



THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

Response to Improving Maternity Services in Australia

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Improving Maternity Services in Australia

Executive summary

The Royal Australian College of General Practitioners (RACGP) supports review of Australia's maternity services with a view to ensure access to safe, high quality care to women before, during and after birth.

The RACGP believes that to achieve the aim of safe, high quality care to all childbearing women the following principles need to be considered:

- All roles support the safety of the woman and family
- Clarity over who leads in any particular case
- Watertight handover between care providers
- Training and ongoing education of those involved in the care of women and babies is accessible, relevant, feasible and affordable
- Care is aligned with training and experience of staff and back up is available in a timely manner
- Infrastructure is aligned with the level of care to be provided in that facility
- Indemnity covers all care provided by each team member to the extent that they provide in alignment with training, experience and back up
- Women agree with proposed strategies

The RACGP favours a team based approach to maternity care in Australia. Team-based models of care should utilise the skills of all members of the team efficiently by involving them at the appropriate level of service delivery.

It is important to maximize use of the present system and make improvements to it ensuring that any changes to maternity care policy continue to provide safe care for mothers and their babies.

The RACGP cautions against approaches that could lead to unintended consequences such as reducing access to care or safety of mothers and babies.

About the Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners is the professional organisation that focuses on the safety and quality of general practice.

The College's mission is to improve health and wellbeing for all Australians by supporting general practitioners, registrars and medical students by assessing doctors skills and knowledge, supplying ongoing professional development activities, developing resources and guidelines, helping general practitioners with issues that affect their practice and development standards that general practices use as part of the accreditation processes. The College has a proud history of achievements including, the development of standards for general practitioners and general practices and introducing continuing professional development.

The college has over 19,000 members, and over 6 000 members of its National Rural Faculty. The college is the largest general practice representative body in Australia and the largest representative body for rural general practice. Over 24,000 general practitioners participate in our Quality Assurance and Continuing Professional Development program (QACPD), making it the largest medical CPD program in Australia.

The RACGP has a number of activities aimed at improving the safety of patients in general practice, in addition to the many activities aimed at improving the knowledge and skills of general practitioners. The RACGP maintains a strong interest in the health and wellbeing of the doctors and members of their teams who care for the Australian community.

The RACGP advocates on issues of national significance, including refugee health and Aboriginal and Torres Strait Islander health.

The RACGP provides representatives for national, state and some local health care committees. These committees work in different areas of health, including the development of new health legislation, developing community based health programs and writing guidelines for general practitioners.

Maternity Services Review questions

What models for maternal services for rural and remote communities are working well?

General practice is the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities.

One GP provided the following description of the relational role GPs have with families: *'GPs offer unprecedented continuity of care in that they know a woman before she is pregnant, can do virtually all of her antenatal and post natal care. The partner and extended family are often patients with the same clinic. Intimate knowledge of family relationships and a bond of trust has often been established well before pregnancy. This is a good position from which to attend the social and emotional issues accompanying pregnancy. The baby usually attends for their 6w check, vaccinations and all ongoing medical care.'*

Maternity care delivered by teams of GPs and midwives supported by specialist services, have been shown to be safe. And in making locally-based care more sustainable, Team-based models also ensure that mothers particularly rural mothers can access the critical support provided to them by their families and friends

Women should have access to maternity care consistent with their level of risk as close as possible to where they live

Collaboration between health professionals is the key to providing quality maternity care. The best outcomes are achieved by all health professionals involved in the delivery of care to mothers and their babies working in partnership with the expectant mother in a collaborative team environment.

Where a woman requires more expert care, the GP refers to a specialist and resumes care at the earliest time after the issue has been resolved.

In many smaller communities hospital midwives are well known to the GP and family, and the GP and midwives work collaboratively. Several GPs have provided descriptions of GP-midwife care models, with high degrees of satisfaction recorded by mothers, midwives and the GP. For descriptions of two such models (rural and suburban) please refer to Appendix A.

What are the key factors to applying such models more broadly?

