Committee membership

Kerrie Tucker MLA, Chair

Karin MacDonald MLA, Deputy Chair

Jacqui Burke MLA

Secretary: Siobhán Leyne

Administration: Judy Moutia

Resolution of appointment

To examine matters related to hospitals, community, public and mental health, health promotion and disease prevention, disability services, drug and substance abuse and targeted health programs.

Terms of reference

To inquire into and report on maternity services in the ACT, with particular reference to:

- continuity of care available throughout pregnancy and during and following birth by all areas and professional services related to the delivery of maternity services;
- comparative costs and benefits of different models of maternity services and systems;
- strategies for involving consumers in the planning and provision of maternity services;
- impact of medical indemnity insurance on the provision of maternity services; and
- any other related matter.

Preface

With every story women told to the Committee, whether they birthed in hospital; at home; in a birthing centre; naturally; or by caesarean section; the key issue was control. When women feel in control of their ante- and postnatal care and birth, however it takes place, the outcomes for them, and their families, are vastly improved.

Sadly, the Committee heard anecdotally that midwives and members of the community on finding out about this inquiry responded by saying 'oh, just another report that won't go anywhere'. This report is based on research and evidence-based practice, but it is also based on the opinions, ideas and needs of women and their families – as expressed *by* women. It is time for the Government to take a brave stand, listen to what the community they serve is saying, and respond to it, without bureaucratic obstruction.

It is time to start redefining the language around normal birth, to create a culture in which midwives, doctors, specialists, hospitals and governments work collaboratively in a woman-centred model of community-based maternity services. Women have birthed naturally since time immemorial, and even with the massive leaps in technology, there is no substitute for the normal birthing process.

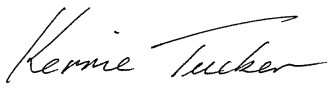
Humans are the only species to have a highly intervened birthing process, because as a society, we have medicalised the process, and consequently taken away the normalcy of this event. Each intervention in birth has the potential to lead to further interventions that can unnecessarily complicate the birthing process.

It is time to create a cultural expectation of normal birth, with medical intervention being necessary only as a method of last resort.

This cultural change will need support from many sources, and must be based on a model of care that is woman-centred and led (by the birthing mother). It will require reform of the medical indemnity system and damages awards, recognition of midwives as independent practitioners in their own right and the development of a social system that is truly supportive of women and their families.

Evidence clearly supports that this will not only deliver better health outcomes for mothers and babies but will also reduce costs to the health system.

The Committee holds a vision for fair and equitable maternity services for all women of the ACT. In this vision, women will direct their care and be given the choice to birth at home, in a birth centre or in a hospital, in partnership with practitioners of their choosing, including independent midwives, general practitioners and obstetricians.



Kerrie Tucker MLA

Table of contents

Table of figures

Summary of recommendations

RECOMMENDATION 1

3.26. The Committee recommends that the Government forward this report to the Federal Government with a call to address the inadequacy of bulk billing in the ACT.

RECOMMENDATION 2

3.44. The Committee recommends that the Government, in consultation with relevant stakeholders, develop a core curriculum for antenatal education and that this be offered free of charge to all women at key locations across the ACT.

3.45. Further, the Committee recommends that the Government require that all persons delivering childbirth education be appropriately accredited and registered as training providers.

RECOMMENDATION 3

3.88. The Committee recommends that the Government undertake a needs analysis to determine the actual level of unmet demand for the Canberra Midwifery Program as a matter of urgency.

3.89. Further the Committee recommends that the Government increase funding to the Canberra Midwifery Program to meet existing demand and following the outcome of the needs analysis appropriately resource the Program to meet demand.

RECOMMENDATION 4

3.100. The Committee recommends that the administration for the Canberra Midwifery Program, including the

development and implementation of all policies and procedures, be immediately placed under the control of midwives.

RECOMMENDATION 5

3.167. The Committee recommends that the Government require all public hospitals to apply Baby Friendly Hospital Initiative standards across all areas of the hospital so that when breastfeeding mothers are admitted they are adequately supported and staff are adequately trained to support them and their babies.

RECOMMENDATION 6

3.180. The Committee recommends that the Government, in partnership with consumers, improve the accessibility of maternal and child health clinics through a return to an appointment based system and ensure that clinic operations are responsive to the needs of parents.

3.181. The Committee further recommends that the Government ensure that the clinics are adequately resourced to meet need, particularly in areas of high growth, such as Gungahlin.

RECOMMENDATION 7

3.187. The Committee recommends that the Government urgently upgrade and expand the Neonatal Intensive Care Unit at The Canberra Hospital.

RECOMMENDATION 8

3.194. The Committee recommends that The Canberra Hospital ensure that the posters and signage displayed in mixed antenatal and gynaecology treatment areas are sensitive and reflective of the mix of patients attending these areas.

RECOMMENDATION 9

4.23. The Committee recommends that the Government undertake a cost benefit analysis of the models of maternity care services available in the ACT.

RECOMMENDATION 10

4.45. The Committee recommends that all public maternity services in the ACT, including those offered at Calvary Hospital, be streamlined into a single service with an appropriate governance structure reporting directly to the Chief Executive of ACT Health.

RECOMMENDATION 11

5.19. The Committee recommends that a Ministerial Advisory Council on Maternal Health be established comprising of consumer and community representatives to advise the Minister on the policy direction for maternity care services with a view to developing a comprehensive model of maternity care that is responsive to and meets the needs of consumers.

5.20. Further, the Committee recommends that the Office for Women within the Chief Minister's Department be resourced to provide secretariat support to this Council.

RECOMMENDATION 12

5.23. The Committee recommends that a working group on maternal and early childhood health care be established comprising of at least the following:

- ACT Division of General Practice;
- ACT Health;
- ANU Medical School;
- Australian College of Midwives Inc.;
- Consumers;
- Maternal and child health nurses;
- Maternity Coalition;
- Midwives (independent and publicly employed);

- Private and public obstetricians;
- Private and public paediatricians;
- University of Canberra nursing school; and
- Women's Centre for Health Matters

RECOMMENDATION 13

5.38. The Committee recommends that the Government fund the ongoing production of comprehensive information relating to pregnancy and birthing and postnatal care options available to women in the ACT to be available from all health care settings, public and private, in the ACT.

5.39. The Committee further recommends that the Government fund bilingual community educators to distribute this information in a relevant and appropriate manner.

RECOMMENDATION 14

6.9. The Committee recommends that the Government lobby the Federal Government to find alternative approaches to the medical indemnity and compensation schemes currently operating in Australia to benefit all health care practitioners, including midwives.

RECOMMENDATION 15

7.13. The Committee recommends that the Nurses Board be dissolved and a Midwives and Nurses Board established in its place until such time that the midwifery workforce is able to support its own board. Until that time, the Midwives and Nurses Board should include professional and consumer positions to represent the interests of midwives adequately.

RECOMMENDATION 16

7.19. The Committee recommends that the regulations under the Health Professionals Bill recognise midwifery as a separate profession not subsumed within nursing.

7.20. In the event that the Health Professionals Bill is not passed by the Assembly, the Committee recommends that the Government introduce a Midwives Bill recognising midwifery as a profession distinct from nursing.

RECOMMENDATION 17

7.25. The Committee recommends that the regulations under the Health Professionals Bill do not require health professionals to hold medical indemnity insurance, and instead the relevant health professional board be responsible for applying reasonable professional standards.

RECOMMENDATION 18

7.37. The Committee recommends that the Government encourage and support local tertiary education institutions to provide three-year undergraduate bachelor of midwifery programs.

RECOMMENDATION 19

8.15. The Committee recommends that the Government develop and implement a program for systemic changes in the provision of ACT maternity services as outlined in paragraphs 8.8 to 8.14 of this report.

RECOMMENDATION 20

8.24. The Committee recommends that two independent primary birthing units be established as outlined in paragraphs 8.16 to 8.23 of this report.

1. Introduction

1.1. The Committee decided to undertake an inquiry into maternity services following concerns about the availability of choices for women in current models of care; the high rate of birth interventions; the insurance crisis precluding independent midwives from the workforce; and concerns raised by women about their ability to control the care received.

1.2. These issues and many more highlighted changes needed to create a safe, equitable and accessible maternity care system were raised during this inquiry.

1.3. The Committee thanks all of those people who contributed to this inquiry, either formally or informally. The Committee was aware that many women with young children found it difficult to find the time to contribute formally to this inquiry and is grateful to those who did, particularly those women who had difficult birthing and postnatal experiences.

1.4. The Committee also received several submissions praising the Canberra Midwifery Program. To receive submissions with the single intent of praise is unusual, and the Committee was pleased to receive these.

1.5. In some instances, the Committee has adopted the recommendations of submitters as its own, and acknowledges these submitters with thanks.

Conduct of inquiry

1.6. Following the Committee's resolution on 7 August 2003 to undertake an inquiry into maternity services in the ACT, advertisements detailing the inquiry's terms of reference were placed in *The Canberra Times* and *The Chronicle*. In addition, letters advising of the inquiry and inviting input were sent to organisations and individuals known to have an interest in the matter.

1.7. In response, the Committee received 24 submissions, three exhibits, and heard from six witnesses at a public hearing. A list of submissions and exhibits is at Appendix 1 and a list of witnesses who gave evidence at public hearings is at Appendix 2.

1.8. On 26 and 27 October 2003, the Committee attended the *6th International Conference on the Regulation of Nursing and Midwifery: Innovations in Regulation*, which was held in Melbourne, Victoria.

1.9. The Committee also held three consumer forums in November and December 2003 in conjunction with the Women's Centre for Health Matters and the Health Care Consumer's Association. The forums were attended by a total of 42 individuals.

1.10. In an effort to ensure that the Committee was as accessible as possible, two forums were held in Pearce, at the Women's Centre for Health Matters, and the third forum was held at the Assembly. The Committee was careful to ensure that the forums were held at times to suit parents with young babies and children and babies were welcomed at all forums.

1.11. In February 2004 the Committee travelled to New Zealand to assess the maternity care program in place there. A short report on this trip is at Appendix 3, other issues are addressed throughout this report.

1.12. The Committee visited the following organisations in the ACT:

- The Canberra Hospital
- Calvary Hospital
- QEII Family Centre

Government response

1.13. This report makes recommendations that, if agreed to, would make fundamental infrastructure changes to the operations of areas of the public hospital system, ACT Health, and the delivery of community midwifery.

1.14. In light of this, and in light of the Government submission to this inquiry, the Committee does not believe that it would be appropriate for ACT Health to be solely responsible for developing the Government response to this report.

1.15. In particular, the Committee suggests that the Minister develop his response in consultation with the Minister for Women and the Ministerial Advisory Council on Women.

1.16. The changes recommended in this report may take some time to implement, but this Government has an opportunity to take the first steps towards meaningful and significant changes in maternity care to benefit women and their babies.

1.17. While there may be opposition to the recommendations in this report, from some stakeholders, the Committee is confident from the evidence received, that the most important group, birthing women, will benefit and support the recommendations of this report.

2. Overview

Background

2.1. Census figures report that in 2001, 3938 babies were born to residents in the ACT, of these 67 were born to Indigenous mothers. Government figures report that in 2000, 4774 babies were born to 4684 women, 4131 of which were ACT residents.[1]

2.2. The 'total fertility rate (TFR), which represents the average number of babies a woman could expect to bear during her lifetime based on current age-specific fertility rates'[2] was 1.51 children per woman. Replacement level[3] is currently 2.1. The ACT has the lowest total fertility rate of the states and territories.[4]

2.3. The median age of mothers in the ACT has steadily increased since 1991 from 28.9 to 30.4. The median age for fathers has also increased from 31.2 to 32.4. The fertility rate (number of births per 1000 women) is highest in the 30-34 age group at 100.4 in 2001. The ACT also has the lowest fertility rate in Australia for teenage mothers (aged 15-19) with 9.8 births per 1000 women in 2001, which has decreased from 14.2 in 1991.[5]

---

[1]Submission 24, ACT Government, p. 6

[2] Dugdale, P and L. Kelsall, *ACT Chief Health Officer's Report 2000-2002*, © September 2003, p. 131

[3] Replacement level indicates the number of babies each woman will need to have in order to replace the current population.

[4] ABS 3311.8., p. 22

[5] ibid., p. 24-27

Figure 1: Age of women giving birth in hospital in the ACT[6]

	The Canberra Hospital		Calvary Public Hospital		Calvary Private hospital		John James Memorial Hospital	
Age groups	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Less than 20 years	120	5.2	54	4.4	0	0.0	<5	-
20 –24 years	364	15.8	220	18.1	13	4.8	19	2.5
25-29 years	701	30.4	434	35.7	97	35.9	182	24.2
30-34 years	689	29.8	335	27.6	104	38.5	326	43.3
35-39 years	361	15.6	144	11.9	50	18.5	199	26.4
40 years or more	74	3.2	28	2.3	6	2.2	26	3.5
Total	**2309**	**100.0**	**1215**	**100.0**	**270**	**100.0**	**753**	**100.0**

Note: Due to the rounding of figures some totals may not equal 100.0.
Source: ACT Maternal Perinatal Collection,1999 data

Indigenous mothers

2.4. Indigenous women tend to give birth at a younger age, as the table below indicates, 71.2% of all Indigenous women giving birth were less than 30 years of age.

[6] ACT Health, Population Health Research Centre, *Maternal and Perinatal Health in the ACT 1999*, Health Series, Number 32, p. 12

Figure 2: Age of indigenous women giving birth in the ACT[7]

	Indigenous		Non-Indigenous	
Age groups	**No.**	**%**	**No.**	**%**
Less than 20 years	15	25.4	161	3.6
20 –24 years	18	30.5	601	13.3
25-29 years	9	15.3	1414	31.3
30-34 years	11	18.6	1451	32.1
35 years or more	6	10.2	895	19.8
Total	**59**	**100.00**	**4522**	**100.00**

Place of birth

2.5. Although the ACT has a high rate of private health insurance coverage, the majority of women gave birth in a public facility.

> In 2000, 73.6 per cent of ACT residents giving birth in the ACT gave birth in an ACT public hospital and a quarter (25.6%) chose to give birth in an ACT private hospital. Less than one per cent (0.7%) gave birth either at home (0.5%) or gave birth before arrival at a hospital (0.2%). Seven percent (6.7%) of ACT residents giving birth in an ACT public hospital gave birth at the Birth Centre at The Canberra Hospital.[8]

2.6. The following table indicates the changes in place of birth in the ACT.

Figure 3: 'Place of birth' for births to ACT residents in the ACT, 1996-2000[9]

[7] ibid., p., 13
[8] Dugdale, op. cit., p. 135
[9] ibid., p. 135

	1996		1997		1998		1999		2000	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Public hospitals	3052	72.8	2981	72.7	2982	73.6	3134	77.5	3020	73.6
Private hospitals	1113	26.6	1073	26.2	1023	25.3	876	21.7	1051	25.6
Home birth	24	0.6	44	1.1	39	1.0	22	0.5	22	0.5
Born before arrival at hospital	<5	0.0	<5	0.1	<5	0.1	14	0.3	10	0.2
Total*	**4190**	**100.0**	**4101**	**100.0**	**4050**	**100.0**	**4046**	**100.0**	**4103**	**100.0**

Data Source: ACT Maternal Perinatal Data Collection, 1996-2000
*Data includes total women that gave birth to ACT residents in the ACT 1996-2000. Record where type of birth facility was "not stated" have been included in the total.

2.7. Non-ACT residents giving 'birth within the ACT in 2000 accounted for 12.6 percent of all women who gave birth in the ACT', which may account for the discrepancy between Government and census figures above.[10] As the ACT services the region and The Canberra Hospital is a major referral hospital, this is not unexpected, however it would be interesting to assess what percentage of women who should otherwise, because of residence location, birth in Queanbeyan Hospital choose to travel to The Canberra Hospital and for what reasons.

Maternal mortality

2.8. Maternal mortality has decreased over the past forty years in Australia, with mortality reducing from 41.2 deaths per 100 000

[10] ibid., p. 132

live births in 1964-1966[11] to 13.0 deaths per 100 000 live births in 1994-1996[12].

2.9. Outcomes are significantly worse for Indigenous women, who have poorer access to healthcare and lower health outcomes in general. Figure 4, below, illustrates the maternal mortality rate for Indigenous women Australia-wide.

Figure 4: Maternal mortality rate for Indigenous and non-Indigenous women in Australia 1994-1996[13]

Indigenous status	Confinements	Maternal deaths	Mortality ratios per 100 000 confinements*
Indigenous	22 996	8	34.8
Non-Indigenous	744 452	75	10.1
Not stated		17	
Total	**767 448**	**100**	**13.0**

Source: State and Territory Maternal Mortality Committees

*For this triennium, calculations of maternal mortality ratios for Indigenous and non-Indigenous women excluded from the denominator maternal deaths where Indigenous status was missing.

Future projections

2.10. The population of the ACT is projected to increase from 315 200 in 2000 to 344 500 by 2010. This increase is largely expected in the northern suburbs. [14]

[11] 4.4 of these deaths were considered incidental – where the mother died within 42 days after giving birth, but from causes unrelated to pregnancy such as motor vehicle accident.

[12] National Health and Medical Research Council, *Report on Maternal Deaths in Australia 1994-1996*. March 2001. p. 21

[13] ibid., p. 33

[14] Submission 24, ACT Government, p. 8

2.11. Although the population is projected to increase, total births are projected to decrease to 3700 by 2020[15].

What are maternity services and what choices do ACT women have?

