NSWMA
New South Wales Midwives Association Inc.
A branch of the ACMI

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Executive Officer
Special Commission of Inquiry
Acute Care Services in NSW Public Hospitals
PO Box A4
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March 28th 2008

Dear Mr Peter Garling

Please find attached a submission from the NSW Midwives Association addressing the terms of reference for the Special Commission of Inquiry into Acute Services in NSW Public Hospitals.

The NSW Midwives Association (NSWMA) is a non-government, not for profit, volunteer-based organisation. The NSWMA provides professional support to midwives as well as a range of information services to women and childbearing families. The NSW Midwives Association (NSWMA) is a branch of the Australian College of Midwives (ACMI). The NSWMA has over 1000 members who are also part of a national membership of over 3000 midwives.

The NSW Midwives Association welcomes the opportunity to discuss the current issues relating to the profession of midwifery in NSW as well as the opportunity to provide suggestions for enhancing the current maternity service through full utilisation of midwives' skills.

Regards

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Submission to the
SPECIAL COMMISSION OF INQUIRY
INTO ACUTE CARE SERVICES IN NSW PUBLIC HOSPITALS
From
The NSW Midwives Association

1. BACKGROUND

In Australia, midwives practise in accord with the international definition of the midwife (2005) (Appendix 1) and work in consultation with women and their families during pregnancy, birth and the postnatal period. As providers of primary health care, midwives offer services that are relevant, accessible, safe and affordable to the community.

NSWMA is concerned with the current **organisation and system** of maternity care in this country and in NSW specifically. Generally speaking, maternity care is:

- Fragmented
- Inequitable
- Inefficient
- Not based on evidence or state or national policy direction
- Not meeting the needs of women
- Out of step with the rest of the western world

As we see it this is because of a lack of any overall “system” of care and because maternity care is seen as an acute service rather than a primary health care model. Healthy women are cared for within an acute service that over-utilizes skills that should be reserved for women with complications or medical risks. For example, healthy pregnant women should receive all their care from midwives as recommended by the World Health Organization. Across NSW, many healthy women are cared for by obstetricians, which is not a cost effective option and means that these providers often have less time to care for the women who do actually need them, the women with complications. This medicalisation of childbirth is also supported by funding structures that reward intervention and morbidity.

Even though every state and national report into maternity services since 1989 has recommended that women have access to continuity of care, widespread change to such a model has not occurred (NSW Health 2000). Whilst there are a few excellent exceptions, there is little or no continuity of care. It has been estimated that most women in the public health system, would encounter on average approximately 30 different health care providers - from first booking at the hospital until going home with their baby. This fragmentation of care increases the risk of errors, particularly relating to poor communication, increases the costs and decreases women’s satisfaction with their care.

Communication problems between health professionals and women have been identified as a common factor leading to adverse events in maternity care in successive NSW Health incident reports (NSW Health 2005a, NSW Health 2006a, NSW Health 2008).

2. THE PROBLEMS: IMPERATIVES FOR MATERNITY REFORM

2.1 Increasing interventions, morbidity and costs

Over 99% of the 250,000 births to women each year in Australia occur in hospital, which makes the birth of an infant the leading cause of hospitalisation. Rates of medical intervention in childbirth (including induction, augmentation, epidural and caesarean section) have risen dramatically in Australia over the past 10-15 years with no apparent improvement in perinatal or maternal mortality (AIHW Australian *mothers and babies* annual reports).

The latest NSW Mother and Babies Report 2005 (NSW Department of Health) show that intervention in birth has never been higher in NSW. The rate of normal birth has fallen to 67.8% for public women and only 50.3% for private women. Caesarean section rates have risen to 23.4% for public women and 35% for private women with no significant decline in perinatal or maternal mortality in the last ten years.

Interventions impact on the cost of services and carry with them the potential for serious morbidities for mother and infant. Nearly a decade ago, a large population based study in Victoria found that more than nine out of ten women had at least one significant medical complaint after giving birth (Brown & Lumley, 1998). There is no evidence that this would be any different in NSW today, in fact, it may be worse. Rising levels of medical intervention are creating increased levels of maternal morbidity including increased problems with postnatal depression and the establishment of breastfeeding (Fisher, et al., 1995, 2001; Row-Murray & Fisher, 2002). Postnatal depression is the second most common complication of childbearing after caesarean section.