- **Credentialing requirements of hospital maternity programs.**

There seems to be some confusion in some parts of the country regarding what GPs should be able to do without requiring further training. It is incumbent on hospitals to seek clarification from the RACGP regarding the ability of GPs to provide antenatal and postnatal care.

It is the RACGP's position that Fellows of the RACGP do not require further training to provide competent care to the majority of women. GPs are expected to be able to recognize when there is a need to refer a woman who requires a degree of care outside the GPs competency.

The RACGP recognizes that, where GPs provide obstetric services, further training is required, e.g. RANZCOG Diploma in Obstetrics or RANZCOG Advanced Diploma in Obstetrics

- **Accessible CPD for all members of maternity care team members**
GPs recognize the need to keep their skills updated. Several GPs have commented on the lack of availability or suitability of continuing education. Some GPs have also suggested that continuing education provided simultaneously to the whole obstetric team would strengthen the effectiveness of the team. This would aid communication in working together.

Currently this model is used in some areas by jurisdictions, but is limited in that a minimum number of participants must be able to attend. In some areas it is not possible for the minimum number of maternity team members to be available at the same time without jeopardizing patient care.

- **Resolution of indemnity issues**
At present midwives must be employed either by a hospital or the GP, as professional indemnity insurance is not available to privately contracted midwives in most jurisdictions.

A GP in Darwin informed the RACGP that the NT administration now indemnifies privately practicing midwives.

The RACGP recommends the Maternity Services Review further investigate this model and seek its replication.

What aspects of the Australian context are driving high intervention rates?

1. Closure of small maternity units

The RACGP believes one of the most influential drivers of higher intervention rates is the closure of smaller maternity units. 50% of all rural maternity units across Australia have been closed in the past 12 years, forcing thousands of rural and remote women to travel to distant centres to give birth. There is data demonstrating that smaller maternity units have excellent outcomes in terms of lower rates of interventions and maternal and perinatal mortality and morbidity. With data matching to compare the outcomes of low risk pregnancies in large maternity units and smaller maternity units, smaller units consistently provide better outcomes.

- 7 year study of 619,298 women who had live singleton term infants
- Rural women had lower rates of induction & higher rates of successful vaginal birth
- City women were significantly more likely to have epidurals & interventions of all types, even if low risk
- Vacuum extraction rates 10-31% rural, 30% city
- Rural women less likely to have episiotomies, partly due to less instrumentation
- Similar rates of LSCS before labour, rates during labour lower the more remote the area¹

Baker (2004)ⁱⁱ, in a study of adverse events found the following rates of adverse events:

- Large teaching hospitals: 10.3%
- Regional hospitals: 6%
- Rural hospitals: 5.2%

He concluded that: *...in teaching hospitals...patients may receive care from several different providers, which may increase risk related to miscommunication and coordination of care.* ‘

Recommendations

Previous submissions by the RACGP and other GP organizations have provided the following recommendationsⁱⁱⁱ:

1) Re-establishment of small maternity units

The RACGP favours the reestablishment of small maternity units, which will entail:

- Providing facilities and infrastructure that may have been redirected away from maternity services.
- Staff training to enable staff to safely resume maternity care

2) Training/ Re-training of Rural Proceduralists

It is vital that GPs are encouraged and enabled to participate in formal training programs to enable them to provide safe maternity care, and to be able to update through relevant and accessible continuing medical education.

- **Locum cover**

Part of this means ensuring GPs have access to locums to cover time away from the practice to upskill.

- **Business costs**

GPs own and operate businesses which must be kept running while the GP is away from the practice. GPs need appropriate remuneration for the time they are away from their practices upskilling for the sake of their communities.

3) Ministerial Role/Responsibility

If a jurisdiction proposes to close a small rural obstetric unit the Minister for Health should be responsible for enunciating the reasons, costs and benefits of closing down the small hospital maternity service. The likely impact increased risks and expenses to mothers and babies needs to be enunciated. Other impacts must be calculated, e.g. probable effects on incidence of postnatal depression, reduction in breast feeding rates, other "hidden morbidity". The affected community must also be consulted.

What, if any, are key support services, including peer support which warrant national coverage?

