OVERVIEW AND RECOMMENDATIONS

This Senate Report is very timely.

It follows a series of State and national reports which have reviewed childbirth services: in New South Wales (Shearman Report, 1989), in Victoria (Having a Baby in Victoria, 1990), in Western Australia (Select Committee on Intervention in Childbirth, the Turnbull Report, 1995) and the National Health and Medical Research Council (Options for Effective Care in Childbirth, 1996). All of these reports made recommendations, almost none of which have been acted upon.

It is time for National leadership!

More than a quarter of a million babies are born every year in Australia. Childbirth is the single most important reason for hospitalisation and accounts for the highest number of occupied bed days.

Childbirth is now very safe in Australia. Maternal and infant mortality rates are the lowest they have ever been and compare favourably with those of other first world countries. There are about 5.3 maternal deaths per 100,000 births and approximately 5.9 infant deaths per 1000 live births.

In the non indigenous population these mortality outcomes are consistent across States, regions, ethnic groups and hospitals. They are not significantly affected by the insurance status of the mother.

However, for indigenous Australians the picture is far worse. Despite recent improvements the maternal death rate for indigenous Australians is double that of the non indigenous population. Infant death rates are three times as high. The Committee was concerned to learn therefore that culturally appropriate services which have been shown to improve outcomes for indigenous mothers and babies have not been widely adopted and in some cases are threatened by funding cuts.

Childbirth was not always so safe. The death rates for mothers and babies in the first month of life have fallen dramatically in the previous 50 years.

Many factors have contributed to the dramatic improvement in maternal and infant mortality in Australia. They include general public health measures such as better nutrition, sanitation and housing as well as a reduction in poverty and more effective contraception. Medical advances have made a major contribution to lower maternal and infant death rates through measures such as improved anaesthesia, antibiotics and techniques for blood transfusion. More recently, medical technology and skill have

increased survival rates for premature and very small, low weight babies who, even ten years ago, would have died at birth or shortly thereafter.

Evidence to the Committee indicated that Australian women value safety during birth for their babies and themselves above all other considerations. For this reason the vast majority choose to birth in hospitals. But while women acknowledge the contribution of the medical profession to Australia's low mortality rates they are generally concerned by the extent to which childbirth has been medicalised. This has led to a significant increase in the level of intervention and consequent morbidity, and in the disempowerment of the women giving birth. While recognising that the medical approach may be justified for women considered at risk, they believe it inappropriate for the majority of women.

While mortality rates are fairly uniform across the country, with the notable exception of the indigenous population, levels of intervention and morbidity for mothers and babies are variable. This is particularly evident in relation to Caesarean section, the rate of which is high by world standards, but it also extends to other forms of intervention. Intervention rates are highest among women with private insurance, women giving birth in major tertiary hospitals and women attended by specialist obstetricians. They also vary by State, with South Australia currently having the highest rate of Caesarean section.

The evidence suggests that the higher rates may be partly accounted for by the greater proportion of older women among the privately insured and by the concentration of women at high risk in tertiary hospitals. But these factors do not fully explain the differences in intervention rates.

The Committee is particularly concerned by the high rate of elective Caesarean section in Australia for which, the evidence suggests, there is no medical justification. The significant variation in Caesarean section rate across the country, between States, between hospitals and between public and privately insured patients, is unacceptable. No evidence received by the Committee justified the variation.

The high rate and increasing rate of Caesarean sections can be lowered. Evidence was given of senior obstetricians in a hospital or a region or a State setting out to lower the rate. These efforts have been successful, with very significant drops in Caesarean section numbers and with no increase in mortality or morbidity of the mother or baby.

It is time for national leadership to reduce Caesarean section rates. The Commonwealth Government should require the NHMRC, in conjunction with the Obstetric and Gynaecology profession and the midwifery profession, to establish best practice guidelines for Caesarean sections and targets for seeing the numbers reduced.

The Committee therefore supports the development of best practice guidelines on interventions and other aspects of maternal and infant care. Such guidelines, the Committee believes, would improve the quality of care, reduce the use of

unnecessary, ineffective services or harmful interventions and ensure that care is cost effective.

The Committee is concerned by the polarisation of views about childbirth which emerged during the course of the Inquiry. On the one hand, some witnesses suggested that Caesarean section and other interventions should be available to women on request, regardless of medical indication. Others felt that all forms of medical intervention were overused and that the ideal to be aimed for was an intervention free, spontaneous, vaginal birth which, they argued, could be achieved in many more cases were the medical profession removed from the scene or put at arm's length.

The polarisation of views in the community was reflected in the polarisation of views among the professionals. Many midwives lamented the medicalisation of birth and the concomitant increase in interventions. Many doctors pointed to the record of the medical profession in achieving historically low mortality and morbidity rates and of the irresponsibility of women and midwives who would ignore these advances by opting for births without medical supervision.