2.12. Definitions of maternity services vary. The Committee considers that maternity services are any services offered to women and their families throughout their pregnancy and up to six weeks following birth. This includes pre-conception, antenatal and some postnatal care and support.

2.13. A range of service providers offer maternity services in the ACT. General Practitioners (GPs) are able to provide central care for a woman and her family from pre-conception through to post birth and beyond. GPs are in a unique position to support women through pregnancy because of their role in treating the individual, and her family holistically. GPs generally do not now attend births and women with GP-led care generally birth in the public hospital system with staff midwives and obstetricians.

2.14. Midwives are specialists in normal birth who offer care and support to healthy women with normal pregnancies from conception through birthing to some weeks after birth to establishing a care and feeding regime. Independent midwives offer some antenatal and most postnatal care to the woman in her home as a norm. In the ACT, women are generally only able to access midwife-led care through the Canberra Midwifery Program, although there is very limited availability to home birth with independent midwives. Midwives also work in hospitals, the Committee considers this to be part of hospital services as distinct from independent midwifery.

2.15. Obstetricians are specialists who can offer private or public care. Obstetricians are essential for the treatment of women with high-risk or complicated pregnancies and treat women throughout

[15] ibid., p. 9

pregnancy to birth with generally one post-birth visit beyond hospital visits, and generally not in a woman's home.

2.16. In the ACT, women can choose to see a private obstetrician, or be treated through the antenatal clinic at their relevant public hospital, where a staff obstetrician will attend them. In the public system in Australia, patients cannot chose their treating doctor, therefore continuity of care provider throughout a pregnancy is not guaranteed.

2.17. Women are able to choose their care provider, however maternity services in the ACT are dominated by GP and obstetric-led care. Because of the medical indemnity insurance situation, independent midwives are not able to gain insurance coverage, so those who do work as independent midwives do so without indemnity insurance.

2.18. Charges for midwifery services are not claimable on Medicare or through most private health insurance schemes (although the Committee did hear reports at consumer forums of women working with insurance companies to claim birth services as 'surgical accessories' or other such creative descriptors). Therefore only women with sufficient finances can access midwife-led primary care.

2.19. Women in the ACT are able to birth in public or private hospitals, or the Birth Centre within The Canberra Hospital, if part of the Canberra Midwifery Program (CMP). There is currently no provision for publicly supported home birth – those women wishing to have a home birth must either pay for an independent midwife, or do so unassisted.

2.20. The Committee supports the right of women to birth safely in a manner that reflects their personal values. The Committee is concerned that choices for women in the ACT are limited, firstly because it is often difficult to access the CMP, and secondly because access to home birth is extremely limited for the reasons explained above.

2.21. The choices for birthing are discussed in Chapter 3, *Providing Care*.

The culture of birth

2.22. Medical advances have greatly improved the health outcomes for at-risk women and babies, however the more general medicalisation of the culture has come at a cost to women's knowledge about childbirth. As a result, women are often now largely reliant on the medical system to 'deliver' their babies, having relinquished control over an event that their bodies are uniquely equipped to perform.

2.23. Control was the primary issue of concern for the women the Committee spoke to throughout this inquiry. Women want to be in control and command of their birthing experiences.

2.24. For this to be the experience of women, there are significant cultural barriers to overcome. Current obstetrical practice is based in technology-based practice which often fails to take a holistic approach. A study of eighteen editions of *Williams Obstetrics*[16] spanning from 1903 to 1989 found that:

> From the first edition (1903) to the ninth (1945), a view of childbearing as quasi-pathological was thought to justify pervasive obstetrical control of birth events; control was widely extended, while childbearing women and others were increasingly excluded from participation. Beginning with the tenth edition (1950), this vision of pathology and medical control has contended with another in which the centrality of social and psychological considerations in obstetrics is increasingly acknowledged. While the breadth of obstetrics is further extended, some control is restored to childbearing women. Yet, the repetition of social and psychological

[16] *Williams Obstetrics* is a leading text of obstetrics used widely in the United States and Canada, the cultural basis can be reasonably assumed to be similar to that in Australia over the same period of time.

> ideas during the past thirty-five years has still not yielded an integration of social and psychological aspects of childbearing into biologically oriented obstetrical theory and practise.[17]

2.25. The institutionalisation of birth within the medical system treats women and their babies as secondary objects, upon which treatments are performed.

> Maternity 'care' delivered within this model is fragmented, episodic, and occurs in the wards and departments of heath bureaucracies and hospitals. This 'care' is centrally located within the medical paradigm and usually involves the application of complex technologies that objectify and dehumanise women and their infants.[18]

2.26. Concurrent with the shift to obstetric practice has been the erosion of the status of midwifery practice, and politicising of birth. While some academics will claim that childbirth has always been political, the Committee does not believe that this is necessarily the case. The political discourse lies within the disparity and shifts of power between men and women, and the historical context of medicine being a man's domain in a period when women were politically and socially subjugated.

2.27. Obstetric practice also offers a notion that is appealing to modern society – a 'pain free' experience. The risks associated with interventions offering a 'pain free' birth are numerous, but the Committee believes that these are downplayed against the fear that has been instilled in women about experiencing a normal birth.

---

[17] Hahn, R. 1995. *Sickness and healing: an anthropological perspective*. © Yale University., p. 211

[18] Donnellan-Fernandez, R. and M. Eastaugh. 'Midwifery Regulation in Australia: A Century of Invisibility'. August 2003. Paper presented at the *6th International Conference on the Regulation of Nursing and Midwifery*, Melbourne, October 2003

2.28. The Committee is concerned that the 'choice' for a pain-free birth is based in uninformed fear. When women make a decision out of fear, or without balanced facts, they are not making an informed choice.

2.29. Traditionally midwifery was always a 'woman's domain' and still largely remains so. This fact is not lost in the politics of medical dominance of childbirth, and women as mothers and professionals are doubly disempowered – even in the face of medical and sociological evidence supporting a return to midwife-led care in childbirth.

2.30. The language around birthing practices has also largely changed. We no longer talk of 'normal birth' or 'caesarean section' or 'birth with interventions', we talk of 'vaginal birth' or 'assisted birth'. The language offered to women to express their experiences is highly medical, which conflicts with an experience that may have been an emotional and spiritual as well as physical transformation. By discouraging holistic care, reducing birth to a physical, medical event, the Committee believes that women are being disempowered.

2.31. It is time to return to the language of normal birth being just that – a normal life event where a woman births her baby supported by professionals, family and friends and not an event where her baby is delivered for her. Giving birth transforms the lives of women, it is the start of a lifelong journey of motherhood and they need to be supported holistically through all parts of this journey. A midwife told the Committee 'we don't help women have their babies, we help them to become mothers'[19].

2.32. Home birth rates are a good indicator of the political climate surrounding childbirth in a region. Women birthing at home with the support of midwives and trained birth attendants are able, by the very nature of the environment to take more control over their

[19] Midwife in conversation with the Committee, 17 February 2004, Christchurch, New Zealand.

birth experience. The Committee accepts the evidence that home birth is a perfectly safe way for women to birth.

2.33. Today the cultural expectation is that women should birth in hospitals. Australia is not unique in this regard, for example, in the United States fewer than five percent of births took place in a hospital at the beginning of the century, this had increased to more than half by 1939 and by the 1980s, 95 percent of births took place in a hospital.[20]

2.34. However, in contrast, the Netherlands has a high home-birth rate, and although it fell during the 1980s, forty percent of women in rural areas and twenty percent of women in urban areas still birth at home. It is considered that this is because of

> the social and financial structure of Dutch maternity care, the special position and high level of training of Dutch midwives that qualify them to practise independently, the availability of maternity home care assistants, the balance of power between physicians and midwives, and the enshrined ideology that pregnancy and childbirth are fundamentally normal events that do not require medical interventions unless there is a clear need for them.[21]

2.35. The United Kingdom also has strong political commitment to maintaining midwifery practice, and midwife-led care is the norm across the UK. While only 2.2 percent of births were at home in England in 1999[22], women still have access to a more integrated and comprehensive model of care, as discussed throughout this report, and are supported in the public health system to birth at home. A home birth rate of 2.2 percent is still a significant increase over that in the ACT of 0.5 percent.

---

[20] Hahn. 1995. op. cit., p. 209

[21] Wiegers, T., J van der Zee, and M. Keirse. 'Maternity care in The Netherlands: The Changing home birth rate'. *Birth* 25:3, September 1998, pp. 190-197., p. 190

[22] *Fertility: Deliveries and Birth, England.* Accessed at http://www.doh.gov.uk/HPSSS/TCH_A14.HTM on 10 December 2003.

2.36. In recent years there has also been a political shift in New Zealand supporting an integrated system, which recognises the value of midwife-led care, that does not derogate from the support of the medical system, but ensures that all women have access to appropriate antenatal care. Now, over 73% of women in New Zealand have midwife-led care, and the national homebirth rate is between 6-10%.[23]

2.37. In addition, the Committee was told that 15% of women birth in primary birthing units. These units are established as independent units where women can birth in a non-medicalised environment. In terms of technology available they are the same as home-birth as there is no capacity to perform epidurals or surgical interventions.

2.38. An added difficulty in changing childbirth in Australia is the disparity in health funding and health service provision, so that even if a Territory or State has the political will to change the maternity care system, it must fund the changes, rather than the funding coming from the Federal Government.

2.39. However, the Committee believes that the Territory has the ability to achieve a change through the redistribution of existing resources and a political commitment to systemic change. Lobbying must continue at a Territory and Federal level to change the political commitment to maternity services, and therefore change the culture of birth in Australia.

2.40. The Committee supports those women, midwives, general practitioners and obstetricians who are lobbying for change in maternity care to return to a system that is women-centred and focussed.

[23] Homebirth Association of New Zealand, in conversation with the Committee, 26 February 2004.

3. Providing care

3.1. Care in maternity services refers to services provided to women and their families throughout the pregnancy, birth and post-natal period. It is also relevant to include pre-conception care as many women seek advice prior to falling pregnant, or are involved in assisted reproductive technology procedures such as assisted insemination or in-vitro fertilisation (IVF).

3.2. The Committee was particularly interested in this inquiry to assess the continuity of care available to women in the ACT. In researching this, the Committee discovered that there is some contention as to what constitutes continuity of care.

3.3. Some of the ways in which continuity of care translates into models of service are described below.

3.4. Firstly, it is a model of service where a woman will develop a relationship with one individual whose philosophy and practices she trusts[24] and who offers continuity of care through all stages of pregnancy, birth and postpartum. This may be better referred to as 'continuity of carer'.

3.5. This model is most often seen in caseload midwifery where an individual midwife has responsibility for a number of women (approximately 40) over the period of a year and is on call for only those women – either in private or public practice. It offers some form of postnatal care on a regular basis for up to four to six weeks, which supports women to establish a breastfeeding and care routine.

3.6. This model of care is available in the ACT through the Canberra Midwifery program, Northside and Central teams, although women are unable to choose their midwife. It is also available from independent midwives, although few are currently able to practise in the ACT due to lack of insurance cover.

---

[24] Submission 24, ACT Government, p. 14

3.7. A more limited continuity-of-carer model can also refer to the model of care offered by general practitioners (GPs) in a 'shared-care' model with an obstetrician or tertiary hospital facility. In this model, the woman attends her GP for all primary health care but her delivery options are limited to the obstetrician or tertiary hospital facility. As the GP will often treat an entire family, they are in a 'privileged position to have a good understanding of the specific social and family situations'[25].

3.8. The shared-care model is common in the ACT with both hospitals utilising it, and Calvary Hospital requiring this model of care for public patients.

3.9. Continuity-of-care can also sometimes refer to a model of service where a woman develops a relationship with a team of carers whose philosophy and practises she trust and who offers continuity of care through all stages of pregnancy, birth and postpartum.[26]

3.10. There is concern that this model of care can lead to some discontinuity of care if practices regarding the sharing of client information are not in place.

3.11. This model is available in the ACT through the Canberra Midwifery Program, Southside team.

3.12. Lastly, continuity-of-care can be a model of service where a woman attends a major obstetric unit which has consistent policies, practices and clinical paths; the aim being to ensure that each time a new medical officer sees a patient, the officer knows what events have previously occurred.[27] The consistency in polices

---

[25] Submission 6, ACT Division of General Practice, p. 3

[26] Brown, Flint, and Lasett in Keleher, H., R. Round and G. Wilson 'Report of the mid-term review of Victoria's Maternity Service Program' in *Australian Health Review* Vol 25, No. 4

[27] Child in *Rocking the cradle: a report into childbirth procedures* Senate Community Affairs Reference Committee, December 1999., p. 17

ensures that a woman receives consistent information although it relies on individuals adhering to policies.

3.13.This model generally does not offer any continual post-birth care and does not allow a woman to develop individual relationships with her carers.

3.14. The Committee considers it important that women have access to continuity of care that leads throughout the antenatal to the post-natal period and offers assistance with establishing a breastfeeding and care routine.

3.15. This is particularly important in the ACT where a large percentage of women are isolated from extended families and other networks of friends who may otherwise fulfil this support role.

3.16. The Committee is concerned that many women in the ACT do not have access to appropriate continuity of care, and that it is limited to a small number of women who are able to gain a place on the CMP, or to women who can afford to pay for care. This is particularly difficult for women in the postnatal period as there are limited services to assist women in establishing a normal breastfeeding and care routine.

3.17. It is expensive and difficult to engage an independent midwife in the ACT, primarily as a result of inadequate medical indemnity insurance and the fact that midwives cannot charge their services to Medicare or to most private health insurance companies.

3.18. Women who access the Canberra Midwifery Program (CMP) do have access to midwife-led care, however this program takes a very small proportion of women each year. The CMP is discussed further below.

3.19. This leads most women to shared care between a GP and obstetrician or GP and some form of hospital-based care, followed by postnatal care in the Child Health Clinics. There are difficulties

with the shared-care model as acknowledged by the ACT Division of General Practice (ACTDGP) such as the lack of uniformity in protocols and delivery of care and the need for improved communication.[28]

3.20. Cost is also a major prohibitive factor in the provision of shared care. With the decline of bulk-billing GPs and increasing gap payments, the Committee heard that some women are forgoing comprehensive antenatal and postnatal care altogether.

3.21. The Committee visited Calvary Hospital, which has shared care arrangements in place for antenatal care but has found that women simply are not attending their GP, citing cost as a prohibitive factor. The Hospital also requires the post-natal care to be provided through the GP but has received complaints from both women and GPs believing that the postnatal care should be offered in the same location as the episode of care (birth).

3.22. The Canberra Hospital does have the ability to provide a post-natal check up through its clinics.

3.23. It is clear that, amongst the other reforms discussed throughout this report, common protocols need to be developed to be applied across the ACT in public and private care on the provision of services. Issues to do with continuity of care are discussed throughout the report.

3.24. The Committee was told very clearly by women that they want more midwifery services offered in the ACT. This is supported by the trends demonstrated in the table below showing the decline in the use of obstetricians and GPs and an increase in the use of the Canberra Midwifery Program and shared care (where care in hospitals is largely delivered by midwives, even though it is led by obstetricians).

[28] Submission 6, ACT Division of General Practice, p. 6

Figure 5: Health Practitioner responsible for antenatal care[29]

Responsibility for antenatal care, ACT, 1995 – 2000												
Service	**1995**		**1996**		**1997**		**1998**		**1999**		**2000**	
Provider	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Obstetrician	2,333	48.3	2,132	45.4	1,914	40.7	1,790	38.6	1,626	35.5	1,584	33.9
GP	813	16.8	634	13.5	285	6.1	256	5.5	136	3.0	42	0.9
Midwife	29	0.6	72	1.5	64	1.4	95	2.1	102	2.2	43	0.9
Antenatal clinic	587	12.2	773	16.4	1,154	24.5	876	18.9	916	20.0	1016	21.7
BC/CMP or CMP					271	5.8	544	11.7	494	10.8	519	11.1
Shared care	908	18.8	983	20.9	989	21.0	985	21.3	1,228	26.8	1340	28.7
Not stated	160	3.3	107	2.3	24	0.5	86	1.9	77	1.7	133	2.8
Total	**4,830**	**100.0**	**4,701**	**100.0**	**4,701**	**100.0**	**4,632**	**100.0**	**4,579**	**100.0**	**4,677**	**100.0**

Note: BC/CMP refers to the combined Birth Centre/ Community Midwifery Program from 1997 to 1998. CMP refers to the Canberra Midwifery Program that commenced in 1999. CMP figures in 1999 from the birth register births were counted as 529 (11.6%), which is very similar to the 1998 figures.
Shared care refers to a model of antenatal care where more than one professional clinician or clinic has been involved in a woman's antenatal care.
Those women where 'no antenatal care' was recorded have been excluded from this analysis.
Due to the rounding of percentages some totals may not equal 100.0.
Source: ACT Maternal Perinatal Data Collection, 1995 - 2000 data

3.25. The Committee is concerned that the decline in bulk-billing GPs available in Canberra is compromising ante- and postnatal care. According to data from the Health Insurance Commission (HIC), there were a total of 1 203 015 unreferred attendances (such as to GPs or other primary care) processed through Medicare in the ACT in 2002-2003. Of these, 471 297 (39.18%) were bulk-billed.