Rising levels of intervention are also causing rising costs to both federal and state governments. The relative cost of birth increases by up to 50% for low risk woman having her first baby. Caesarean sections cost 2.5 times more than a vaginal birth (Tracy & Tracy 2003).

NSW Health is aware of the problems with an escalating caesarean section rate. In mid 2007, NSW Health hosted a full day forum on Caesarean Section and is committed to developing strategies to reduce the climbing caesarean rate. However, any strategy will be difficult to implement as there are no additional resources available. It seems extraordinary that additional resources can be found to support an increased CS rate, however funding to put strategies into place that will reduce the rate, and reduce future costs, is unable to be found.

2.2 High mortality rates for Aboriginal and Torres Strait Islander (ATSI) women and babies

With some important exceptions, maternity services generally struggle to provide adequate maternity care to Aboriginal and Torres Strait Islander women, particularly in rural and remote areas. The latest perinatal mortality report shows that ATSI babies are 2.5 times more likely to die within the first 6 weeks following birth than non-ATSI babies (Laws et al. 2006) Aboriginal and Torres Strait Islander women are 5.5 times more likely to die in childbirth (Kildea et al., 2006; Slaytor, et al., 2004) with serious repercussions (including higher death rates) for the surviving children, the family and the communities

(WHO, 2004).

2.3 Limited choice for consumers

The majority of pregnant women in NSW access public maternity care which offers fragmented care. Some women may meet up to 30 different midwives or caregivers from the time they begin care in pregnancy until the baby is born and the mother is discharged from postnatal care. Women who seek continuity of care through their private health insurance are only able to choose a private specialist obstetrician. Less than 0.3% of the midwifery workforce is in private practice, due to an inability to obtain professional indemnity insurance, lack of visiting access and lack of access to public funding for their services. In 1999 the *Senate Inquiry into Childbirth Procedures* heard that fewer than 5% of women have access to midwifery continuity of care (public or private), despite extensive research evidence on the benefits of such care. The rate might be slightly higher in NSW 9 years on, but it is unlikely that it would reach 10%, despite state government policy supporting continuity of care.

Consumer input is recognised as an integral part of health service design and provision, however they are still poorly represented on Area Health Service and hospital committees. While the NSW Department of Health has made significant and admirable efforts to have consumers on all peek committees this is not translating to the maternity care environment.

2.4 Lack of postnatal care

Most women get little professional support in making the adjustment to motherhood and learning to care for their newborn. There is often limited postnatal support even though it is estimated that 15–25% of women will develop a significant mental health problem between conception and 12 months postnatally (Priest et al. 2005). It is most concerning that there is often a time lag between discharge from hospital and contact with a Child and Family Health Nurse. This can be two to three weeks, a critical time in terms of breastfeeding support and detection of postnatal depression.

- The median length of hospital stay following childbirth is now 3.4 days (NSW Mothers and Babies Report 2005).
- Many women are discharged home early from busy hospitals regardless of whether they have any community support.
- The majority of hospitals provide little or no midwifery follow up once women are discharged.

2.5 Closures of rural maternity services

This has accelerated in the past 10 years, with more than 130 services now closed across Australia. It is hard to get accurate reports on how many maternity services have closed in NSW. Many rural women face increased risk, morbidity, stress, expense and dislocation when trying to access maternity care.

3. THE KEY ISSUES FOR NSW

Through numerous submissions to the NSW Government and various state and national inquiries, NSWMA have consistently identified several key issues that hinder the provision of a woman centred, evidence based maternity service in NSW. There is also a lack of understanding that maternity services are, for the most part, primary health care models rather than acute care services.

The particular issues we wish to address under the terms of reference for this Inquiry include:

1. A shortage of midwives
2. Lack of midwifery models of care that are accessible to women, particularly in rural and remote NSW due to a lack of recognition of midwives' skills
3. Lack of professional indemnity insurance for midwives to allow them to work to their full scope of practice
4. A lack of rural services and access to midwifery care in rural areas
5. A need to improve care for Aboriginal and Torres Strait Islander women
6. Lack of access to birth centres and publicly funded homebirth

3.1 A shortage of midwives

There is a statewide shortage of midwives, in an environment of growing demand for maternity care (90,000 women per year in NSW and rising). Shortages are based on current patterns of workforce utilisation, which are not as efficient or effective as they could be, especially with primary care being routinely provided to low risk healthy women by highly trained specialists.

