MATERNITY CONSUMER NETWORK

Position Statement

Overall, AMAQ maternity submission is inflammatory and unhelpful. In a situation that requires improved integration and collaboration between care providers, AMAQ submission is a transparent bid for tribal supremacy. In the context of tightening financial constraints, they propose a service model that would greatly increase cost, without evidence of being able to improve outcomes. We know we need to improve access to care for marginalised, rural as well as indigenous women, but the proposed AMAQ model can only be delivered in large urban hospitals. Its reference to the evidence is cherry-picked at best, and ignores the great body of papers and systematic reviews that support the safety of primary care models of maternity care in the context of access to medical care when required.

Private Obstetric Care

The AMAQ paper makes repeated and unhelpful comparisons between Australia's public and private maternity services, and the recent NZ paper comparing midwifery and obstetric-led maternity care. In both cases the broader population of women is being compared with a group that has the affluence and social status to enable employment of a specialist doctor for their primary maternity care. The evidence on the social determinants of health predicts that this group of women can expect better outcomes in any measure of health, independent of model of care, so it is not possible to find causation of outcomes such as mortality from specialist medical care. It is pretty shameless for AMAQ to criticise public hospitals, which care for the poorest, sickest women who may have received minimal health care and who suffer the worst outcomes. The paper overlooks the huge excess cost of private care, the indefensible rates of medical and surgical intervention in private maternity care, and the consequences for women and families of excess interventions, both emotionally and physically.

New Zealand

New Zealand's maternity care system is built on community-based primary midwifery care, with well-developed access to public hospitals and collaboration with hospital medical staff. According to WHO, New Zealand's perinatal mortality rate has been the same as Australia's for a long period, while having a significantly lower rate of caesarean section. The facts about New Zealand do not support the AMAQ claims.

Key claims unsupported by evidence

The main claims in the AMAQ paper stand as opinion, unsupported by a broad consideration of the evidence. Some examples:

"public hospital maternity services are led by midwives"

Public maternity services employ a range of models of care, with a range of balances of professional responsibilities. Some are medically dominant, others give midwives increased clinical responsibility. If the AMA/NASOG propositions had merit, the differences in outcomes would be evident in current models. Public hospital models, which increase the clinical responsibility of midwives, have been shown to deliver improved outcomes, not

worse. This does not suggest it is better to have less obstetric input to care, it shows that it is better to have greater continuity of carer and a stronger primary care base, while having access to medical input and acute care when indicated rather than routinely.

"it is possible for a labouring mother to have no obstetrician review unless a midwife requests obstetrician review (which is not mandatory)"

The ACM *National Midwifery Guidelines for Consultation and Referral* are supported by RANZCOG and provide professional guidance to midwives on when women require medical care. The AMAQ paper's claims that midwife referral to obstetricians is "suboptimal" and "ad hoc" indicate ignorance of regulated midwifery practice.

"decreasing direct involvement of the highly trained obstetrician is a significant cause of the inferior outcomes endured by mothers and their babies in public hospital maternity services"

This statement infers that public maternity services have increasing rates of poor outcomes, due to model of care, over time. There is no evidence of increasing rates of poor outcomes in public hospitals over time, and there is high quality evidence of improved outcomes in midwife-led primary care models.

"compelling data that the morbidity and mortality rate for mothers and neonates is significantly lower in the private system"

This is raw, or at best slightly filtered data, which does not meet the standard for evidence. The evidence supporting midwifery continuity models depends on difficult, expensive, time consuming, randomised control trials. There are no similarly robust research trials showing that providing women with private specialist care improves maternity outcomes relative to other models. It is also difficult to collect strong evidence on rare events, which are so often determined by socio-economic or other uncontrollable factors, such as perinatal or maternal mortality. When the most complex obstetric and neonatal cases tend to end up in the public system, it becomes even more difficult to accumulate strong evidence.

It would be irresponsible not to consider the question of cost. Under the AMAQ proposal, the historically increasing professionalization and clinical skill level of midwives would be reversed, and obstetric staffing would be greatly increased. Small maternity units would close (at great cost to communities, if not the hospital authorities), and services would be concentrated in larger hospitals. Without a major increase in health service funding, this would result in significant loss of current services, presumably low-cost primary services, in order to concentrate funding on high-cost acute services. This proposed direction is in opposition to the international recognition of the efficiency and effectiveness of building a strong foundation of primary health care, and towards the American model that delivers relatively poor population health at exceptionally high cost.

The problems in Rockhampton need a much more systematic analysis than the AMAQ paper offers. The views of maternity consumer representative are there are systemic problems in Rockhampton, evident for several years. There had been long-term difficulties maintaining obstetric staffing, and persistent stories of problems with midwifery staffing and morale. These things point to problems in leadership and culture, not a lack of supremacy of any particular professional tribe. The engagement of the AMA in the situation is further evidence of failure of local relationships and culture: in our experience of maternity care politics, when

the AMA becomes engaged in a public hospital issue, it is evidence of serious failure of local leadership and culture.

Summary

The AMAQ paper represents the prejudices and aspirations of an elite group of private practice specialists. It does not address the evidence in a systematic way, and its proposals are divisive, ineffective and unaffordable.

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