[29] Submission 24, ACT Government, p. 25

There were 18 759 referred obstetric services processed, of which only 1506 (8.03%) were bulk billed.[30]

Recommendation 1

3.26. The Committee recommends that the Government forward this report to the Federal Government with a call to address the inadequacy of bulk billing in the ACT.

Antenatal Care

3.27. Antenatal care is essential throughout pregnancy. Proper antenatal care for the average woman in a normal pregnancy does not just equate to a barrage of tests and interventions. It also refers to appropriate emotional and social support and guidance being available from the health professional of a woman's choosing, be that GP, midwife, or obstetrician.

3.28. In the ACT, a woman will generally receive her initial pregnancy counselling from her GP. The relationship she has built with this service provider is important, as the ACT Division of General Practice states:

> GPs deliver the majority of the 1st trimester care of a pregnant woman – clinical examination, counselling, referral for pathology tests, and referral to other care providers as appropriate.
>
> If the woman chooses the share-care model she continues to see her GP at regular intervals throughout the pregnancy. Even with other models of care, however, a woman will often use her GP as the first port-of-call for any pregnancy and non-pregnancy related health problems. This is largely due to the existing rapport and trust between the patient and GP and in some cases the

[30] Health Insurance Commission Annual Report 2002-2003, Medicare statistical tables. Available on the Internet at www.hic.gov.au

GP being more accessible than a private obstetrician or the hospital antenatal clinic for example.[31]

3.29. The Committee agrees that the GP is an important part of antenatal care, but is concerned following reports from consumers that in some instances GPs are obstructing access to midwifery care[32].

3.30. The Committee was told that some women had attended their GP and inquired about midwife-led care only to be told that 'this is your first baby, you really need the care of a specialist'[33]. Women attending the consumer forums strongly expressed the feeling that GPs and specialists were pushing them further into the obstetric medical model. This highlights the imbalance of power between women and the medical system which is accentuated at a time when women expressed that they feel particularly vulnerable.

3.31. Women also reported to the Committee that they were concerned about being pushed into testing that they felt they didn't need, for example, multiple ultrasounds.

Antenatal Education

3.32. Antenatal education is variable in Canberra. All birthing facilities offer some form of antenatal education, as do some independent midwives and birthing educators and community organisations.[34]

3.33. Unfortunately because of the lack of a comprehensive overview of the services available in the ACT, women generally undertake a course at their referred birthing facility, which may not be appropriate to their needs.

---

[31] Submission 6, ACT Division of General Practice, p. 4
[32] Consumer forums, held 3 and 10 November and 6 December 2003
[33] ibid.
[34] Submission 24, ACT Government, p. 17, Submission 14, Women's Centre for Health Matters., p. 3

3.34. There is a perception that current antenatal education structures are not delivering information that is appropriate to women, but rather 'a listing of everything that midwives and management have thought needed to be taught, rather than information that meets the needs of consumers'[35].

3.35. Some women at the consumer forums held by the Committee reported that antenatal education focussed too much on clinical labour management rather than what women themselves could do to manage their labour. Some women also reported that they felt calm facing their birth until undertaking antenatal education classes and were then frightened into believing that they would not be able to manage the pain of labour.

3.36. Yet other women, although significantly fewer in number, reported that their antenatal education was comprehensive and fully prepared them for their birth and allowed them to feel in control of their labour management.

3.37. The general perception though is that antenatal education classes could be more comprehensive and in particular include a section on the emotional, physical and financial impact of having a baby on a woman, her relationship with her partner, and the wider family, particularly in light of the known increase in domestic violence rates when women become pregnant.[36]

3.38. There is also a need for more one-off antenatal courses with a specific focus, such as for women with clinical complications (for example gestational diabetes), for siblings, or for younger or older mothers. This would not only allow specific information, but also introduce women to potential support groups.

3.39. This is supported by the findings of the 1999 Senate inquiry into childbirth procedures, which found that classes were

---

[35] Submission 9, Ms Darlene Cox, p. 6

[36] Submission 21, Ms Joan Garvan

dominated by the needs of the providing institution, and recommended the availability of adequate, appropriate and targeted antenatal education classes.[37]

3.40. The Women's Centre for Health Matters agrees with these findings, and is concerned about the increased medicalisation of childbirth adding:

> … antenatal classes provided by the public health system [have] a strong emphasis on pain management and relief during labour, and possible complications and their resultant procedures during birth. Whilst both these subjects are important in the continuum of antenatal education, they should be provided in conjunction with a health and well being focus on the pregnancy and subsequent birth. This includes a focus on the changing body, emotions and the emotional life of the expectant family.[38]

3.41. The Committee is aware that there are a wide range of classes and courses offered in the ACT, both free of charge and fee-based. The Committee believes that there is a need for an audit of these programs to ensure that they are all delivering appropriate education, and to develop a listing so that women are able to consider their options and find classes that best suit their individual needs.

3.42. The Committee believes that childbirth educators should be independently accredited in adult education and training. Assuring accreditation means that courses will be presented in an appropriate manner to adult learning and cover relevant topics adequately.

3.43. In addition, the Committee is of the view that all women and their families, regardless of their intended birthing location, should have access to free antenatal education, based on a core curriculum

---

[37] Senate Community Affairs Reference Committee. op. cit., p. 36-39.
[38] Submission 14, Women's Centre for Health Matters., p. 3

developed in conjunction with childbirth educators, midwives, consumers and birthing facilities. These courses should also be available in locations other than (but not excluding) the major hospitals.

Recommendation 2

3.44. The Committee recommends that the Government, in consultation with relevant stakeholders, develop a core curriculum for antenatal education and that this be offered free of charge to all women at key locations across the ACT.

3.45. Further, the Committee recommends that the Government require that all persons delivering childbirth education be appropriately accredited and registered as training providers.

Midwife-led care

3.46. There is considerable evidence that the most appropriate form of care for women during and following pregnancy is midwife-led care, particularly in terms of providing social support.[39] This is being increasingly recognised internationally in countries such as the United Kingdom and New Zealand, which both have state support and funding for midwife-led care.

3.47. Although midwives deliver the majority of care in the antenatal clinics and delivery wards of hospitals, the Committee in its discussion here is primarily referring to midwives who work independently of hospitals. There is a distinct difference in the model of care offered by an obstetric midwife, who reports to a hospital department or obstetric specialist, and an independent midwife (whether in individual or group practice) who reports directly to clients.

3.48. It was submitted to the Committee:

---

[39] Submission 12, Australian College of Midwives, ACT Branch, p. 5. World Health Organisation, *Global Action for Skilled Attendants for Pregnant Women*

> The London based Albany Midwifery Practice also shows the ability of one-to-one care to improve outcomes for socio-economically disadvantaged women. This practice provides care to women in a highly deprived area of inner city London. Not only were birth outcomes greatly improved along with levels of satisfaction but also increased breastfeeding rates … were also seen.[40]

3.49. Midwives offer care based on a notion of 'wellness' rather than 'sickness', and are specialists in normal pregnancy and birth. Specialist obstetricians are essential for providing care in complicated pregnancies, but even for women experiencing complications, midwives can provide essential holistic care.

3.50. Midwife-led care is based on the following assumptions:

- pregnancy and childbirth is, in the majority of cases, a normal life event that will proceed to an uncomplicated outcome;
- women make informed choices when factual, unbiased information is readily available;
- women take responsibility for their health and antenatal education;
- women have ease of access to their choice of preferred carer and birth place;
- birth is viewed as normal, with complications able to be readily identified and planned for, or responded to, effectively;
- midwives are educated and experienced in providing primary care and diagnosing complications that require consultation with, or referral to, specialist care;
- specialist obstetric care is a readily accessible secondary, rather than primary, level of care;

[40] Submission 12, Australian College of Midwives, ACT Branch, p. 6

- specialist hospital care is maintained for those women who most need it.[41]

3.51. The College of Midwives suggests that a collaborative approach between obstetricians, GPs and midwives is the best approach for women needing specialist medical care.[42]

3.52. Midwives offer continuity of care through supporting women socially and post-birth to establish care and feeding regimes. However, this is really only possible with one-on-one midwifery care, where a midwife and her patient are able to develop a trusting relationship.

3.53. There is evidence emerging that one-on-one models of care lead to a reduction in the rate of epidural and analgesia, increased normal births and decreased caesarean birth rate, higher intact perineum rate and improved psychological outcomes including 'greater satisfaction and more positive responses to the experience of pregnancy and birth and maternity care'[43].

3.54. This is supported by a study of international trials:

> Evidence from controlled trials shows that women who had continuity of caregivers were less likely to use pharmacological analgesia or anaesthesia during labour and birth, to have labour augmented with oxytocin, to have a labour length of more than 6 hours, or to have a baby with a 5 minute Apgar score below 8. They were also more likely to feel well prepared for labour, perceive the labour staff as caring, feel in control during labour and feel well prepared for childcare.[44]

---

[41] Standards of Care and Protocols for Preceptorship, (2001) 2002 Community Midwifery WA Inc., Fremantle, WA. In Submission 20, Homebirth Australia, p. 6

[42] Submission 12, Australian College of Midwives, ACT Branch, p. 6

[43] Page, L. 'One-to-one midwifery: Restoring the 'with woman' relationship in midwifery'. In *Journal of Midwifery & Women's Health*, V. 48, No. 2, March/April 2003, pp. 119-125., p. 122

[44] Chalmers *et al* in Submission 20, Homebirth Australia, p. 2

3.55. In addition

> such are the demonstrated benefits of one-to-one continuous midwifery care to birthing women and their babies that Chalmers et al actually conclude that 'it is inherently unwise, and perhaps unsafe for women with normal pregnancies to be cared for by obstetric specialists, even if the required personnel are available'.[45]

3.56. Independent midwives have no admitting rights to hospitals, so once their patients are admitted, they lose the ability to attend them (although they do, but only with the consent of hospital staff). The Committee believes that this is unacceptable. Just as a private obstetrician would be able to attend their patient in public wards, so should a private midwife.

New Zealand system

3.57. New Zealand has a mandated system where each woman must have a Lead Maternity Carer (LMC) to coordinate care throughout a woman's pregnancy. The LMC can be an obstetrician, but is generally a midwife or general practitioner (GP), both of whom have the ability to refer to a specialist if necessary. Midwives also have the ability to write prescriptions and referrals for testing, within their scope of practice.

3.58. Over 73% of women choose a midwife as their lead carer[46]. Midwives have admitting rights to hospitals and primary birthing centres and lead the care of their clients throughout birth.

3.59. Services offered by the LMC to women are free, unless the woman chooses care by a private obstetrician[47], or unless she chooses to undergo an elective caesarean with no medical indication for need.

---

[45] ibid., p. 3

[46] Discussions held with New Zealand College of Midwives in Christchurch, New Zealand, 16 to 17 February 2004.

[47] New Zealand Ministry of Health, Maternity Service Information Kit

3.60. The LMC takes responsibility for the care provided to the woman throughout her pregnancy and postpartum period including the management of labour and birth. This includes:

- working with the woman to develop a care plan to be used and updated throughout the pregnancy, birth and following birth;
- one to one education on pregnancy, childbirth and parenting;
- monitoring progress and referring for consultation and/or transfer to specialist care if clinically warranted;
- ensuring that the necessary midwifery, medical and ancillary services are provided from the onset of labour until two hours after delivery of the placenta;
- assessing and caring for the mother and baby during the inpatient postnatal stay and at home until four to six weeks following birth;
- clinical examination of the baby at specified dates;
- five to ten postnatal home midwifery visits;
- arranging transfer to Well Child services and the woman's General Practitioner.[48]

3.61. A LMC allows for women to receive continuity of care, it also provides for a choice of birth at home, in a primary birthing unit or in secondary or tertiary hospital. The LMC develops a relationship with the woman and her family, and has a mandated responsibility to assess women for the risk of postnatal depression

[48] New Zealand Health Funding Authority, Maternity Services: A Reference document. November 2000., p. 33

and/or family violence and to provide appropriate referral and advice.[49]

3.62. The Committee spoke to consumers while in New Zealand and was impressed by the operation of the system and the control that women felt they have over their pregnancy and birth and the autonomy practised by midwives.

3.63. For the majority of women, the system provides one-on-one continuity of care throughout pregnancy and through comprehensive postnatal care.

Indigenous services

3.64. The Committee is acutely aware that mainstream health services are not appropriate for many indigenous people to access. Winnunga Nimmityjah Aboriginal Health Service has previously told this Committee about the holistic services it offers, and how this is the most appropriate form of service for Aboriginal and Torres Strait Islander peoples.

3.65. It is therefore not surprising that 'evidence from New Zealand and Canada suggest that widespread access to midwifery continuity of care has significant positive implications for the care of indigenous women'[50].

3.66. Currently, Winnunga Nimmityjah runs an 'Aboriginal Midwifery Access Program (AMAP) which currently employs a community midwife and a part-time aboriginal access worker to provide individual support, such as clinic-based appointment, home visits for antenatal care, birthing support and limited postnatal follow-up to Aboriginal women'[51].

---

[49] New Zealand Ministry of Health, *Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000*, p. 14

[50] Submission 12, Australian College of Midwives, ACT Branch, p. 5

[51] Submission 24, ACT Government, p. 4

3.67. The Government indicated in its submission that it would be working to further enhance this program to address unmet demand and expand the range of services offered.

Canberra Midwifery Program

3.68. The Canberra Midwifery Program (CMP) is currently the only option for public midwifery-led care offered in the ACT.

3.69. The program offers care to women by midwives in three teams. The northside and central teams offer caseload midwifery practice, where one midwife cares for a woman for the duration of her pregnancy, labour and post-birth.

3.70. For the life of this inquiry, the southside team offered team based midwifery practice, where a team of midwives cares for a woman for the duration of her pregnancy, labour and post-birth.

3.71. However, the Committee is aware that the midwives of the southside team have recently rearranged their work practices to offer caseload midwifery. The Committee is of the opinion that this is the most appropriate form of care, and supports the midwives in this move, even though it is aware that it may not necessarily be supported by hospital administrators as discussed below.

3.72. All women birth in the Birth Centre at The Canberra Hospital which is set up to mimic home-like conditions, with a double bed in each room.

3.73. The CMP is available to all women, and the CMP particularly identifies the following groups to benefit from this model of care:

- any woman who feels she would benefit from knowing her midwife;
- Aboriginal and Torres Straight Islanders;
- other minority ethnic groups especially women with English as a second language;

- lower social economic groups;
- socially isolated women;
- women in abusive relationships;
- women without transport and/or child care;
- those who have had a previous episode of postnatal depression;
- women who are physically or mentally challenged;
- women who are newly single or separated;
- minority groups ie: lesbians, young or mature aged women;
- women who have experienced the death of a baby.[52]

3.74. The Committee is of the view that while the program does offer a form of best practice in maternity care (through midwife-led care) that would benefit all women with low-risk pregnancies, it is concerned that the program is run by a tertiary hospital administration. The benefits are not as great as they would be from a program administered independently from the hospital system, where the CMP would not have to adhere to obstetric policies that may not necessarily fit within a midwifery model of care, as discussed below.

3.75. Regardless, the benefits are still apparent and because of the popularity of the program, women need to book in before seven weeks of pregnancy, and the program has a waiting list of approximately 15 women each month (180 per year).[53]

3.76. This waiting list is without any program advertising. In addition, the CMP does not record women who enquire but are told there is no possibility for them to be accepted into the

---

[52] Canberra Midwifery Program information handout

[53] Submission 12, Australian College of Midwives, ACT Branch, p. 6

program, so it can be reasonably assumed that the demand is much greater than reflected in currently available data.

3.77. ACT Health told the Committee that the waiting list is only 60 women per year[54]. However, evidence received suggest it would be a higher figure than this and the Government needs to undertake a proper needs analysis to determine the actual demand for places and the potential demand if the program were to be advertised.

3.78. The demand for places means that only women who have good networks, good access to information and who have had good pre-pregnancy planning will be prepared and able to book into the program as soon as they are pregnant. This is unlikely to be the case for a majority of the above groups, and also unlikely for first-time mothers who 'often do not begin to think about their care options until much later, by which time they are unable to access continuity of midwifery care even when this is their strong preference'[55].

3.79. Administrators at The Canberra Hospital told the Committee that a team-based midwifery model was preferred for the CMP as it was easier to manage staff absences and reduced burnout. However, only a short time later, CMP midwives told the Committee that they preferred a caseload model of care as it provided greater job satisfaction and reduced burnout through a more manageable patient caseload.

3.80. This is certainly supported by women who spoke to the Committee who preferred a one-on-one model of care offered by caseload midwifery, and also supported by research undertaken internationally on both models of care.

3.81. One woman reported attending the team-based CMP model and seeing a different midwife on each occasion of care so when

---

[54] Proof Transcript of Evidence, 26 February 2004, p. 42

[55] Submission 12, Australian College of Midwives, ACT Branch, p. 6

she came to birth, she had not developed a relationship with any one midwife. This is not best practice midwifery care.

3.82. In addition, women are not able to choose their midwife, but rather are allocated to an available midwife or team, and this can be detrimental to both women and midwives.

3.83. It was submitted to the Committee 'that one full time midwife working in the existing 3-shifts-per-day model could care for (in equivalent terms) 27 women per year. By contrast a typical full time midwife working in a one-to-one continuity of care model such as that being provided by the CMP would care for 40 women per year'[56].