The Productivity Commission's report into the Health Workforce makes some major recommendations for institutional and other reforms aimed at improving the efficiency, recruitment, retention and effectiveness of the health workforce.

The reasons for a shortage of midwives are complex, but there are at least four key contributing factors:

- A lack of access to clinical support and midwifery educators in hospitals for midwifery students and new graduate midwives
- High rates of attrition among recent graduates due to stress and frustration with limited opportunities to provide midwifery care within overly medicalised maternity services
- Lack of access for rural midwives to essential support for ongoing professional development, leading to a loss of professional confidence and increased work related stress
- A lack of professional indemnity to support agencies to backfill temporary vacancies in hospitals with qualified midwives.

There are also shortages in GPs and specialist obstetricians. Workforce shortages could be alleviated by addressing the skill mix. The obstetric workforce (mostly GP in rural areas and specialist in urban areas), should be reserved for the care of a minority of women (<20%) with identified need of medical care, and the majority of healthy pregnant women receive primary care from midwives. At present the majority of women receive

medical maternity services and fewer than 10% of women have access to continuity of care by a midwife.

3.1.1 Student midwives

The shortage of midwives is also driven by a shortage of supported midwifery student places. There is a disparity between the numbers of midwives different hospitals are willing to take on. Lack of adequate resources to ensure clinical support and education is often cited as a reason for this. Appendix 2 highlights the different numbers of student midwives that NSW hospitals currently cater for.

Students who undertake midwifery studies in NSW belong to two groups: registered nurses who complete midwifery as a post registration course, or students who complete a three year undergraduate course. Registered nurses complete the theoretical component of their midwifery program at a University and then work (mostly an employment model of 0.8 full time equivalent) in a maternity unit to complete their clinical practice component. It is also now possible in NSW to undertake a Bachelor of Midwifery where students are not required to be registered nurses in order to register as a midwife. These students, in a similar manner to Bachelor of Nursing students, complete their program at a University, and undertake periods of clinical practice in maternity units.

Maternity services, which are located mainly in acute care settings in NSW, are very busy places. There is no doubt that the presence of any student adds an additional burden to the work of existing staff. Students require supervision, support and education to become competent in a range of areas of midwifery practise. Universities have limited funding to support the education of students whilst on clinical placement. As a result burden does then fall onto registered midwives to work alongside students and support their education. This can lead to concerns regarding the quality and safety of care provided to women and babies:

- Midwives are required to supervise the practice of students, thus adding to their workload, and potentially taking time away from the care of women. This can be significant in very busy times.

- Students sometimes provide care with ‘indirect’ supervision. This may mean that the midwife is busy with another woman, and then student is left, unsupervised, to continue with care provision.

Midwifery students should be placed in maternity services in order to acquire the requisite knowledge and skills of midwifery practice. These placements are therefore very suitable and should continue. However, students should be provided with additional support for their learning needs so that this burden is not placed on the existing midwifery staff.

Skill mix is problematic in some areas of maternity services leaving students with, potentially, limited supervision. For example, a busy postnatal unit may have a staff mix of one registered midwife, with a combination of enrolled and registered nurses. Nurses are unable to supervise the practise of midwifery students thus increasing the existing burden on that one registered midwife.

3.2 Lack of midwifery models of care that are accessible to women

As specialists in normal pregnancy and birth, midwives provide high quality care to women, with referral to medical services, as needed, in line with evidence-based referral guidelines. International experience indicates that 70-80% of women can receive primary midwifery care, with the remainder receiving collaborative care from obstetricians, while retaining low maternal and perinatal mortality rates.

The evidence confirming the health benefits of continuity of care by midwives is extensive. The benefits include shorter duration of labour, reduced need for pharmacological pain relief in labour, reduced rates of caesarean section, reduced rates of admission to special care nurseries, improved confidence in parenting including increased rates of breastfeeding, and reduced vulnerability to postnatal depression. Midwifery continuity of care is cost effective, saving the taxpayer dollars. A randomised controlled study at St George Hospital in Sydney (Homer et al 2001) found continuity of midwifery care resulted in significant savings compared with the usual model of care.

