LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES
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Submission Cover Sheet

Inquiry into Maternity Services in the ACT

Submission Number: 21

Date Authorised for Publication: 05.02.2019

30 January 2019

The Committee Secretary
Standing Committee on Health, Ageing and Community Services,
Legislative Assembly for the ACT, GPO Box 1020, CANBERRA ACT 2601
Via e-mail: LACommitteeHACS@parliament.act.gov.au

Dear Committee Secretary,

Thank you for inviting submissions to this inquiry into the Maternity Services in the ACT.

I would like to address the first item on the terms of reference: Models of care for all maternity services offered at the Centenary Hospital for Women and Children (CHWC) and Calvary Public Hospital (CPH), including, but not limited to, the Birth Centre, the Canberra Midwifery Program, and the Home Birth Trial and whether there are any gaps in care.

A gap does indeed exist in service provision between what is offered at the Centenary Hospital for Women and Children and what women want for their maternity care. Only 25-30% of women are able to access continuity of care at CHWC. When examining the demand for these services, one need only review the wait list for the CatCH program to see that demand currently outweighs access. I note also that many of the submissions already made to this inquiry process are from consumers addressing this discrepancy.

Continuity of (Midwifery) Care:
Continuity of care provides women with access to a single primary midwife, or a small group of midwives, throughout pregnancy, birth and the postnatal period. Midwives work in a flexible and on-call arrangement, with support from back-up midwives, to be able to be responsive to the unique needs of women when they are in labor and during their pregnancy.

Continuity of care offers the benefits of individualised antenatal care, education and counselling, attendance of a known midwife through the pregnancy and birth continuum and increased access to postnatal support. Antenatal and postnatal care is often provided in the woman's local community or home and is at a time that is mutually agreeable for both the woman and midwife. Continuity of care supports the wellness paradigm of pregnancy and birth care and increasing access to the model was a major focus in the National Maternity Services Plan in response to consumer feedback and is the primary area of interest for consumers through the ongoing NSAMS consultation. When examining consultation processes in the ACT, the Women's Centre for Health Matters 2016

report, also identified access to continuity of care as a key theme of importance to women.

When examining the impact that continuity of midwifery care has on perinatal outcomes for low risk women, high quality evidence suggests that it contributes to: Increased rates of spontaneous vaginal birth, reduced caesarean section rates (especially evident for primiparous women), fewer episiotomies, admission to hospital in more advanced labour, shorter postnatal hospital stays, decreased likelihood of fetal loss before 24 weeks of gestation, and decreased likelihood of having a baby admitted to a nursery. There is no documented difference in adverse maternal or neonatal outcomes.

Outcomes that were demonstrated as having a benefit from continuity of midwifery care for all women (low risk and all risk cohorts) include: Fewer elective caesarean sections, less utilisation of epidural/regional anaesthesia amongst women across all risk categories, although one trial found no difference in this outcomes, fewer instrumental deliveries, fewer inductions of labour, and improved breastfeeding rates. There were no differences in adverse maternal or neonatal outcomes for these women.

Whilst there is good evidence for the clinical outcomes for women receiving continuity of care, there are other positive implications for women and health services. The total cost of care per woman was reduced for those receiving care through a continuity model. The flexible nature of the midwives work arrangement means that care is provided when it is actually needed, rather than trying to roster to expected demand (which is difficult to predict in the unpredictable area of birth).

Continuity midwives are able to offer care in local communities meaning women can avoid parking issues, long wait times in busy clinics whilst reducing burden on the hospital facilities. Women need not travel as far and midwives can be flexible to meet the needs of vulnerable women for whom transport may be a large barrier to accessing care.

Most importantly, there is a strong demand for access to these models, with women reporting increased satisfaction with their care, including the physical and emotional aspects and feeling more in control and included in their care. In a practical sense, women are able to develop a relationship with their care provider enhancing trust in information shared and advice provided, midwives are able to know what each woman's unique aspirations goals or needs for pregnancy and birth are, and women and their families are able to share the special moment that their baby is born with a familiar face.

What is available currently at CHWC?
CHWC currently has two distinct continuity of care models.

The CatCH program, provides care to women of mixed risk, ie with risk factors or complications in their health or in their pregnancy, or low risk women who are not wanting a “birth centre experience” or because they want to use pharmacological pain relief in labour (an epidural). The program only has 2 teams of 5 midwives, with the ability to care for approximately 400 women per year. As mentioned, the wait list is very long for this program.