3.84. It has been claimed that the CMP is at best an addition to an acute service as

> CMP is controlled by Obstetrics and managed within the acute setting. Normal healthy pregnancy has no role in a tertiary referral hospital, it is against best practice and possibly unsafe. There is also a huge conflict of interest with the Canberra Hospital being a teaching facility. …
> At the moment the CMP is an add on to an acute service. Despite the commitment of midwives it is not providing evidence based care, eg: requiring women to be admitted to hospital with premature rupture of membranes, requiring women with vaginal birth after caesarean (VBAC) to undergo foetal monitoring, reducing the likelihood of active birth and successful vaginal birth, and general foetal monitoring as a medical defence rather than best practice in the interests of women.
> Unnecessary obstetric control also prevents midwives to work as they were trained (with a scope of practice, collaborating where necessary) rather they need permission of obstetrics [TCH administration] to provide practice.[57]

---

[56] ibid., p. 9

[57] Submission 20, Homebirth Australia, p. 3

Consumer feedback

3.85. By far, the CMP received the most compliments of any service during this inquiry. As one woman told the Committee *I thought by paying to go privately I would get the best of everything, but I didn't and I am so jealous of my friend who went through the CMP, and by far received the best of care, including follow-up visits at home whereas I was discharged from hospital and then left completely on my own*[58].

3.86. In submissions, women indicated that they valued the continuity of care offered by the CMP[59].

3.87. In the face of the ongoing medical indemnity insurance situation forcing many independent midwives out of the workforce, there is an urgent need to immediately increase resources to the CMP to meet the current unmet demand and then to meet the future demand in the ACT.

[58] Consumer forum, 10 November 2003

[59] Submission 4, M Wilson and C Ballard, Submission 11, Ms Sue Hoffmann, Submission 18, Ms Vanessa Smith, Submission 22, Ms Sue Pedder, p. 2

Recommendation 3

3.88. The Committee recommends that the Government undertake a needs analysis to determine the actual level of unmet demand for the Canberra Midwifery Program as a matter of urgency.

3.89. Further the Committee recommends that the Government increase funding to the Canberra Midwifery Program to meet existing demand and following the outcome of the needs analysis appropriately resource the Program to meet demand.

3.90. The Committee makes recommendations in the chapter *The way forward* that will impact on the level of demand for the CMP, and the Government will need to consider restructuring the program in its entirety to blend with the proposed model.

3.91. The Committee received one submission[60] which was highly critical of the birth centre and its staff and which made a number of recommendations for change in the system.

3.92. Primarily, from the matters raised in this submission, the Committee is of the opinion that it must be communicated clearly to women using the Birth Centre, that although it is located within The Canberra Hospital (TCH), the midwives work autonomously, and if individuals are not confident in this model, then they should be encouraged to utilise the services of the main hospital delivery suite.

3.93. Clients should also be made to understand that the midwives do not, and should not be expected to, work under the supervision of obstetricians or other medical specialists. Calls for them to do so will only further undermine the skills and abilities of midwives working within this model.

---

[60] Submission 5, Confidential

3.94. The submission raised the issue of computerised record keeping as a method to ensure consistency in information and to maintain previous birth histories[61].

3.95. The Committee agrees that consistency in accessible record keeping is essential.

3.96. One submission[62] also raised the issue of the 42-week limit placed on women attending the CMP. This means that women who do not give birth by 42 weeks of pregnancy are automatically transferred to the hospital system, or otherwise must be induced, which then has a greater possibility of further interventions.

3.97. This issue was also raised by several women at consumer forums who expressed that the dates of pregnancy can be variable and any 'end date' is quite arbitrary.

3.98. The Committee is concerned that the CMP is being largely controlled by the obstetrics department of TCH, rather than by protocols established and led by midwives. Certainly the CMP should have a relationship with TCH that allows it to utilise hospital services, but the program should otherwise be able to work autonomously, and set its own protocols based on best-practice evidence.

3.99. A midwifery program should be run, and led, by midwives not TCH administration.

Recommendation 4

3.100. The Committee recommends that the administration for the Canberra Midwifery Program, including the development and implementation of all policies and procedures, be immediately placed under the control of midwives.

---

[61] ibid., p. 1

[62] Submission 11, Ms Sue Hoffmann

3.101. Readers are referred to Chapter 8, *The way forward*, for further discussion of this issue.

Homebirth

3.102. Evidence received by the Committee supports homebirth as an option for providing the same, if not better, physical and psychological outcomes for both women and their families.[63]

3.103. There is also ample evidence proving that home birth is safe and as this research is widely available, the Committee will not replicate that evidence here. The Committee accepts the evidence proving that home birth is safe.

3.104. Unfortunately, 'home birth seems to no longer be possible for women in Canberra due to insurance costs forcing midwives to leave this field. This is an ideal option for some women and should be actively encouraged by the Government.'[64]

3.105. The Committee heard anecdotal evidence that some women attend the CMP with every intention of having a home birth call the midwife when it is too late in the labour to be transferred, or otherwise refuse to leave their homes, therefore forcing midwives to attend them at home. The Committee also heard anecdotally that some women are having totally unassisted home births as they are unable to afford a private midwife.

3.106. The Committee is of the opinion that both of these situations are untenable. It is unacceptable for women to feel that they are forced into lying to their primary carer regarding their intentions to home birth and/or feel that they have no choice but to birth at home without the support of a professional carer.

3.107. It also places the CMP midwives in an unacceptable position, where they are unable to plan for a home birth, and may not

---

[63] Submission 16, Ms Dawn Kamprad, Submission 19, Ms Michelle Lines

[64] Submission 7, Ms Clare Wynter

necessarily have the skills, experience and equipment on hand to support this adequately.

3.108. The Committee understands that the Government is supportive of home birth but is unable to gain insurance coverage to offer this through the CMP.

3.109. The Committee is aware that other states, such as Western Australia, are able to fund home-birth, but due to the size of the ACT, the Government is not able to carry the same level of risk. The Committee is of the opinion that the primary birth centres discussed in Chapter 8 will offer an alternative to some that will be acceptable in the short term until this issue is resolved.

3.110. Until such time, the Committee urges the Government to work actively and innovatively towards finding a resolution to allow midwives to offer homebirth.

3.111. The Committee is of the opinion that if this were a viable option, then more women would choose it.

Intervention rate

3.112. The Committee is extremely concerned about the intervention rate in childbirth. While it recognises that interventions have markedly improved the mortality rate as previously discussed, it is concerned that intervention rates are now too high.

3.113. This sentiment was echoed in the majority of submission, including the Government submission which said: 'It is generally recognised that reducing the number of interventions low risk women experience during birth improves the health outcomes of women and their babies'[65].

[65] Submission 24, ACT Government, p. 3

3.114. Although the ACT has lower rates of some interventions than the rest of Australia, the Committee still finds the intervention rate to be unacceptably high.

3.115. In addition, evidence is now showing that birthing location and disruption of the physiological process of birth can have long-term consequences in terms of sociability and aggressiveness[66].

3.116. The Australian Breastfeeding Association also highlighted the following research on the impact of interventions:

- Hodnett (1996) found that women who received continuous support in active labour were less likely to find mothering difficult; less likely to be depressed at 6 weeks and more likely to be exclusively breastfeeding at 6 weeks. In New Zealand one-to-one care provided by a midwife resulted in significantly higher rates of exclusive breastfeeding at 6 weeks than when care was provided by an obstetrician (Guilliland 1999)

- Babies born after the mother has had pethidine in labour may be less active, have less opening of the eyes, less hand to mouth activity, less seeking of the breast and less effective suckling (Ringhard 1990, Nissen 1995).

- Epidurals immobilise women and may therefore increase the risk of iatrogenic[67] illness, increasing the number of operative deliveries that will be necessary with the consequent impact on early bonding and initiation of breastfeeding (Throp 1993).

---

[66] Odent, M. 'New reasons to study birth physiology'. As first published in the International *Journal of Gynaecology and Obstetrics* 75 (2001). Accessed on 30 March 2004 from www.michelodent.com/news.php?id=14.

[67] The Macquarie Dictionary defines iatrogenic illness as that caused or produced by diagnosis or treatment by a physician.

- Routine suctioning: suctioning of newborns interferes with the initiation of breastfeeding by the baby (Widstrom 1987) and should therefore not be practised routinely.[68]

Caesarean section

3.117. The overall caesarean rate in the ACT was 21.8% in 2000. It was 18.9% in public hospitals and 29.4% in private hospitals in the ACT. Over half the caesareans performed (11.5%) were elective.[69] The rate of caesarean section is increasing.

3.118. The World Health Organisation (WHO) considers the caesarean section rate as a key indicator of maternal health outcomes. Below 5% is considered that 'a substantial proportion of women do not have access to surgical obstetric care and probably die as a result' and a rate above 15 % indicates 'over-utilization of the procedure for other than life-saving reasons. This is also dangerous for women's lives because of the unnecessary risk associated with any major surgical operation.'[70]

3.119. The Committee became increasingly concerned about this rate, particularly in light of new evidence finding that:

> delivery by caesarean section in the first pregnancy could increase the risk of unexplained stillbirth in the second. In women with one previous caesarean delivery, the risk of unexplained antepartum stillbirth at or after 39 weeks' gestation is about double the risk of stillbirth or neonatal death from intrapartum uterine rupture.[71]

---

[68] Submission 2, Australian Breastfeeding Association., p. 1-2. References are listed in the Bibliography at Appendix 4.
[69] Submission 24, ACT Government, p. 21
[70] World Health Organisation, 1994, *Indicators to monitor maternal health goals*. WHO/FHE/MSM/94.14. http://www.who.int/reproductive-health/publications/MSM_94_14/MSM_94_14_chapter3.en.html (accessed 10 February 2004)
[71] Smith, GCS, J Pell, R Dobbie. 2003. 'Caesarean section and risk of unexplained stillbirth in subsequent pregnancy'. *The Lancet* 2003: 362: 1779-84, abstract

3.120. The Committee is seriously concerned about the increased trend for elective caesarean sections, and is concerned that women are not being educated about the risks associated with this major abdominal surgery.

3.121. The Committee was told while touring Calvary Hospital that at least one Canberra obstetrician has a 'checklist' to discuss with patients to ensure that they are aware of the risks associated with elective caesarean section. The Committee requested a copy of this 'checklist' because of its concerns as discussed above, however, it was not received.

3.122. Some women reported to the Committee that they felt bullied into a caesarean section by an inappropriate risk assessment by doctors during labour, or by doctors creating such fear about their ability to birth naturally, and disproportionately expressing the risks involved in normal birth.

3.123. The New Zealand College of Midwives pointed out to the Committee that emergency caesarean sections are almost always justified, however many could be avoided if the cascade of interventions had not first taken place.

3.124. It is therefore critical that management of labour is the focus of reform in maternity services and evidence conclusively supports that taking the one-on-one midwife, woman-centred, approach leads to appropriate management of labour.

Onset of labour

3.125. In the ACT, 65.4% of women experience spontaneous onset of labour, with 44.5% going on to have no augmentation[72] during labour or birth. The induction rate is 22.4%[73].

---

[72] Augmentation refers to artificial oxytocin being given to stimulate labour. For a good overview see www.acegraphics.com.au/parents/obstetric/augmentation.html.

[73] Submission 24, ACT Government, p. 22

3.126. Women who spoke to the Committee were concerned that the augmentation rates were too high and augmentation is used too quickly in some settings. They expressed concern that it is used when there is a natural slow-down in labour instead of reassuring and calming women and placing them back in control of their labour.

Other interventions

3.127. Other intervention rates are also high. Australia-wide,

> Between a quarter (public) and a half (private) use epidural anaesthesia. Forceps procedures or vacuum extraction are used to deliver one in every five babies born in a public hospital. One in three public women and half of all private women receive episiotomy. Overall, less than one quarter of public first time mothers and one fifth of private patients give birth without obstetric intervention of any sort.[74]

3.128. Submissions to this inquiry and individuals that the Committee spoke to consistently referred to a 'cascade of interventions', whereby once one intervention is given, it can lead to many others.

3.129. The common example was epidural leading to slowing of labour and augmentation followed by forceps delivery and episiotomy.[75] An epidural reduces the chance of a woman having her first baby by normal delivery by up to 50%, and doubles a

---

[74] Submission 20, Homebirth Australia, p. 14 (Attachment A. Dr Barbara Vernon and Dr Sally Tracy, 'Reassessing risk in Australian public maternity services: A case for Insuring the Canberra Midwifery Program to offer the option of birth at home')

[75] ibid.

woman's chance of having a caesarean section for failure to progress.[76]

3.130. Research is also finding that there may be long-term consequences:

> …if a mother had been given analgesic or sedative medication during labor (opiates, barbiturates or nitrous oxide), her child was statistically at increased risk of becoming drug-addicted in adolescence…. [in addition] adolescents who have been exposed in the perinatal period to 3 doses (or more) of opiates or barbiturates had a risk of becoming drug addicted multiplied by 4.7.[77]

3.131. There is little evidence that routine use of interventions for low-risk pregnancy delivers the best outcomes:

> … the OECD countries with the lowest perinatal and maternal morbidity and mortality rates have been found to be those with comparatively low rates of obstetric intervention in childbirth, and where there is widespread use of midwives as the primary caregivers of pregnant and birthing women.[78]

3.132. It has also been found that in Australia the rates of obstetric intervention were higher amongst women regarded as low-risk attending private facilities than those attending public facilities.[79]

3.133. This indicates to the Committee that the use of interventions is closely aligned to models of care.

---

[76] Buckley, S. 'Epidurals: real risks for mother and baby'. Published on www.acegraphics.com.au/articles/sarah02.html. November 1998. Accessed 11 February 2004

[77] ibid.

[78] Submission 20. op. cit., p. 15

[79] Roberts, C. S. Tracy and B. Peat. 'Rates for obstetric intervention among private and public patients in Australia: Population based descriptive study'. *BMJ* 2000; 321: 137-41, p. 137

3.134. This is supported by findings of the New Zealand College of Midwives. It has been seen in areas of New Zealand where women mostly access primary birthing units, which have no capacity to perform epidurals, the rate of request is very low as there is no expectation that it is needed, whereas in secondary and tertiary hospitals, the rate of request is considerably higher for women experiencing a normal labour.

3.135. This is also supported by the experience of women who spoke to the Committee. For example, some women who birthed in the Birth Centre as part of the CMP reported having to labour in the delivery suite of TCH for a period of time when one of the other labouring women were transferred to the TCH delivery suite for epidural. Several women reported that once in the delivery suite being asked *when are you having an epidural*? Other women who birthed in TCH also reported having to argue against having epidural pain management.

3.136. New Zealand College of Midwives told the Committee that in New Zealand, midwives, obstetricians and anaesthetists have come to an agreement that epidurals will only be offered where there is a clear clinical need, and that anaesthetists must work as independent practitioners to determine that need.

3.137. This agreement was reached after it was widely accepted that a reduction in the rate of interventions would see a reduction in the caesarean section rate.[80]

3.138. The Government submission states:

> … In addition there is now research that shows that medical interventions in low risk women leads to cascading costs to the health system and that accessing epidural pain relief is associated with a sharp increase in costs.

---

[80] Discussions held 16-17 February 2004 with the New Zealand College of Midwives, Christchurch, New Zealand.

> This evidence is important, however it must also be recognised that these interventions, such as caesarean sections and instrumental deliveries are implemented because the woman or her baby are at risk. In addition many women choose to use epidural pain relief.[81]

3.139. The Committee argues that many women are using epidural pain relief without full information, or appropriate midwife support throughout labour, and are therefore not making an informed choice.

Transfer to hospital rates

3.140. A comparison of the outcomes of the CMPP[82], TCH birth centre (TCH BC), the community midwifery program of Western Australia (WA CMP) and midwives in independent practice is below[83]:

Figure 6: Transfer rate comparison

Transfer Stage	CMPP	TCH BC	WA CMP	Independent Practice
Antepartum *During Labour* *Postpartum*	18% 8% 8%*	32% 8% 2%*	Transfer breakdowns not available see total	Transfer breakdowns not available see total
Caesarean section	8%	8%	12.2%	4.8%
Total transfer	**34.3%**	**42.3%**	**23.5%**	**20.0%**
*CMPP postpartum transfer includes the period up to 6 weeks for mother and baby, TCH BC only includes the period up to 24 hours post birth.				

[81] Submission 24, ACT Government, p. 29

[82] The Community Midwives Pilot Program was the forerunner to the CMP.

[83] Submission 20, Homebirth Australia, p. 4-5

Figure 7: Uncomplicated vaginal delivery rate and perineal status comparison

	ACT Hospitals	CMPP	WA CMP	Independent Practice
Uncomplicated vaginal delivery	63%	88%	83%	91.6%
Intact	42.4%	56%	44%	70%
Episiotomy	21.7%	4%	8%	2.3%

3.141. During its visit to TCH, the Committee requested data on the transfer and intervention rates for the CMP however it was not provided.

3.142. From the evidence received, it is clear that intervention rates are linked to place of birth and models of care. The rate of intervention is particularly high in tertiary settings and for this reason, the Committee is of the view that it is imperative to remove normal birth from the tertiary hospital system.