Currently 5-10% of pregnant women in Australia can access continuity of care by midwives. In New Zealand, integrated structural and funding reforms supported by successive governments now enable nearly 80% of women to choose a midwife to provide their lead maternity care.

Every state and territory has at least, one midwifery, continuity of care service. Some states have several. Given the proven health benefits of continuity of midwifery care, we would propose that there should be a state target of 20% of women being able to access continuity of care by a known midwife if they so choose by 2010 and 50% by 2015.

In NSW, the *Evaluation of the Ryde Midwifery Group Practice* (September 2004 to October 2005) showed this continuity of care model was safe and cost effective and highly satisfying to mothers and midwives alike. In 2004, the Ryde Midwifery Group Practice was Highly Commended in the NSW State Treasury Managed Funds Risk Management Awards 'in recognition of the development and implementation of an innovative midwifery led model of maternity care for Ryde Hospital' (TMF 2004). From the time of implementation of the new service there have been no maternal or neonatal adverse outcomes in the 245 women who were part of the service. With a caesarean section rate of 9.6% and 73.1% of women requiring no pain relief, this model demonstrates very low rates of intervention and overwhelmingly positive experiences for the women attending the service and the caseload midwives providing the service. The *Ryde Midwifery Group Practice* demonstrated a cost saving to the Area Health Service. Medical costs were reduced by 85% and midwifery productivity increased by 44% (23 women per midwife increased to 33 women per midwife). Reduced intervention and length of stay also contributed significantly to cost savings in the model. The *Belmont Birthing Service* in The Hunter New England Area Health Service has shown similar findings.

3.3 Lack of professional indemnity insurance for midwives to allow them to work to their full scope of practice

Midwives in Australia have been unable to obtain professional indemnity insurance for private practice since July 2001. The loss of indemnity did not follow any significant payout for damages against a midwife. Rather it followed global uncertainty in the insurance market and increased sensitivity to risk, following the HIH collapse, and the 9/11 in the USA. The relatively small pool of midwives in private practice in Australia meant insurers judged that there was an insufficient premium pool to continue underwrite insurance in this area.

Midwives are the only health professionals in Australia unable to obtain professional indemnity insurance despite being educated and registered to practise on their own responsibility in any setting. Every State and Territory now requires health professionals providing care privately to carry medical indemnity as a consumer protection measure. Midwives are unable to comply with this requirement, and any providing care privately to women, are therefore practising unlawfully. This is an undesirable and untenable situation, especially given the workforce shortage of midwives, and the rising demand from women for access to the type of care private midwives offer: continuity of care from early in pregnancy through to 6 weeks after the birth of their baby.

The loss of professional indemnity insurance has had several significant impacts on women's access to primary care by midwives. The majority of NSW midwives in private practice discontinued their practice, either moving to an employment position that provides vicarious liability cover, or leaving the profession. In many areas of Australia, the only way women can access continuity of care by a midwife is by engaging a private midwife but these are in limited supply due to the lack of insurance. There are also now concerning reports of women choosing to give birth unattended rather than experience the fragmented medicalised models of care available in the acute public hospital system.

A further negative consequence to the lack of professional indemnity for midwives is that private nursing agencies, which traditionally have backfilled midwifery positions in hospitals with qualified midwives as temporary vacancies arise, are no longer able to do so. As a result many hospitals are drawing upon registered or enrolled nurses who have no qualifications in midwifery to provide midwifery care to women. This is resulting in increased stress upon remaining midwives who are then responsible for supervising non-midwives and who are held to account in the event that the nurses make an error in their care of women or babies.

The numbers of midwives providing private midwifery care in Australia has historically been low due to the barriers to such practice, including lack of access to prescribing rights, the inability to order and interpret routine pregnancy tests, the lack of visiting rights to hospitals to attend clients in a professional capacity, and the lack of access to public funding (Medicare rebates) for their services. However, with the introduction of the Medicare antenatal item for rural maternity services (16400) in late 2006, there are increasing numbers of rural midwives interested in providing private antenatal care on behalf of GPs or specialists. Anecdotally, the lack of professional indemnity insurance is acting as a significant barrier to the uptake of this option.

