Many contributors to the Review considered that maternal and perinatal rates of mortality were not an adequate measure of the performance and outcomes of maternity services. Severe maternal and perinatal morbidity were identified as important indicators of system performance

 *Women need to have access to maternity services that are appropriate to their clinical, cultural and social needs … a strict biomedical approach is unlikely to adequately reflect or accommodate the broader health picture for women.17*

Consumer submissions voiced concerns about an absence of choice in relation to maternity services, in both rural and metropolitan areas. In their submissions, some consumers expressed feelings of being subject to coercion, lack of control over the birth process, and dissatisfaction with the outcomes. In some instances, consumers advised that this has led to them giving birth at home on their own without any health professional providing assistance.40 Many of the consumer submissions demonstrated a clear preference for care by midwives, either in birthing centres or in the home setting.

Rural and remote families experience higher rates of maternal death;43 rural women have significantly higher rates of neonatal deaths and remote women have higher rates of fetal deaths.44 While these outcomes are in part reflective of the poorer outcomes for that proportion of these populations identifying as Indigenous, this is not the entire picture.

People living in rural and remote areas face a number of health inequities, many of which result from, or are exacerbated by, problems in accessing health care services.

For rural and remote communities, accessing appropriate maternity services raises particular issues. What exacerbates this is the need for ongoing care throughout the pregnancy and, for higher risk pregnancies, the requirement for a significant period of hospitalisation prior to and sometimes after the birth. Even in a low‑risk pregnancy where a woman has access to a GP, she may still have to travel a considerable distance in anticipation of the birth or for some aspects of her antenatal or postnatal care. Current supports and services, including travel and communication, are inadequate to cater for the needs of all women and their families in rural and remote areas.

As is the case for all health care, however, maternity services require access to an appropriately skilled workforce and associated infrastructure, not all of which can be provided in every community. The alternative to travel by women, for some aspects of care, is for fly-in fly-out services from maternity care professionals. The Medical Specialist Outreach Assistance Program (MSOAP) improves the access of people living in rural and remote Australia to medical specialist services by complementing outreach specialist services provided by state governments and the Northern Territory government. For its part, the Specialist Obstetrician Locum Scheme (SOLS) supports access of rural women to quality local obstetric care by providing locum support to the rural specialist obstetrician workforce, obstetricians and GP obstetricians.

Over recent years, there has been a decline in the availability of facilities providing maternity services in rural and remote Australia. The Rural Doctors Association of Australia (RDAA) reported in 2006 that over 130 small rural maternity units had closed across Australia in the 10 years since 1995.46 State government closure of these facilities has been the result of workforce shortages, safety and quality considerations and, inevitably, cost considerations.

The AIHW reports that the number of hospitals and birth centres fell by one-third between 1991 and 2006, from 617 to 416. Figure 8 shows that this reduction in hospitals and birth centres was greatest in hospitals that saw between 1-100 women who gave birth per year; the number of these centres almost halved from 325 to 159.47 Workforce considerations for rural and remote Australia are discussed in Chapter 5.

* The Review heard of the critical role played by procedural GPs (obstetricians and anaesthetists) in providing maternity services in rural communities, the impact of their declining numbers on rural communities and the opportunities for developing collaborative models of care where procedural GPs were involved.

*It is increasingly common for GPOs (general practitioner obstetricians) to work collaboratively with midwives, deliver only more complex cases and, where neonatal resuscitation skills are good, not necessarily attend the delivery. 49*

* Also highlighted to the Review was the importance of focusing on a range of models of care that allowed services, as far as possible, to be close to home and sufficiently flexible to adapt to local circumstances.

*It is important that maternity care is accessible close to home. An interesting outcome of the Rural Maternity Evaluation was that women were comfortable accessing labour services away from home providing that pregnancy and postnatal services were accessible close to home. 50*

* An issue raised for rural women was the fragmented nature of their maternity care.

*It is well known that adverse events increase when the patient moves between systems or hospitals. Transition between primary care sector and acute care sector whether in the postnatal, antenatal or birthing period requires excellent communication systems, referral processes and clinical guidelines. Clarity around when accountability ends and starts is also important. 51*

*The development of improved networks between rural and major centres will assist education and training, as well as the clinical management of individual cases, particularly high-risk women. Access to improved teleconference facilities will also assist rural centres in particular. 52*

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