3.143. This is supported by research recently published by the Australian Healthcare Association, which found that

> 'primiparous women in private hospitals have consistently received higher rates of obstetric procedures/intervention than their public counterparts, with only 12.2 percent experiencing normal vaginal birth in intact perineum compared to 24.3 percent of public patients in 2001.'[84]

3.144. This is despite the research finding that there was no clear difference between public and private hospital admissions and type of maternal condition and/or complication and indeed found that 'women birthing in public hospitals have the highest rates of

[84] Shorten, B., and A. Shorten. *Impact of private health insurance incentives on obstetric outcomes in NSW hospitals*. Australian Healthcare Association, 14 April 2004.

recorded obstetric complications and appear to have a higher objective risk profile.'[85]

Postnatal care

3.145. Women who discharge early from hospital are visited or contacted by telephone by the Midcall nursing teams, regardless of where they live in the ACT. They are generally visited at home for six to seven days depending on need. The Committee received positive feedback about this service from women.

3.146. Maternal and Child Health (MACH) nurses also provide follow-up care following discharge.

> Telephone contact will be attempted with all women within 2-3 weeks of their discharge. When contacted, women will be consulted about their and their baby's well being, given the opportunity to ask any questions they may have, and given the opportunity to have a MACH nurse home visit arranged.
>
> At a home visit the MACH nurse will address any issues and questions, assess the woman and her baby's health, provide breastfeeding support if required and provide any referral information that may be required. Additional home visits may occur if the MACH nurse identifies a need, however women are encouraged to access Health Centre support services such as sleep and breast feeding clinics, mother's groups and health check clinics.[86]

3.147. With no previous relationship throughout the pregnancy, the Committee is concerned that it may be difficult for the MACH nurses to readily judge the mental health of women following birth.

---

[85] ibid.

[86] Submission 24, ACT Government, p. 17

3.148. The Committee received positive feedback on the services offered by MACH nurses, however women indicated that they would prefer a more integrated model of care – regular visits for six weeks following birth, by a carer known throughout the pregnancy.

3.149. The Committee is of the opinion that this model would be more effective, particularly at assessing for postnatal depression, which may not become apparent for several weeks or months following birth.

3.150. It does not appear that assessment and care for postnatal depression (PND) is cohesively addressed in the ACT. PND is not regarded as a birth outcome and so is not assessed in post-birth checkups (i.e. the six-week obstetrician/GP visit) as a matter of routine.

3.151. The Committee heard that particularly for women who have had difficult births, such as unplanned caesarean sections, that postnatal support is essential, and can make the difference between PND developing or not.

3.152. The Committee was told about a pilot program being undertaken through The Canberra Hospital to assess women for potential or actual PND. The Committee puts its full support towards any program that will proactively address PND at an early stage.

3.153. The Committee believes that any approach to PND needs to be proactive because, in the words of one submitter:

> in terms of postnatal depression, evidence shows that women are unlikely to seek help with postnatal depression and often will keep it to themselves, feeling shame and fear of the consequences of mentioning their state of mind. I was concerned that the only treatment would be medication and as a breastfeeding mother was reluctant to be medicated, therefore avoiding *actively* seeking help. … The proactive approach is far more likely

to be effective for women who are too embarrassed to seek assistance.[87]

3.154. Another woman told the Committee that although diagnosed and treated for PND, it was more likely that she was suffering from post-traumatic stress disorder due to a traumatic induced labour and unnecessary caesarean section, with no follow-up support. Although her second birth also ended up as a caesarean section, she had comprehensive support before and after the birth by an independent midwife and believes that this was a factor in her positive mental state following this birth.[88]

Breastfeeding

3.155. Establishing breastfeeding is an essential part of postnatal care. The World Health Organisation Global Strategy supports breastfeeding as the only adequate form of nutrition for infants[89] and the Committee supports the right of every woman to breastfeed in a supportive environment, where she and her baby are made to feel welcome.

3.156. The benefits of breastfeeding as laid out in submissions[90] are not disputed by this Committee.

3.157. In short, breastfeeding:

- enhances the general health and well-being of infants and children;
- may improve infant cognitive development;
- contributes to the healing of mothers following birth, and reduces the risk of ovarian and breast cancers; and

---

[87] Submission 15, Confidential
[88] Submission 23, Ms Karen Silsby
[89] Submission 1, Dr Julie Smith, p. 1
[90] Submission 1, Dr Julie Smith and Submission 2, Australian Breastfeeding Association

- provides social and economic benefits through less impact by women and children on the health system.[91]

3.158. The Committee acknowledges that some women are unable to breastfeed and recognises the difficulties inherent in this, however the Committee is of the opinion that all women should be supported to establish and maintain breastfeeding.

3.159. The Committee is concerned about anecdotal evidence that when in hospital, babies are sometimes fed formula at night by nursing staff in order to allow mothers to rest, even when this is expressly against the wishes of the mother. The first days of a baby's life are essential for establishing a routine of breastfeeding, and this should not be overridden by misplaced, however good, intentions.

3.160. This is particularly an issue when breastfeeding mothers are admitted to other areas of the hospital for medical treatment. The Committee heard from a woman experiencing a postnatal mental health issue who was admitted to both TCH and Calvary Hospital psychiatric wards.

3.161. Although able to keep her baby with her, she was given medication incompatible with breastfeeding, and later had to fight to ensure that this did not occur again. She also found that some nurses were patronising in their language or that they would pick up the baby when she was trying to settle him, or would feed him without her knowledge. At no point was a lactation consultant or maternal nurse brought in to the care regime.[92]

3.162. This further highlights the concerns that the Committee has about the hospitals as a whole being able to care for breastfeeding mothers. Unless there are serious medical indicators meaning that

---

[91] Submission 1, Dr Julie Smith and Submission 2, Australian Breastfeeding Association., p. 2

[92] Proof Transcript of evidence, 26 February 2004, in camera

a baby cannot stay with its mother, then breastfeeding mothers and babies should not be separated and a lactation consultant should be involved in all levels of care.

3.163. The Committee received two submissions[93] calling for all maternity facilities in the ACT to be accredited under the Baby Friendly Hospital Initiative (BFHI). The BFHI is a World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) joint project to 'ensure that all maternities, whether free standing or in a hospital, become centres of breastfeeding support'[94].

3.164. A centre can be accredited as 'baby-friendly' 'when it does not accept free or low-cost breast milk substitutes, feeding bottles or teats and has implemented ten specific steps to support successful breastfeeding' as outlined by UNICEF.[95]

3.165. The Committee is disappointed to note that as at March 2002, only seventeen Australian facilities were reported by UNICEF as having BFHI accreditation.[96] This should be a standard for accreditation of all Australian maternity facilities. The Committee is pleased to note that The Canberra Hospital and Calvary Hospital are both recently certified with BFHI accreditation.

3.166. However the Committee is aware that this only applies to maternity areas of the hospital. The hospitals should adopt the basic policy that the BFHI standards are to apply across the entire hospital whenever women are admitted while breastfeeding and

---

[93] Submission 1, Dr Julie Smith and Submission 2, Australian Breastfeeding Association

[94] UNICEF 'Baby Friendly Hospital Initiative' quoted from http://www.unicef.org/programme/breastfeeding/baby.htm#10, accessed on 24 October 2003.

[95] ibid.

[96] Current status of baby-friendly hospital initiative, March 2002 as at http://www.unicef.org/programme/breastfeeding/assets/statusbfhi.pdf accessed on 24 October 2003.

all staff involved in her care should be briefed on how to support her role as a breastfeeding mother.

Recommendation 5

3.167. The Committee recommends that the Government require all public hospitals to apply Baby Friendly Hospital Initiative standards across all areas of the hospital so that when breastfeeding mothers are admitted they are adequately supported and staff are adequately trained to support them and their babies.

3.168. The Committee heard from women at the consumer forums that the attitude of midwives in relation to breastfeeding can be the deciding factor in whether they continue to breastfeed or not.

3.169. For example, the Committee was told at a consumer forum by a woman from an Asian background, who birthed in a private hospital, that she received constant pressure to feed her baby, even though it was clear, to herself, that she had no milk. Her milk came through at ten days, which she later discovered to be common in Asian women. However, because she is an immigrant and had no female family in Canberra supporting her, and no ongoing postnatal midwife support, she did not know that this would happen and the whole process was so distressing that she did not continue breastfeeding.

3.170. On the other hand, her friend of the same background, who birthed in the CMP, had an understanding midwife, who supported her in feeding during the first days of the baby's life and then supported her to establish breastfeeding when her milk did come through.

3.171. It is important that all health professionals working with new mothers receive training in cultural diversity so they are able to support them adequately.

Maternal and child health centres

3.172. The Committee received a great deal of feedback about the maternal and child health centres in the ACT.[97]

3.173. The maternal and child health centres offer services such as child health checks and immunisations. Parents reported to the Committee that they like to use the services for a range of reasons, including cost and the perception that the nurses, being more experienced, are better at giving painless immunisations to children.

3.174. However, parents reported difficulty in accessing the centres due to the length of waiting lists, which some found distressing and the move away from appointments to drop-in has made waiting times in the clinics long. This is unrealistic for parents with a baby and toddler and/or other small children.

3.175. Parents also reported confusion in accessing the centres in the first place with the numbers available for intake lines confusing, and the 'on hold' waiting times lengthy. They reported preferring a previous system where they could leave contact details instead of waiting on hold as this system was more responsive to parents who may have a chaotic household with several small children.

3.176. One woman at a consumer forum suggested that the effectiveness of the clinics should be assessed from the point of view of a parent with three small children, all of whom find lengthy waiting periods trying.

3.177. Even for new parents with one baby, the current arrangements are daunting. The Committee was told 'apparently, we should brace ourselves for 'Immunisation Day' which could have at least 20 families ahead of us at any time of the day'.[98]

---

[97] Submission 7, Ms Clare Wynter, Submission 18, Ms Vanessa Smith, feedback at consumer forums held in November and December 2003.
[98] Correspondence, 30 January 2004, Peter and Katrina Jordan

3.178. The Government must ensure that the clinics are user friendly for the clients who are actually using them and the Committee is concerned that consumer feedback on this matter to ACT Health is being ignored or dismissed.

3.179. The Committee also heard that the Gungahlin area is under-serviced and waiting lists for programs are lengthy because of the high number of births in this area. The Committee is concerned that under-resourcing may be impeding access to the clinics.

Recommendation 6

3.180. The Committee recommends that the Government, in partnership with consumers, improve the accessibility of maternal and child health clinics through a return to an appointment based system and ensure that clinic operations are responsive to the needs of parents.

3.181. The Committee further recommends that the Government ensure that the clinics are adequately resourced to meet need, particularly in areas of high growth, such as Gungahlin.

The Canberra Hospital

Neonatal Intensive Care Unit

3.182. TCH Neonatal Intensive Care Unit (NICU)

> provides the only intensive care services in the ACT and South East NSW, it is part of the NSW Perinatal Services Network and is one of 10 referral centres for neonatal intensive care services and is linked to the NSW Neonatal and Paediatric Emergency Transport Service (NETS). It provides up to level 6 care, for high-risk deliveries.[99]

3.183. The NICU plays a vital role for the health and welfare of infants not only in the ACT and region, but from regional Victoria

[99] Submission 24, ACT Government, p. 18

as well. Because of its location in the ACT, parents with critically ill babies only need transfer interstate for care in extremely rare cases.

3.184. The Committee was shocked at the space available to the NICU, and is aware that the staff undertake a lot of community fundraising in order to update equipment. Staff indicated to the Committee that the NICU is in a difficult location in the hospital in regards to transport of infants to operating theatres and other treatment areas, but there were plans for an upgrade being considered.

3.185. The Committee believes that upgrade of the NICU is a matter of urgency, particularly considering its position servicing the ACT and region.

3.186. The Committee has noted that the Government has recently supported a community fundraising effort to raise funds for a transport crib for the neonatal unit.[100]

Recommendation 7

3.187. The Committee recommends that the Government urgently upgrade and expand the Neonatal Intensive Care Unit at The Canberra Hospital.

Signage

3.188. During its tour of The Canberra Hospital, the Committee noted that some clinical and ward areas were used for both ante- and postnatal patients and patients being treated for gynaecological conditions.

3.189. The Committee was told that clinic appointments for these two groups of patients are scheduled on separate days to avoid the situation whereby women potentially dealing with infertility

[100] Minister for Health, 'Neonatal crib to help sick babies', media release, 23 March 2004

issues were confronted by seeing a number of obviously pregnant women. While this scheduling may take place, the Committee was concerned to note that the posters and information displayed in the waiting areas were all to do with pregnancy and breastfeeding related issues.

3.190. This in itself can be upsetting and difficult for women with serious gynaecological conditions, or those receiving treatment following miscarriage.

3.191. The Committee is also aware that this is an issue in the Antenatal/Gynaecology ward (Ward 2B). This ward is accessed primarily through the maternity entrance to the hospital and has an emphasis on maternity-related issues in the signage and posters on the ward.

3.192. Hospital staff told the Committee that women who have experienced miscarriage welcome being on this ward because it acknowledges their pregnancy. However, individual members have heard from a number of women who have spent time on the ward following miscarriage or gynaecological surgery that found it an extremely difficult place to be because the environment was clearly focussed on antenatal issues and, as a result, invalidated their experience, was confronting, or otherwise affected their recovery.

3.193. While it may be physically impossible to have separate ante/postnatal and gynaecological clinic and ward areas, the Committee believes that the Hospital has to be very sensitive to the needs of all its patients and recognise that the environment created by posters and signage can be damaging on the emotional processing and healing of patients.

Recommendation 8

3.194. The Committee recommends that The Canberra Hospital ensure that the posters and signage displayed in mixed antenatal and gynaecology treatment areas are sensitive and reflective of the mix of patients attending these areas.

4. The cost of maternity services

4.1. A comparative analysis of the cost of different models of maternity services is difficult due to the fragmented nature of federal and territory funding and the high cost of hospital services in the ACT.

4.2. However, it is possible to gain a picture of the costs involved in births. A tertiary hospital system is one of the most expensive to run. In ACT we admit normal, healthy women into an expensive system when they could be better served by birthing in primary units that do not have the same cost implications.

4.3. Few studies have been undertaken into the comparative costs of models of care. More studies are now being undertaken as the economic impact of tertiary-level care for normal birth is being felt by the health system.

4.4. For a baseline, a study based on NSW costing data indicates that a normal birth with no interventions in hospital cost an average of $1717, 'a birth ending in forceps or vacuum extraction and an episiotomy' averaged at $2306 and an emergency caesarean averaged at $4452.[101] This does not include costs for length of stay.

4.5. Using these figures and modelling a 10% reduction in the use of epidurals, there would be an overall saving of 2.99% of the budget in a public hospital setting, a 20% epidural reduction would result in a 6.16% budgetary saving.[102]

---

[101] Tracey, S., and M Tracey. 'Costing the cascade: estimating the cost of increased obstetric intervention in childbirth using population data'. In *BJOC: an International Journal of Obstetric and Gynaecology*, August 2003, Vol. 110, pp. 717-724, p. 718

[102] ibid.

4.6. Costs were also found to have increased when women accessed the private system. The study found that:

> … the overall cost of private episodes of care is increased by 9% for primiparous women and 4% for multiparous women … women in New South Wales stay an average of 3.4 days in hospital in the public system and an average of 4.9 days in the private system. Furthermore, the rate of stay for seven days or more is three times greater for women with private status at 17.3% compared with 5.6% for those with public status.[103]

4.7. Studies have recently been undertaken into the cost of standard hospital care (referred to below as the control group) at St George Hospital (Sydney) with the St George Outreach Maternity Program (referred to below as the STOMP group), a model of continuity of midwifery care. In both programs, women birthed in the hospital.

4.8. The research found that 'overall the mean cost of providing care per woman was lower in the STOMP group compared with the control group ($2579 versus $3489)' [104]. This result was found even though STOMP midwives had on-call costs, and more home visits (increasing preparation and transport costs). The caesarean rate was considerably lower in the STOMP versus the control group (13.3%: 17.8%), and the cost saving was maintained even when the STOMP caesarean rate was modelled at nearly 20%.[105]

4.9. The Committee has already discussed the benefits of midwifery care in reducing intervention and caesarean section rates, and as the research above suggests, even in the hospital setting, caseload midwifery is more cost effective than current models of care.

---

[103] ibid., p. 723

[104] Homer, C et al 'Community-based continuity of midwifery care versus standard hospital care: a cost analysis'. In *Australian Health Review* [Vol. 24, No 1] 2001., p. 85-93, p. 88

[105] ibid., p. 90, 91

4.10. It was put to the Committee that caseload midwifery, offering comprehensive at-home postnatal care, has the potential to save the ACT $1.826 million per annum based on a reduction of hospital stay to two days for all women except those who have had a caesarean section. Caseload midwifery also has the potential to significantly reduce the caesarean section rate through the reduction in obstetric interventions, resulting in further savings. [106]

4.11. Australia-wide, a reduction in the caesarean section rate in line with the WHO recommendation of 10-15% would save the Medical Benefits Scheme (MBS) $41.713 million per annum.[107]

4.12. There are also considerable national savings to be gained in reducing the number of ultrasounds performed during pregnancy. Evidence indicates that only one ultrasound is necessary, but on average, women have at least two. Halving the number of ultrasounds performed has the potential cost saving to the MBS of $19.3 million per annum.[108]

4.13. Women reported to the Committee that they felt pushed into medical testing, including ultrasounds, which they felt were not necessary. One woman reported to the Committee that she attended an antenatal clinic appointment quite firm in her own mind that she did not want or need to have an ultrasound, but ended up having one, she related that *once I was in the system, it was so easy for them to push me further and further into it*.[109]

4.14. A comment was also made to the Committee by a practitioner that *women like to have a picture of their baby*.

4.15. The Committee sees this as no reason why unnecessary medical testing should be performed. Clinicians need to be clear in their own mind that testing is strictly medically necessary, and

---

[106] Submission 13, Maternity Coalition, ACT Branch, p. 3
[107] ibid.
[108] ibid.
[109] Feedback received at maternity services consumer forum held on 10 November 2004

the culture that promotes the idea the women can have an ultrasound to 'have a look' at their baby must be actively discouraged.