However, many women and many medical and midwife professionals recognise that an intermediate position is likely to prove most beneficial and most acceptable to women. Where cooperation between midwives and specialists is well established women's satisfaction with the birth experience is enhanced and safe and successful outcomes are maintained, as the Committee was able to observe at visits to maternity hospitals during the Inquiry.

The most concrete and the most successful examples of the intermediate position are the birth centres, where women at low risk give birth in home like surroundings attended by midwives but with specialist back up should unexpected complications develop during birth.

Birth centres are oversubscribed everywhere. They fulfil women's desire for a less medicalised approach to childbirth without sacrificing the benefits which medical advances have made possible. When the demand for low intervention birth centres cannot be met, it is both disappointing and uneconomic that little effort is being made to shift resources from expensive interventions like Caesarean section to birth centres. The Committee supports the expansion of birth centres as part of our mainstream health system, with funding from hospital budgets.

Current funding arrangements for antenatal, birth and post natal care serve to increase fragmentation in service provision. Instead of encouraging a seamless episode of care extending from the beginning of pregnancy through birth and into the post natal period, with continuity of carer where practicable, existing funding arrangements break that care into episodes centred around the groups which provide it and the

settings in which it is organised. This has adverse consequences for the quality of care. Fragmentation and cost shifting are features of health provision generally in Australia and maternal and infant care are no different in this respect. The Committee believes that major improvements in the quality of maternal and infant health care will be difficult to achieve without attention to broader funding issues.

A further concern is the discrepancy in funding between antenatal, birth and post natal care. Evidence to the Committee indicates that a significant and increasing proportion of funding is spent on routine ultrasound scanning, the medical benefits of which are unproven. The major concern about antenatal care was ultrasound screening. Evidence confirmed that this very important test is a rapidly growing, very expensive and often inappropriately used procedure. The use of ultrasound screening needs to be rapidly evaluated and properly used with clear best practice guidelines.

On the other hand, post natal care, with possibly the greatest potential for long term benefits, is the most neglected area of maternal and infant care. The Committee was particularly concerned because of the move to early discharge from hospital after birth and funding cuts to services which previously provided domiciliary support to mothers and new babies.

The Commonwealth Government has a major interest in maternal and infant care during the antenatal, intrapartum and post natal period. It directly funds major providers, including general practitioners, indirectly contributes to the funding of others, through public hospitals, and has played a direct role in instituting new approaches to care through funding of the Alternative Birthing Services Program, which is now part of the Public Health Outcome Funding Agreements.

At present, far too many practices in maternal and child health are based on custom and fashion rather than evidence and evaluation. The Commonwealth Government also has a role in encouraging and funding evidence based best practice guidelines developed by health professionals and consumers under the auspices of the National Health and Medical Research Council.

High intervention rates in pregnancy and childbirth are influenced by the threat of litigation, in response to which some obstetricians are practising defensive medicine or leaving obstetric practice altogether. The extent of the threat is a matter of dispute but there is no doubt that fear of litigation is having a powerful influence on obstetrical practice.

Childbirth in Australia is safe for mothers and babies. Preventable adverse outcomes are rare and decreasing. But problems remain. The recommendations of this report address those problems.

RECOMMENDATIONS

Note: References to State governments should be taken to include Territory governments.

Chapter 2

The Committee RECOMMENDS that the Commonwealth Government work with State governments to implement the recommendations of the National Health and Medical Research Council as they relate to continuity of care and shared care during pregnancy and birth.

The Committee RECOMMENDS that all pregnant women in Australia be provided with a maternity record by their principal carer giving details of their health as it relates to their pregnancy and any test results or treatment, with a duplicate to be held by their principal carer.

The Committee RECOMMENDS that the Commonwealth Government fund major tertiary hospitals to extend the provision of satellite clinics and visiting teams of obstetricians to assist women in rural and remote areas.

The Committee RECOMMENDS that the Office of Aboriginal and Torres Strait Islander Health provide recurrent funding to ensure continuity for existing antenatal programs for Aboriginal and Torres Strait Islander women and to establish new programs in areas of need.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to reinstate programs to assist women from non English speaking backgrounds to gain access to antenatal services, using funding provided through the Public Health Outcome Funding Agreements.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to promote antenatal programs targetted to adolescent mothers.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that comprehensive, accurate and objective information is made available to all pregnant women on the antenatal and birth options available to them, with funding provided through the Public Health Outcome Funding Agreements.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that comprehensive, accurate and current information is made available to all principal carers of pregnant women about the antenatal and birth options and services available in their area, with funding provided through the Public Health Outcome Funding Agreements.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that antenatal information is made available to all

indigenous women in a language and format that meets their needs, with funding provided through the Office of Aboriginal and Torres Strait Islander Health.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that antenatal information is made available to all women from non English speaking backgrounds in a language and format that meets their needs, with funding provided through the Public Health Outcome Funding Agreements.

