care models of maternity care

The AMA considers that the nationally preferred model of maternity care should be obstetric-led, collaborative care models. Current evidence supports this model of care as providing the best rates of survival for mother and baby, and optimising a range of other outcomes.

Models of care should not result in situations where obstetricians only become aware of a labour problem once it has become acute or serious, i.e. midwife-led then obstetrician rescue.

It is standard practice in all other areas of health care that the attending doctor has the opportunity to meet a patient at the beginning of their healthcare journey and at critical points along the way. This allows a therapeutic relationship to develop between the mother and doctor so that if complications occur, the doctor who is required to rescue the situation has prior personal knowledge of the mother and an understanding of their needs.

There are too many instances in public hospitals of poor recognition of deteriorating patients with slow escalation to the obstetrician and a paucity of obstetrician involvement in risk assessment and clinical team leadership. This is leading to unacceptable differences in outcomes between public and private care.

- At a minimum, an obstetrician or obstetric registrar should review all women when they visit a public maternity service for their first antenatal visit.

  The initial antenatal visit of a woman at a maternity service is an important opportunity to assess the possible impact of co-morbidities and risks that might be associated with the pregnancy. It should involve review of woman's history with physical examination, not just mere supervision or sign-off of midwife assessment. It should also include a report to the woman's general practitioner.

  The outcome of the first antenatal visit should include a full assessment of medical risk and a review schedule based on this assessment. Discussion between the obstetrician and midwife should clarify what symptoms/findings would trigger additional medical review.

  The importance of obstetrician-led maternity services care is supported by 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.

  This initial review and planning is therefore critical in improving mother and baby safety.

- An obstetrician or obstetric registrar should review all women when they are first admitted to the labour suite and at least every four hours to assess progress.

  This is crucial for re-assessing risk and putting in place a management plan in collaboration with the midwife. This ensures early recognition of complications and the best chance of minimising difficulties for mothers and their babies.

General practitioner role in continuity of care

Most maternity health care in Australia is in fact provided by general practitioners within general practice.

- General practitioners provide almost all pre-pregnancy counselling and care. With increasing advanced maternity age, body mass index, comorbid conditions, alcohol and drug use, medicine use and genetic testing for mother / partner, the role of general practitioners is increasing and crucial.

- General practitioners provide care for almost all women until about 20 weeks, even if they choose to birth in a public hospital, including: organising, reviewing and acting on all initial testing; assessment, investigations and referral for congenital genetic disorders;

assessment, interventions and referral for domestic violence and mental health problems; and administering vaccines, e.g. influenza, pertussis.

- General practitioners provide the care/organise referrals/coordinate care for the many other issues that may arise in pregnancy, e.g. musculoskeletal pain, iron deficiency, carpal tunnel, hyperemesis, mental health problems, diabetes care, thyroid problems urinary tract infections, treatment of STIs, etc.

- General practitioners provide almost all postnatal care including the general 6-week check, immunisation, contraception, screening and interventions referrals, as well as issues with breastfeeding, settling and parenting concerns.

The role of general practitioners in providing antenatal, postnatal and newborn care is undervalued and often ignored under midwife-led models of care. This fragments care and distances the primary care provider who will have sole responsibility of the longer-term care of both mother and baby after delivery.

It is logical that general practitioners be better recognised and utilised in the care of pregnant women in a national strategic plan for maternity care.

A woman's usual general practitioner may have known her for many years, be aware of her entire medical history and will be in the best position to monitor other conditions that may be adversely affected during pregnancy.

Utilising general practitioners to provide real continuity of care for women, babies and their families is effective and cost-effective. An excellent example of this working well is at the Royal Women's Hospital in Melbourne where shared care is the most popular model of care. Eighty-five percent of women choose to go to their regular general practitioner for this shared care, thus providing continuity of care from preconception to post-partum.

When this concept of continuity of care is not emphasised, AMA general practitioner members report many instances where women present after discharge but without sufficient timely communication about the pregnancy / delivery or concerns raised to allow a seamless transfer of care back into the community.

Commonwealth and State/Territory government funding should better support the realities of general practitioners' role in maternity care and recognise the opportunities for increasing their role. Governments should seek to minimise out-of-pocket costs for women accessing general practice care in the community.

6. Specific strategies for rural/remote services, and/or Aboriginal and Torres Strait Islander women, and/or women from culturally and linguistically diverse backgrounds

Workforce shortages are critical in some rural and remote areas in Australia. There is little point in identifying national '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. Access to maternity services cannot be 'equitable' if some women – particularly those in rural and remote areas – are only offered substandard models of care. Harnessing the services and expertise of general practitioners is even more important in these communities.

The recruitment of obstetricians to regional areas will require cooperation between State/Territory and Commonwealth governments to offer attractive employment prospects that facilitate opportunities in public and private practice, and support the practitioner and family, recognising the difficulties of regional practice.

7. Measuring and monitoring strategies and their success

The key and obvious quantifiable measures – maternal and perinatal illness and death – must be included in any list of National Core Maternity Indicators.

Whole-of-state data can mask emerging problems in individual health service areas. Area health services and hospitals should publicly report on a regular basis on how they compare against state and national benchmarks.

Pre-pregnancy and antenatal care provided by general practitioners is not captured in current health care measures. This needs to be measured so the services provided can be better understood and further opportunities realised.

18 JUNE 2018

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