4.16. Cost savings also need to be considered holistically, taking into account the social impact on women and their families. As one submitter pointed out, 'although I used the private hospital system for my first birth, thereby 'saving' the public health system the expense, I ended up 'costing' a lot in dealing with the trauma of a negative experience (community nurse visits, social worker, etc.)'[110].

ACT Government submission

4.17. Considering the cost involved in maternity services is essential to proper planning. Therefore, the Committee identified this as one of its terms of reference. The Committee was disappointed to note that the Government submission contained no analysis of the matter.

4.18. In fact, in the three short paragraphs addressing *cost benefits and different models of care*, the Government submission states:

> What is important in the ACT context is that women have access to adequate information to make informed decisions about the model of care that they use and participate in decision making about the interventions that may occur during birth.[111]

4.19. For women to make choices about models of care, there have to be choices to make. Women made it clear to the Committee that if they had the choice (as the Government suggests here that they do) that they would choose the 'cheaper' option of midwifery-led care.

---

[110] Submission 23, Ms Karen Silsby

[111] Submission 24, ACT Government, p. 29

4.20. As it is, the only model of public care available to the majority of women in the ACT is the model that has the highest rate of intervention use and is the most expensive model of care.

4.21. It is the Government's responsibility to offer a model of care that is safe and cost effective with low intervention rates and resulting in low caesarean section rates. The Committee is confident that once women have the choice to receive care in such a model that they will take it.

4.22. The Committee notes the recent media reports that NSW Health is considering publicly funded home births due to the pressure on birth services, consumer demand, the safety of home versus hospital births and that 'hospitals and health services that can no longer sustain the cost of high-intervention births when they're not necessary'.[112]

Recommendation 9

4.23. The Committee recommends that the Government undertake a cost benefit analysis of the models of maternity care services available in the ACT.

The cost to consumers

4.24. The cost of care during pregnancy can be high for consumers, particularly if they choose to receive care from an independent midwife, as this is not covered by Medicare or private health insurance.

4.25. For a woman during a normal pregnancy receiving shared care through a public hospital and her GP the cost is moderate, with the average co-payment being between $25 to $50.

---

[112] Robotham, J. 'Publicly funded home births for health women on agenda'. Sydney Morning Herald, 1 March 2004. www.smh.com.au/articles/2004/02/29/1077989435235.html

4.26. If she were to develop one complication needing specialist care, her costs can nearly double, although there is a very high level of care available through the public hospital free of charge.

4.27. Most concerning to the Committee is the lack of bulk-billing GPs in the ACT. Some women reported to the Committee that they did not have a regular GP prior to falling pregnant and found the frequency of visits and costs associated to be a significant strain on their budget. As previously discussed, this leads some women to forgo comprehensive antenatal and postnatal care altogether.

4.28. There must be options for care in place that do not require GP visits or that encourage more GPs to bulk-bill, to ensure that women are able to receive comprehensive care. With cost savings made in the provision of maternity services as a primary, not tertiary service, there is the potential to offer a model of care whereby service providers are paid to deliver 'episodes of care'. This is discussed further in the chapter *The way forward*.

Multiple tertiary level services

4.29. The ACT has a high level of hospital services providing maternity care, but there is relatively low usage in comparison to the level of services available. The Committee received three submissions raising this as a matter of concern.[113]

4.30. There is a danger that if such high levels of services are maintained, that all services will be lost which 'would be a significant retrograde step in relation to the provision of high quality maternity services for the people of the ACT'[114].

4.31. It was submitted to the Committee that given the relatively low usage which is not likely to increase with the trend of lowering fertility rates, and the cost of maintaining two high-level

---

[113] Submission 3, Professor Paul Gatenby, Submission 8, Women's Hospitals Australasia, Submission 10, Canberra Clinical School

[114] Submission 3, Professor Paul Gatenby

services, and increased demand for alternative services such as the CMP, the two public hospital maternity services should be consolidated and offered from The Canberra Hospital as the most economically viable solution.[115]

4.32. It is realistic to expect that usage will only continue to decrease in the short term with the decreasing fertility rate as previously discussed. 'The total number of births to ACT women is projected to slowly decline to 4000 by 2008 and by 2020 be 3700 each year.'[116]

4.33. Service levels offered at The Canberra Hospital should remain high due to its position servicing high-need mothers and babies in the ACT, southern-NSW, and the northern-Victorian region. The Canberra Hospital also houses a Centre for Newborn Care (CNC) and a Special Care Nursery, which collectively receive 600 admissions per year[117].

4.34. Certainly when the Committee visited TCH these services were stretched almost to breaking point, and the Committee commends the staff that work in the NICU, the CNC and Special Care Nursery for working as they do in difficult and cramped conditions.

4.35. On the contrary the special care nursery facilities at Calvary Hospital were under utilised when the Committee visited, although it was fully staffed.

4.36. It needs to be acknowledged that usage is not high enough to maintain high-level services at both sites, therefore decisions need to be made based on the level of hospital maternity services needed in Canberra and provision of services to women on the northside of Canberra that does not compromise their ability to birth in a location near their homes.

---

[115] Submission 8, Women's Hospitals Australasia., p. 8
[116] Submission 24, ACT Government., p. 9
[117] Submission 10, Professor David Ellwood., p. 2

4.37. The Committee does not put forth the argument that Calvary Hospital maternity services should be withdrawn, but does acknowledge the conflict in having a private company provide public services, and the competition to maintain high levels of services that therefore occurs. Senior executives of Calvary Hospital told the Committee that the public and private services in the hospital jointly subsidised each other and without the other neither would be very cost effective.

4.38. It was suggested to the Committee that the first step in the solution to this problem is to streamline services so that maternity services are not offered in the currently disjointed fashion. For example, at any one time in the ACT, three women could be undergoing a caesarean section in three different locations[118] (four if Queanbeyan is included in this equation).

4.39. This is a significant duplication and drain on resources, which has the overall impact of increasing the cost of maternity services.

4.40. The ACT has the luxury of being a small jurisdiction where transfer between hospitals does not take any longer than the preparation of theatre for a caesarean section.

> Preparation of a theatre for an emergency caesarean section takes a minimum of 30-40 minutes even when the woman is in hospital when a decision is taken that an emergency [caesarean section] is required. Women in labour at home for whom an emergency [caesarean section] becomes necessary can safely transfer to hospital during the time that the theatre is being prepared.[119]

4.41. While the maintenance of high-level tertiary services in the public system may reduce the choice of birth locations for women

---

[118] The Canberra Hospital, Calvary Hospital and John James Memorial Hospital: Private and public services at Calvary Hospital share facilities.
[119] Vernon , B and S Tracey. In Submission 20, Homebirth Australia, Attachment A. op. cit.

with medium- to high-risk pregnancies, the Committee is of the opinion that if women have the option of comprehensive at-home postnatal care, then hospital birth location will be less of an issue.

4.42. In the Committee's view, a streamlined maternity service should encompass all publicly offered services in the ACT, including hospital services, maternal and child health services and alternative birthing options so that these services are able to respond collectively to demands while maintaining high-level medical services to the region.

4.43. Any streamlined service will need to have a clearly defined governance structure that is focussed on providing the best outcomes and choices for women. The service should have the ability to define what services are offered in the public hospital system, including Calvary Hospital.

4.44. 'Throughput' at the hospitals should not be prioritised at the expense of alternative birthing choices for women. If services are compromised significantly because of low throughput, alternative strategies will need to be put in place.

Recommendation 10

4.45. The Committee recommends that all public maternity services in the ACT, including those offered at Calvary Hospital, be streamlined into a single service with an appropriate governance structure reporting directly to the Chief Executive of ACT Health.

Calvary Hospital

4.46. The Committee is seriously concerned about several issues raised regarding treatment offered at Calvary Public Hospital. Namely, the alleged refusal to perform tubal ligation, the inability of the emergency department to dispense emergency contraception, and the general feeling amongst staff that they are unable to promote family planning methods.

4.47. The Committee raised these issues with Calvary Hospital. The response from Calvary stated that 'Calvary's policies and procedures reflect the 'Code of Ethical Standards for Catholic Health and Aged Care Services''[120]. Copies of brochures given to postnatal women were also provided to the Committee.

4.48. The Committee was extremely concerned at the response from Calvary Health Care ACT, as it was clear that patients seeking public services were having a particular religious ethos imposed on them both through services provided or not provided as the case may be, and the omission of balanced information on contraceptive care.

4.49. The Minister responded to the letter received by the Committee from Calvary Health Care stating,

> There are a number of agreements that cover the arrangements between the Territory and Calvary Healthcare ACT in relation to the provision of public health services. Many of these agreements pre-date ACT self-government.
>
> Under these arrangements services such as abortions, tubal ligations and vasectomies are only performed at The Canberra Hospital. These arrangements preceded ACT self-government and do not affect access to publicly funded reproductive health services. The Canberra Hospital provides a full range of reproductive health services for the people of the ACT.[121]

4.50. The community has the right to expect a standard in the provision of public hospital services, including the right to information and treatment not based on a particular religions ethos.

---

[120] Correspondence from Ms Deborah Clark, a/g Chief Executive, Calvary Health Care ACT, 14 January 2004.

[121] Correspondence from the Minister for Health dated 10 February 2004

4.51. As discussed later in this report, there is a need to have standard policies and practices across the public health system to ensure all women have access to a basic common standard of treatment and information.

4.52. The Committee is of the opinion that the argument put forward by the Minister further supports the need for a streamlined maternity service with consistent policies, practices and procedures as recommended above.

4.53. Given that the Minister states that current policies precede ACT self-government, the Committee believes that it is timely to review these policies.

5. Consumer involvement

5.1. The Committee is of the firm belief that consumer involvement in health care services is essential in the provision of relevant, appropriate services that meet the needs of all consumers.

5.2. This is particularly important in maternity care services because, as discussed, women (consumers) are an active part of the service provision rather than passive recipients of a service and it is essential that they are able to birth in an environment that is responsive to their needs.

5.3. It has been seen in 'New Zealand, where a genuine partnership model exists between women and midwives not only in relation to individual care but in all aspects of consultation and creation of services, there has been an improvement in maternal and neonatal outcomes'[122].

5.4. Consumers must be encouraged to give feedback, which must then be utilised by the service because

> consumer feedback is a vital part of a system which helps to save lives and prevent injury. … The consumer experience of the health system extends beyond the clinical aspects of care and includes each interaction with staff from health services [and] is one of the most basic levels of consumer participation in health services.[123]

5.5. Feedback mechanisms must be incorporated as part of routine service provision. Once women return home with a new baby it is difficult for them to then find the time to give comprehensive feedback. It is also important that mechanisms are in place to allow women to give feedback some time after their birthing experience, having had time to process and consolidate their experience.

---

[122] Submission 12, Australian College of Midwives Inc., p. 10

[123] Submission 9, Ms Darlene Cox, p. 5

5.6. The Committee is concerned, from anecdotal reports, that when women do give feedback to the Government it is ignored or dismissed. By ignoring this valuable information, the opportunity to improve the services is lost.

5.7. The Committee is aware, however, that ACT Health does have new consumer feedback standards to 'improve the quality and safety of health care in the ACT.'[124]

5.8. The Committee wishes to stress that these standards must be implemented in such a manner that values and acknowledges consumer participation in the feedback mechanisms of the health care system. This must be clearly communicated to all staff in ACT Health, including those in policy areas who may not necessarily have direct contact with consumers.

5.9. The feedback from consumers to this inquiry is very clear that women want an expanded CMP and access to independent midwives. The Committee is concerned that the Government is ignoring the feedback of consumers through their inability to find creative solutions. This appeared evident throughout the Government submission, which was focussed on the needs of the tertiary hospital service, even when acknowledging the benefits of other models of care.

5.10. However, this issue appears to be wider than just the area of maternity services. It was submitted to the Committee that:

> there is a strong need for the development of a consumer participation strategy across ACT Health. Each facility and service is developing individual consumer participation strategies, with consumer involvement, but there is a need for a broader policy and framework across the health portfolio.[125]

---

[124] ACT Health. 'Listening and learning: ACT consumer feedback standards'. August 2003

[125] Submission 9, Ms Darlene Cox, p. 4

5.11. The Committee agrees with this. The Committee identified *strategies for involving consumers in the planning and provision of maternity service* as a key term of reference that it wanted to investigate. In short, it has discovered that there are very few. Indeed, the Government submission addressed this reference in three sentences:

> It is also important that consumers participate in policy development and planning processes. TCH and Calvary Hospital both have maternity services forums that are attended by consumer representatives.
>
> In recognition of this, the Government will establish a Consumer Advisory Committee on Maternity Services to provide advice on Maternity Services in the ACT.

5.12. While the Committee was pleased to see that the Government intends to establish an advisory committee, it has some concerns about the membership and direction of the committee.

5.13. For example, an advisory committee formed during the life of this inquiry has a membership of ten individuals representing the hospital and/or other medical service and only five individuals representing consumer and midwifery interests.

5.14. The committee's framework is set within the ACT Health *clinical* services plan. The Committee is extremely concerned about this leading to the continued dominance of clinical focus over maternity services.

5.15. Despite assurances[126] from the Minister and the Chief Executive of ACT Health that this does not necessarily mean that all services will be adopting a clinical services approach, the Committee is not convinced. A 'clinical services plan' is just that, and the Committee is of the opinion that clinical services should be

---

[126] Proof transcript of evidence, 26 February 2004, p. 36

a component of a community health plan and not the other way around.

5.16. The Committee is not convinced that with the current membership of this advisory committee that it will be able to give independent advice to ACT Health for policy development. Further it is of the opinion that it will be no more than an internal working group aimed at maintaining current models of service provision.

5.17. The Committee has identified the need for a ministerial advisory council that is independent from ACT Health to advise the Minister on the policy direction for maternity services. This council should be comprised of key community, consumer and professional (including midwives) representatives. The professional representation should not outweigh the collective community and consumer representation.

5.18. To assist in broadening the focus and ensuring policies are woman-centred, the Office for Women within the Office of Multicultural and Community Affairs of the Chief Minister's Department should be resourced to provide secretariat support.

Recommendation 11

5.19. The Committee recommends that a Ministerial Advisory Council on Maternal Health be established comprising of consumer and community representatives to advise the Minister on the policy direction for maternity care services with a view to developing a comprehensive model of maternity care that is responsive to and meets the needs of consumers.

5.20. Further, the Committee recommends that the Office for Women within the Chief Minister's Department be resourced to provide secretariat support to this Council.

5.21. There is also the need to convene a working group on maternal and early childhood health to foster relationships

between key stakeholders, to develop cooperative and consultative practices across professions, and to involve consumers in the development of policies and procedures to ensure they are relevant and meet the needs of consumers.

5.22. The Committee sees that this working group would also take leadership of the detailed implementation of the policy direction defined by the Ministerial Council.

Recommendation 12

5.23. The Committee recommends that a working group on maternal and early childhood health care be established comprising of at least the following:

- **ACT Division of General Practice;**
- **ACT Health;**
- **ANU Medical School;**
- **Australian College of Midwives Inc.;**
- **Consumers;**
- **Maternal and child health nurses;**
- **Maternity Coalition;**
- **Midwives (independent and publicly employed);**
- **Private and public obstetricians;**
- **Private and public paediatricians;**
- **University of Canberra nursing school; and**
- **Women's Centre for Health Matters**

Information dissemination

5.24. Individuals and submissions to this inquiry told the Committee that there is a lack of comprehensive information to

inform and guide women in making choices throughout their pregnancy and in preparation for giving birth.

5.25. There is an urgent need for comprehensive information to be produced that covers aspects of pre-pregnancy care through to antenatal care options. This was raised by the ACT Division of General Practice (ACTDGP):

> For a population that boasts the highest level of education, which presumably translates into a population that rightly expects to be informed, it is a paradox that women who have their children in Queanbeyan have access to information that has been developed by their state government specifically for their care during pregnancy.
>
> There is an expectation that 'best practice' in medicine involves providing consumers with up to date written information that can be taken away by the consumer and read, and so allow informed decisions to be reached. It is also considered good practise in this age of increasing litigation to provide written information, as it is well recognised that patients are understandably unable to recall many items discussed in a consultation.[127]

5.26. Consumers at several forums also raised this issue. Networks of friends and relatives are often the source of information about care options, however this information is often unreliable, based on dated experience, or unhelpful. As one woman told the Committee *once you become pregnant, everyone has plenty of advice, not all of it useful or wanted and certainly most of it is confusing for a first-time mother*.[128]

5.27. The Committee is also concerned that information be provided about the impact of interventions and which models of care minimise intervention.

---

[127] Submission 6, ACTDGP, p. 8

[128] Consumer forum held on 3 November 2003

5.28. Women want information that is published in written form and on the internet but also easily translated into oral form so that it can be distributed in culturally and linguistically diverse communities through bilingual educators, elders and any other forum that these communities think are appropriate.