GPs report that there are some excellent programs of postnatal care, some properly evaluated, but it is all piecemeal without uniform availability in all areas. Some examples are Australian Breastfeeding Association, Maternal and Child Health hotline provided by Victorian DHS. Most useful interventions started or were available in the antenatal period.

GPs consider that although continuity of carer may enhance the mother's experience of birth, the crucial issues of supporting the new mother in the postnatal period really hinges on integrating her into the social and health care networks in the community

Some GPs describe models of post natal care such as the mothercraft workers, in which support for new mothers in the community is delivered by TAFE trained workers. This model offers realistic opportunities for employment for other mothers with young children and can be targeted to specific communities. This approach can physically support mothers on their return to home after giving birth but can also address the all too frequent problem of poverty and lack of employment opportunity for mothers of young children.

GPs are concerned about the lack of coordinated community based preconception education. GPs think that many complications of pregnancy and birth could be prevented with better preconception care, e.g. prevention and treatment of STIs, vaccination, genetic screening for at risk couples, prevention and management of diabetes.

What is required to ensure the quality and consistency of key support services?

Undergraduate and post graduate education

There is a pressing need to change the teaching of medical and midwifery students at both undergraduate and postgraduate levels about the postnatal period: the social and physical upheaval needs to be understood by the providers of care.

Paid maternity leave

Some GPs report that they support the provision of paid maternity leave to support women being able to stay home and look after their children.

How is current Commonwealth funding targeted?

At present there is general agreement of organizations present at the round table discussions that funding for maternity services is inadequate. At present most Commonwealth funding is channeled into Public hospitals and private obstetric services. This perhaps reflects the state of play in Australia with public antenatal care and most deliveries occurring in public hospitals. Only 15% of Commonwealth funding is provided to mothers through GP consultations.

To increase the rate of collaborative care, the Commonwealth needs to consider how to adequately fund the role of midwives working with GPs and the associated costs. At present GPs who employ midwives must cover all their costs and overheads (provision of room, equipment, insurance), yet for many GPs there is no reimbursement for services provided by midwives.

Recommendation

The RACGP recommends that the Commonwealth prioritise accessibility to the MBS item number for nurses and midwives providing antenatal care for and on behalf of general practitioners, to all general practices in Australia.

What are the key professional development needs of the maternity workforce?

1. Screening tests recommended

There is no nationally consistent and readily available list of what antenatal screening tests are required. This could be provided as an on line resource through RANZCOG and the RACGP.

Support for the Medical Software Industry Association (MSIA) to provide 'drop down' menus in medical software alerting GPs to the need to perform the appropriate screening tests.

2. Relevant accessible continuing education to all members of maternity care teams

In promoting mutual understanding and respect in a collaborative team based approach to maternity care, there needs to be provision of procedural training for teams.

In addition, staff in hospitals and other health care settings where emergency unplanned birth may occur need ongoing updates on managing obstetric emergencies.

3. Indigenous cultural safety education of mainstream maternity care teams (especially hospital staff)

NOTE Aboriginal Health Council of WA Cultural Safety Training as a resource here

- Two-way learning approach
- Orientation manuals
- Guidelines such as the CARPA guidelines
- Accreditation of training
- Cultural Safety built on long term respectful relationship

How will models of workforce support vary in rural and urban settings?

Urban settings have much more immediate access to specialist care when required.

Rural GP Obstetricians report that it is often difficult and time consuming for them to access specialist advice when it is needed. It must also be remembered that not all doctors working as GPs have obstetric training, e.g. international medical graduates working in areas of need. Additionally not all hospitals have trained midwives, e.g. rural hospitals without obstetrics may only have general trained nurses.

One GP reported having to make 17 phone calls in order to obtain advice from an obstetrician and arrange the transfer of a woman in premature labour.

GPs working in rural and remote settings need immediate access to specialist advice.

Recommendations

1. The RACGP recommends the setting up of a national 'hot line' to be able to contact an obstetrician in an emergency.
2. The RACGP recommends the setting up of a national body to coordinate the transfer of mothers facing obstetric emergencies to the most appropriate and closest facility.
3. In addition GPs in rural and remote settings need access to accurate on line tools and information.