3.4 A lack of rural services and access to midwifery care in rural areas

In many rural communities, women have difficulty obtaining access to universal (free) antenatal care. In many towns, antenatal care is provided by either specialist obstetricians, GP obstetricians or GPs. Most of these services are not bulk-billed. The need to pay for weekly or fortnightly visits has a significant impact on access to care. For example, in Taree, there is no free antenatal care as GPs and obstetricians in private practice are the only providers. Bulk billing can be arranged on request at the discretion of the practice managers. Local consumer groups are requesting a hospital based antenatal clinic.

In NSW many maternity units close in the temporary absence of a medical officer, and all women, regardless of risk, are transferred to another maternity unit. This has happened even for low risk women in midwifery programs. The Belmont Birthing Service (HNEAHS) and Ryde Midwifery Group Practice (NSSCAHS) demonstrate that the care of low risk women can be managed safely in the absence of medical officers. While there are women with complex issues who require medical input into birth, not all women need to be transferred away from their communities in the absence of a local medical officer, or indeed of anaesthetic services. In Gloucester, one hour away from Taree, emergency guidelines have been developed which will enable services to continue in the absence of the town's only practicing GP obstetrician. There is, however, a widely held belief that birth in the absence of a doctor is unsafe, and that the health services require a service to close during periods of medical leave.

The capacity of a midwife to demonstrate her scope of practice is restricted by the system in which she is employed. Midwifery models of care in rural areas are restricted by the power of GP obstetricians who, rather than "surrender market share" threaten to resign from the local hospital when change is suggested. In almost every rural maternity unit there are midwives who will say "Our doctors won't let us do that". However, there are communities such as Manilla and Gloucester where doctors and midwives are working in professional collaborative models of care.

In many rural and remote areas in NSW women are unable to access midwifery care due to funding arrangements and the medical monopoly of birthing services. Antenatal care is a prime example with many midwives wanting to offer antenatal care and many women requesting this option, but no incentive for Area Health Services to offer midwifery services. Midwives clinics are viewed as ‘free care’ and are often opposed by obstetricians and GPs who see this as a competitive service.

In January 2008, the Department of Health announced funding to expand antenatal clinics in 47 rural and remote maternity services. Whilst this will provide women access to services not currently available, further commitment is required to offer rural women access to comprehensive midwifery care throughout pregnancy birth and the postnatal period (IB2008_004).

NSWMA is concerned about closure of small maternity units in recent years and the continued questions being raised about the safety of giving birth in small units. Closures of small maternity services over the past decade have had a devastating effect on many

communities and caused more babies to be born by the roadside. Such closures fly in the face of the latest evidence about the safety of small maternity units. A recent landmark, Australian study published in the *British Journal of Obstetrics and Gynaecology* (January 2006) *s*howed that low risk pregnant women can now be reassured that giving birth in small maternity units in Australia is safe.

3.5 A need to improve care for Aboriginal and Torres Strait Islander women

Research into Aboriginal perinatal health in NSW (the NSW Aboriginal Perinatal Health Report 2003) shows that Aboriginal babies are far more likely than other Australian babies to die in the first month after birth, have a much higher rate of preterm birth, and have almost double the rate of low birthweight (less than 2500g). Low birthweight and preterm birth is associated with higher risk of death and illness in the first month after birth.

A number of successful models of care have been evaluated and are being implemented across NSW. NSW is to be commended for this approach. The NSW Aboriginal Maternal and Infant Health Strategy (NSW Health, 2005b) is one such model. This primary health care model, based on partnership with midwives and Aboriginal health workers is an important example for other services, including for non-Aboriginal women, especially those from vulnerable groups (migrants, young women etc).

There is a lack of choice for Aboriginal women regarding their birthing options particularly in remote areas. Relocation for these families is stressful, separates families during the birthing process and is not culturally appropriate or safe. It is proposed that remote area birthing centres should be established in consultation with communities. There should be a comprehensive evaluation with a view to increasing the number of such birthing centres if proved effective over a two year period.

3.6 Lack of access to birth centres and publicly funded homebirth

Birth Centres in NSW are limited in number many have extensive waiting lists. Very few new birth centres have been established since the initial introduction in the early 1990’s after the NSW Government’s *Shearman Report* (1989). Most birth centres are oversubscribed suggesting a large unmet demand.