5.29. It was pointed out to the Committee that merely translating written information into a variety of languages is not necessarily the best way for women to understand their options. For example, the Committee was told that in one particular cultural group, being able to afford specialist care is a mark of wealth, and midwifery care is seen as something only for 'peasants', whereas in fact community-based midwifery care would be the most appropriate form of care for this group of women who are often isolated from their traditional female supports.

5.30. It is important therefore for bilingual community educators and others involved in multicultural communities to be able to teach communities about the most appropriate care options.

5.31. The ACT is also perceived as having a largely 'transient' population. People tend to move here for work and if they stay only a few or many years, may not have the traditional family support networks, nor may they have large networks of friends in similar life circumstances (i.e. commencing child rearing).

5.32. The Committee is concerned that the choice in antenatal care is largely only a 'middle-class' option, because there is a lack of comprehensive published information, and because it relies so much on personal information networks.

5.33. For example, although the Canberra Midwifery Program identifies a range of 'at risk' clients as being in a target group, such as teenage mothers, the need to book into the program before five weeks of pregnancy essentially excludes them. This form of care is therefore only available to women who have comprehensive pre-pregnancy care and planning.

5.34. The Women's Centre for Health Matters (WCHM) does produce a very good brochure, titled *Having a Baby in Canberra*, which outlines available options. However the WCHM does not have the resources available to produce and maintain more comprehensive information sources.

5.35. The Government said in its submission:

> The Government has identified that there is currently a limited capacity to coordinate this information, ensuring that it is regularly updated and that women know what information is available to them. The Government has identified this as an area that would benefit greatly from increased coordination and has establishing [sic] a process for the development of a coordinated package of information for women about pregnancy, birth and postnatal care. This process should involve Obstetricians, GPs, consumer representatives and staff at Public and Private Hospitals and other relevant stakeholders.[129]

5.36. While the Committee sees this as commendable, it would like to see an actual commitment from the Government to produce this information, not merely an identification of the need – something that the Committee easily identified within the first half-hour of talking to consumers.

5.37. This resource should be produced in consultation with consumers and key stakeholders.

Recommendation 13

5.38. The Committee recommends that the Government fund the ongoing production of comprehensive information relating to pregnancy and birthing and postnatal care options available to women in the ACT to be available from all health care settings, public and private, in the ACT.

---

[129] Submission 24, ACT Government, p. 28

5.39. The Committee further recommends that the Government fund bilingual community educators to distribute this information in a relevant and appropriate manner.

Communication

5.40. Communication between health consumers and providers is essential for ensuring that health services are provided in a manner that meets the needs and expectations of consumers. This is particularly important in maternity services as the consumers, the birthing mother, are active participants in the process rather than passive receivers of a health service.

5.41. Overwhelmingly, the Committee heard from consumers that maternity services are currently not driven by or focussed on women. They felt that currently the policy is directed more by medical indemnity insurance or hospital administration needs than by the needs of women.

5.42. The Committee also received feedback that women were disillusioned with consumer feedback processes run by the Government – even when feedback is positive, action seems to be blocked by the bureaucracy.

5.43. It was also reported that within the health system communication is dysfunctional. The ACT Division of General Practice (ACTDGP) is calling for systems to be put in place to assist obstetricians, midwives and GPs to communicate and provide uniformity for patient records. For example 'there are many accounts of GP's not being informed about foetal demise or a change in pregnancy care which can cause distress for the woman when they attend their next GP appointment'.[130]

5.44. The Committee hopes that a streamlined service and alternative systems discussed previously in this report will alleviate this problem. As the ACTDGP points out, 'the best

[130] Submission 6, ACTDGP., p. 7

standard of care for the woman and child is only possible if all health providers work together and communicate effectively'[131].

5.45. The Committee agrees with this, but recognises that a great deal of work needs to be done to not only improve communication, but to improve the recognition between the professions of the professional standing of midwives so that all professions are empowered to work collaboratively.

[131] ibid., p. 5

6. An issue of insurance

6.1. The issue of access to medical indemnity insurance has created a crisis in the maternity workforce – a crisis because obstetricians are leaving the profession, independent midwives are unable to practise and women's birthing choices are severely limited – in some opinions unsafely limited. '…the crisis in this area has robbed women of choice in terms of their preferred practitioner whether that is an independent midwife or obstetrician.'[132]

6.2. The Committee is aware that both the Federal and Territory Governments have made significant efforts to improve the situation regarding medical indemnity insurance for doctors both in terms of legislative and financial assistance. The Committee is also aware that the same level of effort has not been made on behalf of midwives.

6.3. In the words of one submitter:

> 'The [Australian College of Midwives Inc.] is concerned to see that the ACT government has responded to the current indemnity crisis solely with strategies for supporting doctors and restoring the status quo in maternity services delivery in the Territory. Rather it could be an opportunity to review the Territory's services, and examine what evidence based options exist for lowering the risks of adverse outcomes and the risks of women resorting to litigation in the courts in their grief over adverse outcomes.'[133]

6.4. It is well understood that there are a significant number of obstetricians leaving the profession due to the impact of medical indemnity insurance.

---

[132] Submission 14, Women's Centre for Health Matters, p. 3

[133] Submission 12, Australian College of Midwives Inc., p. 11

6.5. The strategies to reform the provision of maternity services as discussed in this report are aimed at improving birth outcomes by creating an evidence-based system. A system resulting in improved birth outcomes, with lowered intervention rates and lowered emergency caesarean section rates will also lower litigation due to adverse outcomes. The Committee hopes that, in time, this will improve the standing of the ACT in terms of insurance premiums for both doctors and midwives.

6.6. The 1999 Senate Committee report *Rocking the Cradle*[134] recommended that the Federal Government establish an independent inquiry into medical indemnity and litigation to look at alternative approaches to compensation payments. The Government of the day did not support this recommendation.

6.7. The Federal Government needs to revisit this idea. Many jurisdictions have 'no fault' compensation schemes, including New Zealand and several states in the USA. While in New Zealand, the Committee was told that this is why insurance premiums for doctors and midwives were at a manageable level, instead of in the tens of thousands of dollars as they are here.

6.8. The Committee notes that there are increasing political and professional calls for Australia to introduce a 'no-fault' insurance scheme, similar to that in place in New Zealand.[135]

Recommendation 14

6.9. The Committee recommends that the Government lobby the Federal Government to find alternative approaches to the medical indemnity and compensation schemes currently operating in Australia to benefit all health care practitioners, including midwives.

---

[134] Senate Community Affairs Reference Committee. op. cit., p. 184

[135] *The Canberra Times*, p. 11, 29 March 2004 and p. 20, 31 March 2004

6.10. The Committee is aware that the ACT Insurance Authority (ACTIA) considers that low-intervention births provide the lowest litigation risk. The General Manager of ACTIA, Mr Peter Matthews, indicated to the Committee that he would be supportive of models that lowered the intervention in births.

6.11. This is also recognised in other jurisdictions:

> The West Australian insurance authority … *Risk Cover WA* is convinced that the risk profile of birth is reduced when normal birth is kept that way via midwifery care and in fact when it agreed to self insurance it did so on the proviso that the program remain in the community and not under hospital management as placing healthy women within the acute setting heightened the indemnity risk.[136]

6.12. Mr Matthews also told the Committee that following lengthy negotiations undertaken internationally, reinsurance was not able to be obtained to cover midwives performing home births. Once home births were removed from the equation, insurance coverage is readily available. He agreed that this was not based on evidence, but rather on a perception of risk obtained by the insurance companies.[137]

6.13. Mr Matthews pointed out to the Committee that insurance companies are not looking for business so there are no incentives for them to change the packages that they currently offer, so therefore ACTIA was looking at different ways of structuring how it insures and reinsures Government.

6.14. The Committee feels reassured following the discussion with Mr Matthews that there is a solution to the insurance difficulties facing independent midwives, and the proposals put forth in Chapter 8, *The way forward* are possible.

---

[136] Submission 20, Homebirth Australia, p. 8

[137] Proof transcript of evidence, 26 February 2004

6.15. The Committee is strongly of the view that the Government needs to accept the evidence that community-based care reduces litigation risk, and put policies in place that have a community, not clinical focus.

7. Workforce supply

7.1. The midwifery and obstetric workforce in Australia is facing increasing shortages. Doctors are either not training as obstetricians or leaving obstetric practice due to the pressures of the medical indemnity insurance situation. The limitations on independent midwives practicing and a shortage in appropriate training courses are also limiting workforce supply.

7.2. Like many other professions, the profile of midwives is ageing and the current opportunities within the profession are dissuading young midwives from entering. Currently there is a shortfall of 700 midwives across NSW and the ACT[138].

7.3. The Government projects that although there are few midwifery vacancies in the obstetric model at present, over the next five to fifteen years there will be a large shortfall of midwives across the board which will not be met by the current numbers being trained. The Government also proposed in its submission that the popularity of midwifery-led care may lead to more midwife: doctor team models of care.[139]

7.4. The Committee is of the opinion that with a change in structures that will allow midwives to practise autonomously that this will encourage more people to enter the profession. It will also ease the burden on obstetricians.

7.5. The Committee is also aware that there is a significant GP shortage in the ACT.

7.6. The provision of universal midwifery care to all women has the potential to significantly improve the situation regarding GP shortage through midwives providing care that is currently provided by GPs.

---

[138] Submission 13, Maternity Coalition., p. 5

[139] Submission 24, ACT Government, p. 30

7.7. Proper partnerships between independent midwives, GPs and obstetricians have the potential to significantly improve the workforce capability of both GPs and obstetricians, and solve many of the current workforce supply issues.

Legislative Framework

7.8. Currently midwives are regulated under the *Nurses Act 1998*. They are required to:

- be registered as a general nurse;
- have completed a relevant training course and qualified to practise as a midwife; or
- be recognised to practise as a midwife in a jurisdiction covered by the Mutual Recognition Act.[140]

7.9. Currently the Nurses Board of the ACT is responsible for the registration and enrolment of nurses, and the supervision of education and standards. Midwives are subsumed into these responsibilities, and the main emphasis of the Board is on nursing regulation.

7.10. Other countries, such as New Zealand and the United Kingdom recognise that it is not necessary for midwives to first be nurses and, as discussed below, Australian education institutions are now recognising this, supported by the midwifery profession.

7.11. It is inappropriate for nursing to continue to regulate midwifery practise, although until midwifery becomes re-established, particularly in a small jurisdiction such as the ACT, the Committee recognises that the regulatory function will be combined.

7.12. The Committee was advised by the Chair of the Nurses Board that the Health Professionals Bill 2003 will rectify this issue,

---

[140] *Nurses Act 1988*, S 12(2)

but not having seen the regulations under this Bill at the time of writing this report, the Committee makes the following recommendation.

Recommendation 15

7.13. The Committee recommends that the Nurses Board be dissolved and a Midwives and Nurses Board established in its place until such time that the midwifery workforce is able to support its own board. Until that time, the Midwives and Nurses Board should include professional and consumer positions to represent the interests of midwives adequately.

7.14. The Health Professionals Bill 2003 has been introduced into the Assembly, and the successful passage of this Bill will repeal the Nurses Act. It is expected that the regulations under the Bill will continue to regulate midwifery as per the current provisions in regards to nursing.

7.15. The regulation of midwifery must be legislated in such a way that gives autonomy to midwives to regulate their own profession, and gives higher recognition to the professional standing of midwives.

7.16. It is not necessary that midwives be first required to be registered nurses, as there are many direct entry education courses that lead to a stand-alone midwifery qualification, discussed below. This requirement as currently stands in the Nurses Act should not be included in the regulations.

7.17. It is important that midwives be recognised as a distinct professional body. Should the Health Professionals Bill fail to be passed in the Assembly, separate legislation regarding the regulation of midwifery should be prepared to recognise midwifery as a profession distinct from nursing.

7.18. However, the Committee sees no reason why the Bill should fail to pass, its intent creates a more rigorous health professional

board process, including the requirement of community representation on boards.

Recommendation 16

7.19. The Committee recommends that the regulations under the Health Professionals Bill recognise midwifery as a separate profession not subsumed within nursing.

7.20. In the event that the Health Professionals Bill is not passed by the Assembly, the Committee recommends that the Government introduce a Midwives Bill recognising midwifery as a profession distinct from nursing.

7.21. Under Section 75 of the Health Professionals Bill, registered health professionals indemnity insurance is to be regulated by the regulations under the Bill to be set by the Minister. Currently independent midwives operating without medical indemnity insurance personally assume that risk and communicate it to their clients. A requirement to hold insurance would effectively eliminate the ability of independent midwives to practice.

7.22. The inability of independent midwives to gain indemnity insurance means that, in effect, insurance companies are regulating midwifery practice.

7.23. A similar debate was recently held in the United Kingdom:

> The UK Nursing and Midwifery Council (NMC) recently canvassed professionals and the public about including a clause in the Code of Professional Conduct requiring that all nurses and midwives have professional indemnity insurance. Based on the response generated, and the debate between proponents and opposers of mandatory [professional indemnity] insurance, the Council concluded that indemnity insurance would be

recommended, but would not be a requirement for independent practitioners to practise their professions.[141]

7.24. If the regulations under the Bill require indemnity insurance to practise, then the Government has a responsibility to ensure that insurance products are available for all health professionals to allow them to continue to practise. If the Government is unable to do this, then the regulations must allow professional registration boards to regulate the issue of indemnity insurance.

Recommendation 17

7.25. The Committee recommends that the regulations under the Health Professionals Bill do not require health professionals to hold medical indemnity insurance, and instead the relevant health professional board be responsible for applying reasonable professional standards.

7.26. The Health Professionals Bill does include the requirement to have community representation on boards, and the Committee is of the opinion that this is a positive move at increasing consumer involvement.

Education and training

7.27. Midwifery education in Australia is disjointed. Currently in the majority of Australian universities offering midwifery education, it is offered as a graduate diploma to individuals who have already undertaken a nursing undergraduate degree and have some (at least one year) workforce nursing experience.

7.28. This means that before qualifying, midwives have a total of five years combined formal education and work experience. This is in conflict with what is offered in other counties, namely New Zealand and the United Kingdom, where midwives undertake a

---

[141] Johnston, J. 'Commentary – The Insurance dilemma in Australian midwifery regulation'. Paper presented at the *6th International Conference on the Regulation of Nursing and Midwifery*, Melbourne, 26-28 October 2003.

three-year undergraduate qualification and then are able to practise as professionals in their own right – not subsumed into nursing.

7.29. Two universities in South Australia and Victoria have commenced a three-year undergraduate bachelor of midwifery courses. In the first year that these courses were advertised, 600 and 1000 people applied for 40 and 60 places respectively[142].

7.30. In light of this, the Committee is confident that given scope to practise in a rewarding manner, and with the introduction of more independent degrees, then the pending workforce shortage can be averted.

7.31. The Government is concerned that a direct entry midwifery course 'may help to address this shortfall in the medium term, however it may reduce the current flexibility of our workforce that requires midwives to become Registered Nurses in the first instance'[143].

7.32. Acknowledging that there is also a significant worldwide shortage in registered nurses, the Committee does not agree that limiting training opportunities for midwives will go any way to addressing this shortfall. Rather, it was suggested to the Committee that if midwives are allowed to practice appropriately in the full scope their professions, that this would actually free more nurses to practise in the acute sector.[144]

7.33. It was commented to the Committee that The Canberra Hospital currently tries to offer job opportunities to all midwifery graduates from the University of Canberra, and the hospital would not be able to offer this to an increase in graduates.

7.34. The Government is not responsible for placing all ACT university graduates in a job, but should ensure that the

---

[142] Submission 12, Australian College of Midwives Incorporated., p. 13
[143] Submission 24, ACT Government, p. 30
[144] Proof transcript of evidence, 26 February 2004, p. 25

environment is such that employment opportunities are available. With the worldwide shortage of midwives the Committee is confident that appropriately trained midwives would not have difficulty in gaining employment.

7.35. However, wider employment opportunities need to be available, such as the ability for independent midwives to practise.

7.36. Limited opportunities to practise means that 'we are failing to avert the impending crisis in the midwifery workforce looming 5-7 years down the track'[145].

Recommendation 18

7.37. The Committee recommends that the Government encourage and support local tertiary education institutions to provide three-year undergraduate bachelor of midwifery programs.

General Practitioner education and training

7.38. Given that GPs are currently responsible for a large proportion of antenatal care in the shared care model, it is essential that they have appropriate training to ensure that they are aware of developments in the area and of services available and also have the ability to network with their peers in other fields of expertise.

7.39. It was submitted to the Committee that 'many areas in Australia have programs in place that require GPs to undergo regular training and accreditation by local obstetric and gynaecology departments as a prerequisite for participation in the shared care program' and that 'GPs would appreciate formal obstetric and gynaecology upskilling opportunities being developed to assist them in keeping abreast of changes in the area'[146].

---

[145] Submission 12, Australian College of Midwives Inc., p. 13

[146] Submission 6, ACTDGP., p. 7

7.40. The ACTDGP also suggested that any training be jointly held with GPs, midwives and specialist obstetricians, but also practise nurses who would be able to deliver some of the antenatal care to reduce pressure on GPs.

7.41. The issue of training for obstetric GPs was also raised at a consumer forum, with women expressing the need for more GPs to be trained to support women planning a home birth.