4. In order for women to avoid long distances to travel to see obstetricians, the RACGP recommends the funding of telemedicine technology.

What are the potential areas for change to expand midwife-led care across antenatal, birthing and postnatal services?

The RACGP sees a role for team based approaches to maternity care in Australia. It is important to maximize use of the present system and make improvements to it.

In relation to indigenous maternity care there needs to be a Primary health care team approach with access to specialist expertise as required. The team based approach includes Aboriginal Health Workers, Midwives and GPs and specialists. Care needs to be accessible in country, and culturally sensitive.

Alaska introduced an interesting concept of care of indigenous families several years ago based on respect for the culture of family first. This model has the patient at the centre of care provided by the primary health care team consisting of a doctor, nurse and administration assistant. Where specialist or allied health care was required it was brought into the team. Principles of lean thinking applied: doctors performed what only doctors could do, and passed onto nurses everything else. Nurses did what only they could do, and passed administrative duties to the team administrative assistant.

Recommendation

The RACGP recommends the routine use of GP-midwife teams, as outlined in Appendix A.

What are the existing models for midwifery-led maternity models?

Midwifery led care in Australia is currently restricted to private midwives. In this model, parents must cover the full costs of the services provided, with the exception of some private health insurers that will provide rebates for postnatal services.

Some hospitals provide birthing centres with models of midwifery led care, but these have strict guidelines for access. Only women assessed to have a low risk pregnancy and labour are permitted to access such services.

Overseas midwifery led models such as the UK and New Zealand are often referred to as credible models to be used in Australia. The RACGP advises caution in the adoption of such models. A recent publication by Lynda Exton^{iv} examines the effects of the introduction of an autonomous midwifery profession. Her research has uncovered:

- a four-fold increase in referrals to outpatient medical clinics for pregnant women in some areas, in 10 years (during a static birth rate)
- a more than 100% increase in admission rate for pregnancy complications in just 5 years
- an accelerating LSCS rate with the rate of increase being inversely proportional to the number of GP obstetricians remaining in maternity
- a declining rate of women attempting home birth even though it has never been easier for women to arrange a home birth
- a rising rate of transfer to hospital for those who attempt to birth at home (from 9% when GPOs were widely involved to 45% now)

- a sudden increase in the average length of stay in level 2&3 special care units for term babies when the last large group of GPOs withdrew
- a falling then static breastfeeding rate since the maternity reforms began
- a static perinatal mortality rate over the last 10 years following on from steadily declining rates during the previous decades
- a rising maternal mortality rate

What are the workforce barriers to integrated models of care?

- **Insurance**

As stated previously the RACGP finds the present unavailability of insurance for privately employed midwives a deterrent. Some GPs want to access midwives on a sessional basis as they do for other doctors, but find this not possible in the current climate.

The RACGP recommends the Commonwealth examine the NT model of providing professional indemnity insurance to privately employed midwives.

- **Remuneration of midwife work**

At present an MBS item number for nurses/midwives/Aboriginal Health Workers is only available in rural areas. This is a deterrent to other GPs who must bear all costs of employing a midwife.

The RACGP recommends the item number be accessible to all general practices in Australia.

- **Deskilling of GPs**

GPs report that, where maternity services are closed down, they are finding it increasingly difficult to maintain the skills necessary to provide safe maternity care.

In addition some GPs have reported that, in some areas it seems they are being discouraged from providing maternity care.

The mechanism seems to be the unrealistic approach to credentialing and defining scope of practice of GPs providing maternity care in conjunction with hospitals. Some GPs have reported hospitals requiring them to undergo additional training in order to provide shared antenatal care. This requirement ignores the training GPs receive in the Fellowship process or other qualifications gained. Where hospitals have enforced unrealistic approaches to credentialing some GPs have decided to no longer provide maternity services to their communities.