The Canberra Midwifery Program (offering care at the Birth Centre) offers low and some moderate risk women continuity of care with the added benefit of being able to birth in a comfortable, home-like, less medicalised space. The CMP is bigger than CatCH with capacity for approximately 680 women per year. It appears to be appropriately subscribed at this number, with a focus also needing to remain on women being able to access a place of birth that meets their needs (a birth centre, rather than a traditional birth suite).

The evidence supporting expanding the Continuity of Midwifery Care models at CHWC:

Whilst evidence of the highest quality exists for the benefits of continuity of midwife care (both Australian based randomised control trials and a Cochrane review synthesising all of the evidence from a number of randomised controlled trial from Australia and countries with health care systems that are similar to ours), this evidence has not translated into practice and service development towards increasing woman’s access to continuity of midwifery care.

For this reason, I undertook a study as part of a Master of Midwifery, to look at the benefits of continuity of care specific to the Centenary Hospital for Women and Children. In order to ensure fair comparisons of outcomes between continuity and core care models, I categorised women according to whether they were at low risk, moderate risk or high risk of complications in their pregnancy and birth.

To ensure that the “tertiary” factor did not skew the results, a strong attempt was made to remove any women from the dataset that were transferred from another hospital due to risk factors for the women and baby requiring tertiary care.

I found that overall approximately 26.4% of woman were deemed low risk (according to the criteria set out in the study), and the remaining 73.6% had identified risk factors. It is important to note that some of these women with risk factors would still be eligible to birth in the birth centre as these risk factors were not likely to affect their birth but rather required some input from an obstetrician during their pregnancy.

What these figures highlight though is that there are far more women with risk factors at CHWC than not, and thus the current offering for women with risk

factors to access continuity of care is not appropriate. Women with complex medical and obstetric histories would surely benefit most from having a single care provider planning care in partnership with the woman, individualising her care according to her preferences, coordinating her care with obstetricians and the multidisciplinary team as needed and being available to attend to her during her labour and birth, because it means she would not have to share her story and history multiple times with many different care providers as is typical in the fragmented core care system that exists.

The study that was undertaken at CWHC is supportive and representative of the evidence of outcomes that already exists in the Australian randomised controlled trials and Cochrane review. The study demonstrated a statistically significant increase in vaginal birth rates amongst women that received continuity of care compared with women in core care models across all risk classifications (Low risk 75.2% vs 68.5%, p 0.001; moderate risk 66.9% vs 53.2%, p <0.001; high risk 54.7% vs 46.4%, p <0.001). In addition, the study showed lower rates of elective caesareans in the continuity groups (low risk 0.8% vs 2.3% p 0.004; moderate risk 5.6% vs 15.3%, p=<0.001; high risk 13.2% vs 19.2%, p 0.003).

There was a smaller proportion of women that underwent any type of caesarean section in the continuity groups if they were moderate risk (19.8% vs 30.5%, p <0.001) or high risk (33.8% vs 41.7%, p 0.006), with no difference detected in the low risk group. For low risk women in continuity, there were also lower rates of instrumental delivery compared with core care (14.1% vs 18.7%, p 0.017) but no difference was detected for the moderate and high-risk groups.
For moderate and high-risk women there were fewer inductions in the continuity group (moderate risk 24.1% vs 27.8%, p 0.002 and high risk 37.1% vs 45.6%, p <0.001).

For low and moderate risk women there was less epidural usage in continuity (low risk 20.8% vs 30.8%, p <0.001; moderate risk 24.3% vs 33.5%, p <0.001) and less episiotomy in the continuity groups (low risk 11.0% vs 14.6%, p 0.021; moderate risk 9.3% vs 13.1%, p 0.003).

There were no significant differences in neonatal outcomes. Severe perineal trauma demonstrated mixed findings across the risk groups, but there were no other increases in adverse maternal outcomes associated with continuity of care models.

Many more women at CHWC with risk factors in the pregnancy could benefit greatly from being able to access continuity of care. If this model was expanded and if funding was directed into this model, there would likely be cost savings for the organisation based on assumptions from other research that this is a cost effective model and because it has been demonstrated that there are fewer interventions (that cost money) for women that receive continuity of midwifery

care. It would help CHWC to achieve the highest quality of care as evidenced by the clinical outcomes that were found in the study, but most importantly, it would provide women increased access to a model that they are demanding through every consumer focussed consultation process. We are here to provide a service for women and their families first and foremost, so this should come above all else.

Please find below a list of references that helped to inform this submission.

Yours Sincerely,

[redacted]

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