CHAPTER 8

POST NATAL CARE

8.1 Post natal care was variously described in evidence to the Committee as the 'orphan', the 'Cinderella' and the 'poor sister' of care for mothers and babies. It was said to compare most unfavourably with the quality, choice and duration of post natal care in countries such as Holland and the United Kingdom and Holland.

8.2 Many witnesses considered that, if afforded the funding and attention it deserved, post natal care had the potential to significantly improve health and social outcomes for mothers, families, and especially for babies. A number expressed disappointment that the Committee's terms of reference which, they claimed, are essentially restricted to the first few weeks of an infant's life, continue the pattern of neglect of this area and deprive the Committee of the opportunity to suggest how current deficiencies might be overcome.

> I was disappointed to see that the Terms of Reference only appear to look at 1-2 weeks post delivery as suggested by referral to early discharge programmes.
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> To me the big deficiency in our care is for families in the first 2-3 years from birth. There are a number of trials currently being conducted in Australia but this area needs to be expanded considerably.
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> If we are to improve birth and after outcomes, we need to address this period much more than the antenatal and delivery care in obstetrics.[1]

8.3 The Committee does not agree with this assessment. It believes the post natal period extends to six weeks after birth and overlaps with infant welfare care, which usually commences soon after the mother leaves hospital.

Length of hospital stay and early discharge

8.4 There is no agreed definition in Australia of what constitutes early discharge or of how it is calculated (from day of arrival in hospital, from day on which labour commences or from day of delivery). What is clear however is that average length of stay in hospital following delivery is decreasing everywhere.

8.5 In 1991 the average length of stay was 5.3 days.[2] By 1996 it had declined to 4.2 days. In 1991 only 20.2% of mothers were discharged less than four days after

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1 Submission No. 5, p.3 (Dr B.R. Pridmore, Queen Elizabeth Hospital, Adelaide).

2 Figures in this section are from Australian Institute of Health and Welfare. *Australia's mothers and babies 1996,* pp.22-26.

giving birth. By 1996 the figure had doubled to 40.3%. There were no major differences between States.

8.6 Earlier discharge following childbirth mirrors developments in other areas where patients are now discharged much more quickly following surgery and other procedures than was previously the case. Some witnesses argued that because of the emotional impact of childbirth and the social readjustment which it entails the factors precipitating early discharge in other areas do not apply to the same extent to women who have recently given birth.

8.7 Women with private health insurance stay longer in hospital, on average, than do others.

> [In 1996]…mothers who had private status in hospital had an average postnatal stay of 5.4 days, compared with 3.6 days for those who had public status and were less likely to have short postnatal stays.[3]

> …The proportion of hospitalised mothers with a postnatal stay of less than 5 days was 32.8% for those with private status in hospital compared to 73.2% for mothers with public status…. For mothers having their first baby, 62.9% in the public category stayed for less than 5 days compared with only 20.2% in the private category.[4]

8.8 Women having shorter stays in hospital following birth tend to be privately insured, to be younger, to have other children at home and to have had spontaneous deliveries. Indigenous women also tend to have shorter hospital stays.[5]

8.9 Women giving birth by Caesarean section stay longer in hospital than do others.

> In 1996, among mothers in Australia (excluding Victoria and the Northern Territory) who had caesarean sections, 19.7% admitted as public patients and 52.5% admitted as private patients were hospitalised postnatally for at least 7 days compared with 3.4% and 12.2% respectively, for those who had a spontaneous vaginal birth.[6]

The rationale for early discharge

8.10 The Committee received many submissions stating that early discharge was a cost cutting exercise designed to increase patient ‘throughput’ without regard to possible adverse consequences for mothers and babies.

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3 Ibid, p.24. These figures exclude data from Victoria, Tasmania and the Northern Territory, which were not available for these comparisons.