A GP provided the following example:

'Our practice is having great difficulty getting agreement for shared care from NSW public hospitals – despite post grad obstetric qualifications and experience – general view is that GP's are gradually being phased out of any involvement in the care of these patients. It may not be policy, but it is practice.'

The older attitudes of cooperation and teamwork seem to be dying out. Our practices' participation as VMO's in the clinic Roster for antenatal shared care is at risk – the general view amongst Hospital staff is that obstetrics is no longer the realm of general practice. We are probably going to pull out as the shortage of gp's is

so acute we are better paid and more useful in terms of efficiency, in our own practice. There is very little insight into the need for an understanding of the patient's general health in maternity services, and also very little recognition of the quality inherent in the longer term relationship between GP's and patients as having any benefits or safety. In particular I find that mental illness and personal or family matters are not dealt well in maternity services, although specific matters relating to the skill set in hospital such as management of classic obstetric situations are managed well.'

What key infrastructure is required?

As stated earlier in this paper the following infrastructure is required:

- **Obstetric emergency 'hot line'**

The RACGP recommends the setting up of a national 'hot line' to be able to contact an obstetrician in an emergency, and to arrange transfer to appropriate facilities.

- **Online tools and information**

The RACGP recommends availability of screening tests, assessment for high risk as freely accessible tools

- **Telemedicine technology**

In order for women to avoid long distances to travel to see obstetricians, the RACGP recommends the funding of telemedicine technology.

- **National Neonatal Emergency Transport Systems**

Neonatal services provide care for sick babies in the period immediately following their birth, including premature and low birth weight babies and babies born with congenital or other conditions which compromise their health or survival.

- **Nationalisation of tertiary obstetric hospitals**

The RACGP believes that tertiary obstetric hospitals are a national resource. At present the number of neonatal intensive care unit (NICU) cots is determined by factors other than the national interest, which means that occasionally mothers need to be flown from one end of the country to the other. This adds an extra layer of stress to the mother and family.

The RACGP recommends the Commonwealth examine the possibility of closing gaps in the current system by nationalizing tertiary obstetric hospitals, and coordinating the transfer of mothers with an anticipated need for a NICU cot.

- **Access to sufficient support services**

At present the RACGP hears that there are waiting lists for access to sleep units, mother baby units, psychiatric services for pre and post natal depression and other mental illnesses, lactation clinics.

In addition mothers required to travel to other areas to access maternity services often need to stay overnight. This expense is a deterrent to women accessing the care they need.

The RACGP recommends the Commonwealth ensure that there is sufficient quarantined funding to provide adequate community based resources for mothers experiencing difficulties in pregnancy or post natally.

Other issues

Lack of communication between maternity care providers

The RACGP is concerned that in setting up additional models of care maternity care could be further fragmented. Fragmentation of maternity care can lead to break downs in communication, with potentially devastating effects.

The RACGP routinely provides advice and input to Coroners around Australia. In some cases patients have died due to the break down in communication between the several people involved in the care of one patient.

In relation to maternity care one GP provided the following anecdote:

'There was disquiet that when we are involved in home births it is often to only write referrals for pathology, scans and prescriptions for items like Syntocinon. The midwives doing home births did not formally communicate with us and we felt uncomfortable in being vulnerable to vicarious liability in case of mishap as the communication from the midwife was so poor but we wanted to be supportive to our patients. We were unhappy that the midwives would send us patients from other practices simply for the paperwork to be done. There was a feeling that there was quite an 'anti-doctor', 'anti-conventional medicine' attitude that extended to things like immunisations for the babies in this sector.'

Reporting mechanisms

In considering changes to the present system the RACGP recommends data collection in the following areas:

1. Clinical incident data
2. Maternal morbidity & mortality data (national standardised data)
3. Sentinel event reporting
4. Measuring gaps between evidence & practice
5. Measuring access
6. Workforce utilisation and monitoring
7. Data to assess effective models of care

Appendix 1 Models of GP-midwife care Werribee

I've been practicing obstetrics in Werribee for 20 years. The last 10 years has involved team midwifery. I employ 7 midwives from the hospital to work in the rooms. There are three half days a week in the rooms. The midwives then try to roster themselves so that each shift at the hospital is covered. As Werribee Mercy is a public hospital, I am covered by the hospital insurers, therefore I don't have the exorbitant insurance bills.