7.42. The Committee finds the idea of joint education sessions commendable, however would be concerned about these being run exclusively by a tertiary hospital facility – again this maintains the focus of maternity care in the hospital setting.

7.43. The Committee would like to see more support given to independent midwives to enter joint partnership practice with GPs to deliver midwifery services, and for GPs to recognise midwife-led care in the shared-care model: and more education for GPs on the role and ability of independent midwives to foster GP/midwife shared care arrangements.

8. The way forward

8.1. The Committee is seriously concerned that the provision of care in the ACT is not based on best-practice evidence to the cost of women. This chapter sets forth the systemic changes that need to take place in the ACT.

8.2. The Committee believes that there is a need for an integrated model of maternity care that:

1. Supports best practice in maternity care.
2. Reduces intervention rates.
3. Provides ACT women with the option of receiving primary care from a known carer on a one-to-one caseload basis, based on her needs, and the needs of her family, before, during and after birth.
4. Provides safe birthing facilities.
5. Is free and available to all women, regardless of personal circumstance.
6. Considers consumer feedback as an integral part of service delivery.
7. Allows midwives to act as independent practitioners; and provides all ACT women with the option of care provided by a known midwife.
8. Fosters partnerships between practitioners to work collaboratively.

8.3. Submitters support an integrated model of care, including the ACTDGP:

> …an integrated model for maternity care in the ACT aims to develop an inclusive rather than fragmented system of maternity care. It acknowledges that women have very different preferences and that they should be

> able to choose whatever model of care is most suited to their situation and needs. It seeks to value all members of the team of health providers involved in maternity care and proposes that they all work together cooperatively to ensure the best outcome for mother and child.[147]

8.4. There is also a need for non-hospital birthing locations and a system where independent midwives can practise fully, with admitting rights to hospitals.

8.5. The Committee understands that the system recommended below will require an initial capital injection and significant infrastructure changes. It will take time to fully implement, as it will require changes in the composition of the current midwifery and obstetric workforce.

8.6. However the Committee is of the opinion that it will create a system that will make the ACT an employment location of choice, particularly for midwives. It also believes that collectively, the recommendations made in this report can result in integrated and equitable delivery of maternity services that is cost effective and delivers safer outcomes for women and their babies.

8.7. The system recommended by the Committee is as follows.

8.8. Under the streamlined maternity service as recommended earlier in this report, an administrative arm for managing community maternity services should be established. This must be separate from hospital/clinical administration and could incorporate the administration for the CMP, which as discussed earlier must be separated from TCH administration as a matter of priority.

8.9. Independent midwives and general practitioners offering obstetric services should be given admitting rights to hospitals and birthing units (discussed below). ACT Health should offer an

---

[147] ibid., p. 7

agreement to independent midwives to afford them admitting rights and also allow the department to offer them indemnity cover such as that currently offered to Visiting Medical Officers.

8.10. The Committee believes that it is reasonable that independent practitioners (whether they be midwives, GPs or obstetricians) admitting to hospitals be required to be present to monitor their clients throughout the labour and for a period of time following birth.

8.11. This would mean that the staffing needs for hospital delivery wards would be reduced, needing only a small core group of staff midwives to support women who would be primarily supported by their chosen primary carer.

8.12. This would create a workforce shift, allowing some midwives currently working in the hospital environment to work independently, some to remain in the hospital and others to staff primary birthing units as discussed below.

8.13. The significant budget savings that this would create should be moved in to a general maternity budget so that independent practitioners offering public services can be paid for 'episodes of care' (i.e. first, second and third trimester, labour, birth and postnatal care). This will require a contractual relationship to be established between independent practitioners and ACT Health for the provision of services, but until such time that midwifery services are recognised by Medicare and private health insurers then there is no other way to ensure the cost is not passed directly to consumers for independent midwifery services.

8.14. The Committee would like to make it clear that this must be a contract for episodes of care, not an employment relationship, as the practitioner should be bound to serve her/his client within a reasonable scope of practice established by the profession, not the department or hospital.

Recommendation 19

8.15. The Committee recommends that the Government develop and implement a program for systemic changes in the provision of ACT maternity services as outlined in paragraphs 8.8 to 8.14 of this report.

Birthing units

8.16. Throughout this report, the Committee has expressed concern about the provision of services for normal birth being located in the tertiary hospital setting. Therefore the Committee is of the opinion that it is imperative that low-technology primary birthing units be established as a matter of priority.

8.17. As already discussed, primary birthing units operate successfully in countries such as New Zealand and the Netherlands and have the capacity to significantly reduce the intervention rates in birth.

8.18. Therefore, two facilities (one on the northside and one on the southside of Canberra) should be purchased and/or established as primary birthing units. These units should have low levels of technology (i.e. no capacity to perform interventions such as epidurals), but should have alternative methods of pain management available for each birthing suite such as birthing pools. The units need to be run independently of either hospital, but with policies and procedures in place regarding transfer.

8.19. While administratively these units may need to be considered part of TCH for the purposes of funding, they must not operate under hospital policies – the governing policies must be written based on best-practice evidence regarding safe care of women in childbirth, in consultation with midwives.

8.20. The Committee is aware that TCH, the medical school and ACT Health are concerned about 'throughput' and the accreditation of TCH as a tertiary facility. The Committee shares

these concerns as it would not wish to see the loss of these services to the ACT and region.

8.21. However, as discussed previously, it may be necessary to consider the service across several campuses, with secondary and tertiary services delivered at the hospitals and primary services delivered at the birthing units. The Committee believes that the primary birthing units will offer a unique training opportunity for midwives *and* doctors in normal birth, and as this is the ideal for all women and practitioners to perform, it should not undermine the viability of training.

8.22. The Committee is concerned that because of the lack of low-technology centres, doctors and midwives are not being trained appropriately in their own skills without a heavy reliance on technology, which is only of detriment to them if they end up working in an environment where such high levels of technology are not available.

8.23. How are practitioners to recognise the abnormal if they are not fully trained in the normal? The Committee believes that the establishment of primary birthing units will not only improve outcomes for women but also enhance training for students.

Recommendation 20

8.24. The Committee recommends that two independent primary birthing units be established as outlined in paragraphs 8.16 to 8.23 of this report.

9. Conclusion

9.1. The provision of maternity services is an integral part of any health care system. However, maternity care encapsulates more than traditional health care. Pregnancy and childbirth is a normal part of life and only in the minority of cases do women need medical intervention.

9.2. Unfortunately the normalcy of this event seems to have been lost within our current system of providing care in an acute setting.

9.3. In this report, the Committee has discussed the need for cultural change regarding the provision of services, the status of midwifery, and the expectation of a 'pain free' experience that leads to abnormal birth.

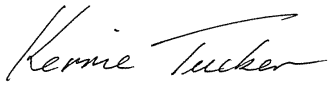
9.4. The Committee has discussed and proposed a new way to provide maternity services, which includes moving normal birth out of the tertiary hospital setting and the need for greater partnerships between practitioners and between practitioners and consumers.

9.5. The Committee has also discussed concerns about the erosion of midwifery practice. With independent midwives essentially unable to practise, and obstetricians leaving practise in ever-increasing numbers outcomes for women and babies will suffer.

9.6. The majority of women are not able to access one-on-one midwifery care and this is against best practice in maternity services, and possibly dangerous.

9.7. The Government, doctors, midwives and consumers will need to work collaboratively to change the provision of maternity services. Not only is this essential for better outcomes for women and babies, but the Committee believes that the healthcare system cannot afford to continue to provide such high levels of services to normal health women.

9.8. The Committee looks forward to the day when all women can be confident that their maternity care is based on best practice evidence and delivering the safest possible outcomes.



Kerrie Tucker MLA
Chair
15 April 2004

Appendix 1 – Submissions received

1 Dr Julie Smith

2 Australian Breastfeeding Association (ACT/Southern NSW Branch)

3 Professor Paul Gatenby, Associate Dean, Canberra Clinical School

4 Meredith Wilson and Chris Ballard

5 Confidential

6 ACT Division of General Practise

7 Ms Clare Wynter

8 Women's Hospitals Australasia

9 Ms Darlene Cox

10 Professor David Ellwood, Canberra Clinical School

11 Ms Sue Hoffmann

12 Australian College of Midwives Incorporated

13 Maternity Coalition (ACT Branch)

14 Women's Centre for Health Matters

15 Confidential

16 Ms Dawn Kamprad

17 Ms Julienne Kamprad

18 Ms Vanessa Smith

19 Ms Michelle Lines

20 Homebirth Australia

21 Ms Joan Garvan

22 Ms Sue Pedder

23 Ms Karen Silsby

24 ACT Government

Exhibits received

1 Ms Meredith Wilson

2 Chris Ballard

3 Ms Joan Garvan

Appendix 2 – Public hearings and events

On 3 November 2003

The Committee heard from twelve consumers at a forum held in partnership with the Women's Centre for Health Matters.

On 10 November 2003

The Committee heard from eighteen consumers at a forum held in partnership with the Women's Centre for Health Matters.

On 6 December 2003

The Committee heard from twelve consumers at a forum held in partnership with the Health Care Consumers Association.

On 26 February 2004

The Committee heard from the following witnesses at a public hearing:

For the ACT Insurance Authority:

- Mr Peter Matthews

For the Nurses Board of the ACT:

- Ms Mary Kirk

The Committee also heard from the Minister for Health, Mr Simon Corbell MLA, accompanied by the following officers for ACT Health:

- Mr Tony Sherbon;
- Ms Susan Killion

The Committee also heard from one witness in camera.

Appendix 3 – Committee trip to New Zealand

On 16 to 19 February 2004 the Standing Committee on Health undertook an investigative trip to Christchurch and Wellington, New Zealand, in regards to its inquiry into Maternity Services in the ACT. Issues raised are largely addressed in the bulk of this report.

The Committee was treated with generous hospitality and kindness by individuals and organisations who went out of their way to spend a significant amount of time with it, for which the Committee is indebted.

Monday 16 February 2004

The Committee met with Ms Karen Gulliland, CEO, Ms Norma Campbell, Ms Norma Campbell, and Ms Bronwyn Pelven.

The College was extremely generous with its time and the Committee thanks them for this. The time spent with the College gave the Committee a firm grounding in the current maternity care system, its political and social history, difficulties facing the workforce and the future direction of the system in New Zealand (NZ).

The College gave the Committee an overview of the operation of maternity services in NZ, including the professional support and review structures available to midwives.

The Committee also met with consumers, educators, new graduates and midwives, both independent and core (hospital based). This meeting reiterated to the Committee how important the system is to women, both in terms of improved birth outcomes and improved social outcomes, and community engagement.

Tuesday 17 February 2004

The Committee met with educators and consumers at the Christchurch Polytechnic Institute regarding the three-year Bachelor of Midwifery degree program. The Committee was

interested to note that students are selected to enter the degree program by an interview panel, including consumers.

The Committee then visited an independent midwifery practice and met with midwives. The Committee noted that the midwives expressed a great degree of respect for other professionals working in maternity services, but that professional working relationships often depended on the individual midwives and other professionals.

Although independent midwifery practice requires significant personal commitment, it was obvious to the Committee how rewarding it can be.

The Committee then met with managers from the Christchurch Women's Hospital. The issue of professional working relationships was again raised, in particular the need for professionals to work together and present a united front to combat rising intervention rates.

Wednesday 18 February 2004

The Committee met in Wellington with the Select Committee on Health for the New Zealand Parliament. All members of the Select Committee were supportive of the continuation of the current system, although there were some concerns raised about general practitioners being excluded from delivering maternity care.

The Committee then had an opportunity to talk with some members of the Select Committee over lunch. The Committee thanks the Chair,
Ms Steve Chadwick.

The Committee also met with the Minister of Health,
Hon Annette King. The Minister expressed concerns about the need to enhance continuity of postnatal care, the rate of interventions, and the elective caesarean rate, stating that they would not be publicly funded.

Thursday 19 February 2004

The Committee met with officers from the Ministry of Health for an overview of the administration of the maternity services system.

The Committee also met with a midwife from Nga Maia, the National Maori Midwives Association, who assisted the Committee in its understanding of the challenges facing Maori midwives in particular, such as workforce issues and cultural challenges.

The Committee also toured the facilities at Wellington Hospital.

Dr Pat Tuohy, Chief Advisor, Child and Youth Health very kindly hosted dinner for the Committee with staff from the Ministry and the Committee once again expresses its thanks.

Appendix 4 – Acronyms

ACTDGP – ACT Division of General Practice

ACTIA – ACT Insurance Authority

BFHI – Baby Friendly Hospital Initiative

GP/s – General Practitioner/s

IVF – In-vitro Fertilisation

TCH – The Canberra Hospital

UNICEF – United Children's Fund

VMO/s – Visiting Medical Officer/s

WHO – World Health Organisation

Appendix 5 – Bibliography

ACT Health, Population Health Research Centre, *Maternal and Perinatal Health in the ACT 1999*, Health Series, Number 32

Brown, Flint, and Lasett in Keleher, H., R. Round and G. Wilson 'Report of the mid-term review of Victoria's Maternity Service Program' in *Australian Health Review* Vol 25, No. 4

Chalmers I., M Enkin, M Kierse (eds) *Effective care in pregnancy and childbirth*., Oxford University Press, Oxford.

Senate Community Affairs Reference *Committee Rocking the cradle: a report into childbirth procedures*, December 1999.

Donnellan-Fernandez, R. and M. Eastaugh. 'Midwifery Regulation in Australia: A Century of Invisibility'. Paper presented at the *6th International Conference on the Regulation of Nursing and Midwifery*, Melbourne Vic., October 2003

Dugdale, P and L. Kelsall, *ACT Chief Health Officer's Report 2000-2002*, © September 2003

Guilliland, K. 'Managing Change in Midwifery Practise: The New Zealand experience'. Paper presented at the Future Birth Conference, Australia, February 1999.

Hahn, R. 1995. *Sickness and healing: an anthropological perspective*. © Yale University

Hodnett, ED. 'Support for caregivers during childbirth'. In Neilson JP, A Crowther, E Hodnett, G Hofmeyer, M Kierse and M Renfrew (eds). *Pregnancy and childbirth module of the Cochrane Database of systematic review*. Available in The Cochrane Library, the Cochrane Collaboration; Issue 2. BMJ Publishing Group, London, 1996.

Homer, C. G Davis, P Brodie, A Sheehan, L Barclay, J Wills, M Chapman. 2001. 'Collaboration in maternity care: A Randomised controlled trial comparing community-based continuity of care

with standard hospital care'. In the *British Journal of Obstetrics and Gynaecology*, Vol 108:16-22.

Homer, C. D Mather, L Jordan, Jo Wills, G Davis. 'Community-based continuity of midwifery care versus standard hospital care: a cost analysis'. In *Australian Health Review* [Vol. 24, No 1] 2001., p. 85-93.

Johnston, J. 'Commentary – The Insurance dilemma in Australian midwifery regulation'. Paper presented at the *6th International Conference on the Regulation of Nursing and Midwifery*, Melbourne, Vic., October 2003.

National Health and Medical Research Council, *Report on Maternal Deaths in Australia 1994-1996*. March 2001

Nissen E. *et al*., 'Effects of maternal pethidine on infants developing breastfeeding behaviour'. *Acta Peadiatricia*, Vol 86, No. 2, February 1995:140-145.

Odent, M. 'New reasons to study birth physiology'. As first published in the *International Journal of Gynaecology and Obstetrics* 75 (2001). Accessed on 30 March 2004 from www.michelodent.com/news.php?id=14

Page, L. 'One-to-one midwifery: Restoring the 'with woman' relationship in midwifery'. In *Journal of Midwifery & Women's Health*, V. 48, No. 2, March/April 2003, pp. 119-125.

Renfrew, JM and S Lag. 'Feeding schedules for neonates in hospital'. In *Pregnancy and childbirth module of the Cochrane Database of systematic review*. Available in The Cochrane Library, the Cochrane Collaboration; Issue 2. BMJ Publishing Group, London, 1996.

Righard, L and M Made. 'Effects of delivery room routines on success of first breastfeeding'. In *The Lancet* 1990; 336 (8723): 1105-1107.

Roberts C., S Tracey and B Peat. 2000. 'Rates for obstetric intervention among private and public patients in Australia: population based descriptive study'. In *British Medical Journal*, Vol 321: 137-141.

Smith, GCS, J Pell, R Dobbie. 2003. 'Caesarean section and risk of unexplained stillbirth in subsequent pregnancy'. In *The Lancet* 2003; 362 (9398).

Thorp, J. *et al*. 'The effect of intrapartum epidural analgesia on nulliparous labor: a randomised, controlled, prospective trial'. *American Journal of Obstetrics and Gynaecology*. Vol. 169, No. 4, October 1993: 851-858.

Tracey, S., and M Tracey. 'Costing the cascade: estimating the cost of increased obstetric intervention in childbirth using population data'. In *BJOC: an International Journal of Obstetric and Gynaecology*, August 2003, Vol. 110, pp. 717-724

Widstrom, A. *et al*., 'Gastric Suction in health newborn infants: effects on circulation and developing feeding behaviour'. *Acta Paediatrica* Scandinavia 1987: 76 (4): 566-572.

Wiegers, T., J van der Zee, and M. Keirse. 'Maternity care in The Netherlands: The Changing home birth rate'. *Birth* 25:3, September 1998, pp. 190-197.

World Health Organisation, 1994, *Indicators to monitor maternal health goals*. WHO/FHE/MSM/94.14