4 Ibid, pp. 25-26.

5 See Ibid, pp. 24-25.

6 Submission No. 170, p.8 (Australian Institute of Health and Welfare).

> In fact it has become increasingly apparent that the pressure to reduce the duration of hospitalisation has more to do with funding pressures than clinical outcomes.[7]
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> In the public sector it seems the main impetus for early discharge was political and financial pressure to improve ‘efficiency’ and demonstrate the ‘effectiveness’ of hospitals; these complex objectives were seen in simplistic terms and translated into increasing patient ‘throughput,’ often at the expense of quality.[8]
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> Average postnatal stay for vaginal delivery is 3.5 days, and 5.5 days for caesarean delivery. Extension of stay is only considered if a medical condition requiring inpatient treatment is present. **This is a purely financial and cost containment strategy, is certainly not based on any evidence (there are no data whatsoever suggesting an ideal postnatal length of stay) and ignores the need of some women to stay longer.[9]**

8.11 Casemix funding was said to be a major factor contributing to shorter post natal hospital stays for an increasing number of women and their babies. However, the Committee was unable to establish any definitive link between the two. Moreover, it notes that declining length of stay in hospital was an established reality in Australia well before casemix funding was introduced. The Committee was also advised that casemix data for 1996-97 shows that maternal length of stay in hospital following birth was similar in hospitals in New South Wales (which does not fund its public hospitals by casemix) and those in Victoria, (which does).[10] It therefore concludes that while overall cuts in funding may well have led to reductions in hospital stay, the casemix funding approach itself is unlikely to have done so.

8.12 Some submissions suggested that the original rationale for early discharge was entirely laudable. This was to redirect funding saved through early discharge to domiciliary services to support women and babies at home after their discharge. Had this intention been fulfilled, these submissions argued, early discharge would have received wide support and health outcomes for mothers and babies would not have been compromised. In reality however, the savings were not fully used for domiciliary back up services, to the detriment of women and babies discharged early.

> …on August 1st, 1999 the press reported the announcement by the Victorian Government of a four year Maternity Services Enhancement Strategy

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7 Submission No. 108, p.3 (Professor P Marshall, Flinders Medical Centre).

8 Submission No. 109, p.16 (NSW Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research).

9 Submission No. 34, p.6 (Westmead Hospital).

10 By the Parliamentary Information and Research Service.

> promising new mothers at least *one* home visit by a domiciliary nurse or midwife. But early discharge was introduced with the promise of at least *four* days of home visiting. Victoria is obviously still falling far short of this.[11]

8.13 The difficulties for women have been exacerbated because early discharge policies were introduced at a time when there were significant cut backs to community based services which might previously have provided some support to newly discharged mothers. This was certainly the case in Victoria.

> During the first term of the Kennett Coalition Government in Victoria Women's Action Alliance became alarmed at the reductions in hospital funding leading to the earlier discharge of maternity patients and changes to the funding of the Maternal and Child Health Centres. These seemed to be added to a withdrawal of subsidized home help services to newly delivered mothers which had already occurred by that time.[12]

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> The number of visits to infant welfare centres in Victoria is rationed. New mothers do not have free and ready access to those services whereas, in the past, if they felt bad one week or the next, they could roll in each week, each day, or whenever they felt like it. But now they are only allowed to have a certain number of visits, postnatally.[13]

8.14 The Committee is sympathetic to the views expressed in these submissions. It deplores the cutbacks to maternal and child health services at a time when early obstetric discharge places increased pressure on new mothers and babies. It also believes there are hidden costs in such as an approach as health and other problems which might otherwise have been recognised and treated early are more likely to develop and result in readmittance to hospital and longer terms costs to the health system.

8.15 The provision and funding of early discharge programs illustrates quite starkly the fragmentation evident in maternity care. For public patients, care in hospital following birth is the responsibility of the hospital and paid for from (State) hospital funds. If a woman is discharged early then domiciliary care may continue to be funded by the hospital and provided by its outreach staff. Alternatively, it may be funded by the hospital and contracted out to community based organisations.

8.16 Where domiciliary programs are not funded by the hospital, or are not adequately funded, the mother may seek additional support from community based services which might be State funded, might be Commonwealth funded or might be jointly funded, such as the Home and Community Care Program. The mother may

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11 Submission No. 79, p.2 (Women's Action Alliance (Australia) Inc).