The advantages of the system are;

1. continuity of care for the women, involving midwives and doctor
2. satisfaction of care for the women (we demonstrated this with a survey a few years ago)
3. satisfaction for the midwives
4. Time saving for me with antenatal care
5. I still have specialist back up if necessary.

The disadvantages are;

1. Cost of employing midwives, viz wages, room rent
2. It may not be possible to do it with private patients as the insurance costs become prohibitive

Northlake's Models of Care for Antenatal patients attending the Redcliffe and Caboolture Hospitals.

Northlakes is one of the Queensland Health's Place Based Initiatives. Northlakes is a "Green Field" Site in a rapidly growing area north of Brisbane. Models of Care have been developed to consider the "whole" patient with a particular emphasis on Healthy Lifestyles.

Pregnant women can choose their model of antenatal care. Options are GP shared care, Midwives Clinic, Team Midwifery (Midwives and Child Health Nurses), Young Parents Group, Hospital Doctors and GP/Midwifery Led Share Care.

The patient is assessed and if any risk factors are identified then this also influences the model of care. If there is an Obstetric Risk the women are seen by the Obstetrician at the hospital, if there is an issue of previous parenting difficulties the Child Health Nurse may be the prime carer, if there are social risks then the social worker may be the prime carer.

GP/Midwifery Led Share Care.

At present our practice is the Pilot Site for this type of antenatal care. The midwife from Redcliffe Hospital visits weekly. On confirmation of the pregnancy the GP discusses the models of care. Women with no obstetric risk factors are offered an appointment with the midwife at the practice. The patients like this concept as it is often easier for them to attend the GP surgery rather than the hospital. It is a familiar place and re enforces that health for the patient, baby and family is an ongoing process and having a regular GP is important. The woman sees the same midwife for each visit and gains rapport with her. The Local Child Health Clinic nurse visits the practice too to discuss feeding and parenting issues. The GP checks the patient at 28 and 34 weeks of pregnancy. Although ideally the midwife would like to be present at the birth this is not always possible. The midwifery service from Redcliffe Hospital visits the patient after discharge from the maternity ward. The Mother is strongly encouraged to return to the GP for ongoing checks especially the 5 to 7 day check. Hopefully this will help to improve breast feeding rates as support can be given at this time.

Instead of having a patient held share care record the patients have an electronic record which is accessible in the practice and at the hospital, the HRX. The midwife has access to Medical Director and records the visit in the antenatal records. This is attached to the HRX and is able to be viewed at the Hospital on admission of the patient. Information about the birth can be added to the electronic record and viewed by the GP. This model of care connects the patient and future family with the General Practice. The shared electronic record connects the Care Team midwife, GP, Obstetrician, Child Health Nurse and allied health.

Business model

The General Practice lets the midwife use the room on a Wednesday afternoon. This does decrease the income from this room as a GP doesn't work that afternoon in that room. The advantage to the GP is the close connection with the midwife which aids continuity of care and communication. I suppose it is early days and the practice owners are being generous from a business perspective in not charging for the room. In future if it does save Qld Health Money maybe there could be a fee for the room. Indemnity is the same as the more traditional share care model with the hospital sharing the responsibility. The midwife is a QH employee.

ⁱ Roberts, Algert, Peat, Henderson-Smart 2001 Differences and trends in obstetric interventions at term among urban and rural women in New South Wales: 1990–1997 ANZJOG Volume 41 Issue 1, Pages 15 - 22

ⁱⁱ Baker et al. The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada JAMC 25 May 2004; 170 (11)

ⁱⁱⁱ Joint ACRRM / RDAQ submission to the Review of Maternity Services in Queensland November 2004 available at:
<http://www.rdaq.com.au/downloads/MSR%20Final%20Submission%20text.pdf>. Last accessed 31st October 2008

^{iv} Exton L. The Baby Business, what's happened to maternity care in New Zealand?