The NSW Government has a Policy Directive on publicly-funded homebirth (PD 2006_045). This was released in 2007. Despite this, only two sites in the state offer publicly-funded homebirth (St George Hospital and Hunter New England Area Health Service). This means very few women across the state have access to a safe, cost effective model of care.

As already discussed there are women in NSW choosing to give birth without professional care providers because of the lack of access to publicly-funded homebirth and inability to find privately practising midwives.

4. KEY SOLUTIONS FOR NSW

A number of key solutions for NSW are proposed. These include:

- A statewide midwifery workforce strategy be developed in consultation with the midwifery profession and all relevant stakeholders to set clear objectives for addressing the workforce shortages within the next 5 years, and include provision for coordination of funding made available to support education and retention of midwives
- Increased commitment to addressing workforce re-design in maternity care ensuring that the skills of midwives are used to their full capacity in collaboration with medical staff when needed
- Increased commitment and resources to support community-based midwifery continuity of care especially in rural areas
- Expansion of Birth Centres and publicly-funded homebirth models
- Extending professional indemnity insurance to midwives
- Increased incorporation of consumers into Area Health Service and Hospital committees
- Support and resources for expanded collaboration between GPs and midwives. GP obstetricians may be more willing to practice where midwives carry the bulk of the load of caring for healthy women, and only call on the GP when their expertise is genuinely needed.

Additional regulatory reforms are needed by the NSW State Government to support midwifery practice**.** These would include legislative amendments to:

- authorise midwives to order and interpret routine diagnostic tests in pregnancy and childbirth
- grant midwives prescribing rights for routine drugs (e.g. syntocinon for post partum haemorrhage)
- facilitate private midwives gaining visiting access to hospitals

The NSW Midwives Association recognises that many of the issues cross both state and Commonwealth jurisdictions but under the terms of reference we have chosen to talk mainly about NSW State issues.

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Appendix 1

International definition of the midwife (2005)

The international definition of the midwife was first created in 1972. The latest edition was adapted by the International Confederation of Midwives (ICM)[1] in July 2005 and supersedes the 1972 and 1990 definition.

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the women, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. A midwife may practice in any setting including the home, community, hospital, clinics or health units.

[1] International Confederation of Midwives, *Definition of the Midwife*, 17th July 2005. http://www.internationalmidwives.org

Appendix Two

Figure 1. Student midwife intake in Level 6 hospitals in NSW

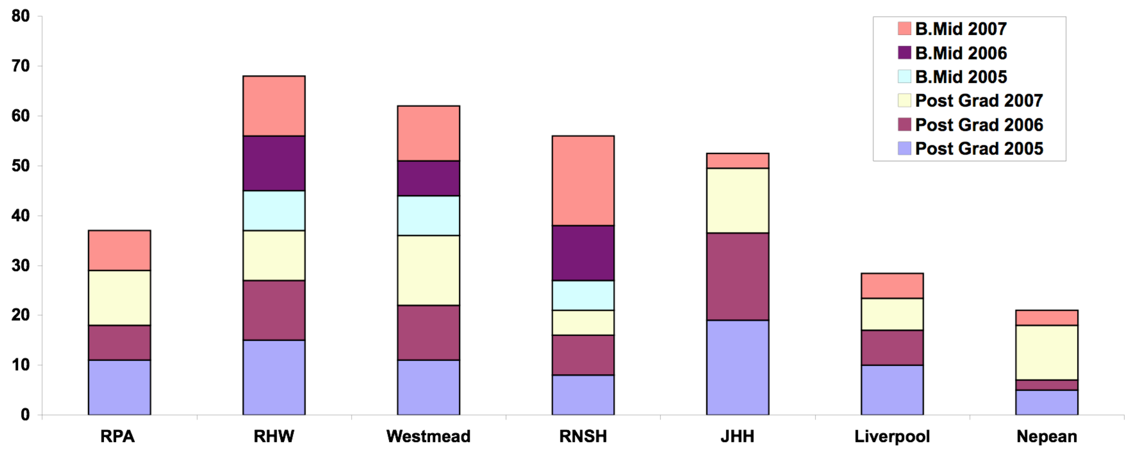

Figure 2. Student midwife intake in Level 5 hospitals in NSW