The Committee RECOMMENDS that the National Health and Medical Research Council, in conjunction with professional medical bodies and midwives' organisations, establish guidelines governing the prior provision of counselling and information on all antenatal screening tests, for adoption and implementation by the professional bodies.

The Committee RECOMMENDS that the National Health and Medical Research Council, in conjunction with professional medical bodies and midwives' organisations, establish guidelines governing the provision of counselling and information on the benefits and disadvantages of the various forms of intervention which may be required by women during birth, for adoption and implementation by the professional bodies.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that adequate and appropriate antenatal education classes are generally available, using funding provided through the Public Health Outcome Funding Agreements.

Chapter 3

The Committee RECOMMENDS that the National Health and Medical Research Council develop standards for the training of operators of all obstetrical ultrasound equipment and for those who interpret the results of those tests.

The Committee RECOMMENDS that the National Health and Medical Research Council develop guidelines governing the safe use of all obstetrical ultrasound equipment.

The Committee RECOMMENDS that the National Health and Medical Research Council develop or coordinate the development of evidence based assessments of the efficacy of routine ultrasound scanning in pregnancy and that it conduct a cost benefit analysis of current ultrasound practices.

The Committee RECOMMENDS that the National Health and Medical Research Council conduct or oversee the conduct of an Australian multicentre trial of nuchal fold screening to determine its efficacy for use among pregnant women generally, and among those considered at particular risk of carrying babies with Down's Syndrome.

The Committee RECOMMENDS that earlier recommendations relating to the training of operators and the regulation of equipment used in routine ultrasound screening should also apply to nuchal fold screening.

Chapter 4

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure the continuation and expansion of hospital birthing centres.

The Committee RECOMMENDS that the Commonwealth Government continue to fund midwives to assist at home births for women at low risk through the Public Health Outcome Funding Agreements.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to assist Aboriginal and Torres Strait Islander women who have to give birth outside their communities by funding an accompanying family member, with funding provided through their patient transfer assistance schemes.

The Committee RECOMMENDS that the Commonwealth Government, through the Office of Aboriginal and Torres Strait Islander Health, fund culturally appropriate birthing services, either in hospitals or stand alone, in centres with large Aboriginal and Torres Strait Islander populations.

Chapter 5

The Committee RECOMMENDS that the National Health and Medical Research Council work with the relevant professional bodies to develop best practice guidelines for elective Caesarean sections.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to decide a target rate for Caesarean sections, moving towards the target of 15% recommended by the World Health Organisation.

The Committee RECOMMENDS that the Joint Maternity Services Committee monitor the implementation of best practice guidelines for Caesarean sections and report upon the extent to which individual hospitals meet the proposed target for Caesarean sections of 15%.

Chapter 7

The Committee RECOMMENDS that research and guidelines on the use of routine ultrasound in pregnancy be an immediate priority for the National Health and Medical Research Council. An earlier recommendation set out those aspects of routine ultrasound requiring urgent attention.

The Committee RECOMMENDS the enhancement of the Joint Committee on Maternity Services to include professional groups involved in antenatal, birth and post natal care as well as consumers. The Joint Committee should have responsibility for advising Ministers on the implementation and evaluation of best practice guidelines in

maternal and infant health care and on measures to reduce current fragmentation in the provision of maternal and infant health services.

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure the annual publication of a list of all of its hospitals where births take place, with statistics on each of the birth-related interventions performed there and the insurance status of the women on whom they are performed.

Chapter 8

The Committee RECOMMENDS that the Commonwealth Government work with State governments to ensure that maternity and infant welfare services are in place to assist women following their return home after childbirth.

The Committee RECOMMENDS that community care services for women discharged early from hospital following childbirth be eligible for funding through the National Demonstration Hospitals Program.

The Committee RECOMMENDS that the National Health and Medical Research Council conduct research into post natal depression.

Chapter 9

The Committee RECOMMENDS that the Health Insurance Commission monitor the new Medicare rebate for complex births to ensure that it does not lead to overservicing.

The Committee RECOMMENDS that the Health Insurance Act be amended to define as ‘patients’ all neonates in hospital who require medical attention, regardless of whether they are located with their mothers or not.

Chapter 10

The Committee RECOMMENDS that the Australian Institute of Health and Welfare establish national comprehensive data on medical defence organisations to cover negligence cases and include such data as premium payments, number of cases, number of claims, number of out of court settlements, size of payments and size of fund reserves.

The Committee RECOMMENDS that the Commonwealth Government establish an independent inquiry into medical indemnity and litigation, including the impact of litigation and indemnity on the provision and practice of obstetric services, alternative approaches to the funding of medical litigation and alternative approaches to the funding of compensation for disability.

Senator the Hon Rosemary Crowley
Chair