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Rural Maternity Care Brief - May 2018

The recent commitment to the rural healthcare workforce is a welcome move towards improving health care for rural families. We strongly support a greater emphasis on rural maternity care. Focus on rural healthcare must be a priority, to ensure more equity in access and improve outcomes. Furthermore, rural maternity hospitals are more attractive to recruit to when they have maternity care as they offer midwives, nurses and doctors an opportunity to work across a greater skillset.

Primary care maternity models create a service for rural families, are economical and have been found to deliver good outcomes for mothers and babies.

Problem:
The last Commonwealth Review (2009) into maternity services reported rural families experienced higher rates of maternal and neonatal death. There has been no improvement, particularly with ongoing closure of rural maternity units around the country. More than half Australia's small maternity units have been closed. In 1991 there were 325; in 2007 there were just 156 (ABS).

Without maternity care, staff can't work across their full skillset, which makes recruitment difficult. Hospitals then also have drastically reduced services, often becoming geriatric facilities. The Rural Doctors Association of Queensland most recently reported the following:
Statistics taken from QLD perinatal data collection for the period 91' - 09'.
Perinatal mortality rates:-
Metro maternity units 10.5 deaths/1000 births
Rural maternity units 8.5 deaths/1000 births
Rural towns without birthing services = 23 deaths/1000 births

The system can't (and shouldn't) dictate where women will birth, especially prematurely. If you remove a service the babies will be born anyway, planned or unplanned. It is a basic human right to have access to maternity care close to home. Contrary to the lines often peddled around safety, the safety is in local birthing. Perinatal data confirms it is very safe to birth in rural areas with GP obstetricians and midwives providing care (Hall, J. 2018).

An issue raised for rural women in the Commonwealth maternity review 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."

The Federal DOH has undertaken the task of completing the National Strategic Approach to Maternity services, however, all the consultations are in metropolitan areas. Furthermore, only 2 consumers out of 24 stakeholders are represented on the Expert Advisory Group. This group reports to the Project Reference Group (the state/federal representative committee), who also make the decisions. There is no consumer representation on the PRG.

Benefits/Solutions:

- Healthcare staff are easier to attract to a fully functioning service, as they can work across a skillset. When birth is lost from a hospital, a lot of other services go too. Rural trained doctors need facilities to work in.

- New models of care: caseload system where the midwife works when women require care rather than in a conventional shift schedule has been demonstrated to be cost effective, with midwives caring for more women in the same amount of time. Levels of job satisfaction are very high and the opportunity to work exclusively in their chosen profession is a compelling recruitment incentive for midwives (Rural Health Alliance, 2012) . => the private practicing midwifery profession could easily fulfil the roles in offering primary maternity care in rural areas, though there is so much red tape, the population of private midwives has dwindled to about 110 nationally.

- The Commonwealth review into maternity services (2009) reported the important role played by procedural GPs (obstetricians and anaesthetists) in providing maternity services in 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".

Our asks:

- In order for rural maternity services to meet the needs of rural families, rural consumers need to be involved in the National Strategic Approach to Maternity Services. Currently, we have a Central Queensland representative on the Expert Advisory Group. There is no consumer representation on the Project Reference Group.
We would welcome:
a) increased emphasis on meeting the needs of rural birthing families
b) consumer representation on the PRG.
We believe the exclusion of funding mechanisms and models of care from the NSAMS discussion, as is currently the case, will negatively impact on rural maternity care. We firmly believe birthing women should be involved in decisions made about them (ie. involved in the PRG).
- Focus on re-opening and maintaining rural birthing units as a service to rural families. There are many closed maternity facilities which need little more than staffing, as the infrastructure is already in place.
- Continuity of midwifery care, close to home is desired by rural birthing families.

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END OF BRIEF