12 Ibid, p.1.

13 *Committee Hansard*, 27.8.99, pp.76-77 (Women's Hospitals Australia).

also seek assistance from her general practitioner, who is Commonwealth funded. The potential for cost shifting between jurisdictions is considerable. So is the likelihood that the needs of some mothers and babies will be overlooked in a situation where there are many service providers funded by, and responsible to, different organisations.

8.17 A specific example of cost shifting was brought to the Committee's attention by the Royal District Nursing Service (RDNS) in Victoria. It provides post natal care for women discharged early from three Victorian hospitals. The care is funded from these hospitals' budgets. However, in these cases the RDNS advised:

> The fees paid fall well short of the cost of a postnatal visit.
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> 15% of clients discharged home on these programs require more visits than the program pays for.
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> Additional costs are carried by RDNS therefore these EDP [early discharge programs] are substantially subsidised by the Home & Community Aged Care Program.[14]

8.18 For privately insured women there is limited access to domiciliary care on discharge as most health funds and Medicare do not have appropriate rebates. However, as noted, privately insured women tend to have longer post natal hospital stays. Some health funds are beginning to address this issue. The Australian Health Management Group for example advised the Committee of its maternity options package, launched earlier this year, which will fund a range of services such as midwives' visits, cleaner/carer services and nappy wash. Services are provided for up to seven days from the day of birth for Caesarean section and for up to five days for normal deliveries.

8.19 Privately insured women whose principal carer is a midwife and who give birth at home or in hospital normally receive up to ten visits from the same midwife over a two week period following the birth.

8.20 Some evidence to the Committee suggested that, far from being a cost cutting exercise, early discharge programs, if properly designed and adequately resourced were in fact more expensive than longer stays in hospital.

> It is fair to say that the [early discharge] programme [at Westmead Hospital] is well received by the target population, but significantly this model of post natal care was found to be more expensive than conventional inpatient postnatal care.[15]

8.21 While this may be the case at Westmead, most evidence to the Committee suggested that, as currently operating, most early discharge programs were at best cost

14 Submission No. 111, p.1 (Royal District Nursing Service, Vic).

15 Submission No. 34, p.6 (Westmead Hospital).

neutral but were more likely to be designed to achieve cost efficiencies in hospital budgets.

The pattern of early discharge care

8.22 The nature of early discharge programs is very varied, as are the criteria for access to the programs. In all programs, as far as the Committee has been able to ascertain, early discharge is limited to women and babies with no obvious indications of poor health or complications following birth. In most cases it appears that women are offered a choice of longer stays in hospital or early discharge. In some hospitals domiciliary support appears to be restricted to women discharged from hospital within 48 hours of the birth. In others it extends to women discharged within 72 hours of birth.

8.23 The RDNS advised that in the three Victorian hospitals with which it was working 'entry into the [early discharge] program is capricious; there are no written criteria or benchmarks', with arrangements regarding number of visits and the amount of money the hospitals are prepared to pay for post natal care differing markedly.[16] Evidence to the Committee suggests that such variations are not restricted to Victorian hospitals.

8.24 The most usual form of assistance provided to women following early discharge is home visits by midwives. Again, the number of visits is very variable. Women's Hospitals Australia, for example, advised the Committee that in its hospitals women are seen on average 2.5 times after discharge.[17] The figure at King Edward Memorial Hospital in Perth is 2.62 times.[18]

8.25 These figures compare very unfavourably with the situation in the United Kingdom, for example, where there is a mandatory requirement for all women and babies to be provided with follow up care on a daily basis for ten days from the date of birth and for up to 28 days where complications develop or where the woman or baby are assessed as at high risk. In the United States recent legislation requires insurers to fund a minimum stay of 48 hours following concerns about readmission rates for babies discharged early.

> In the United States the reduction in the hospital stay was extreme and the AVLOS [average length of stay] of less than 48 hours was noted to compromise maternal and neonatal safety. This was evidenced by legal action taken by an Ohio family who alleged that their health insurer's policy of early discharge was responsible for their daughter's brain damage. This and other examples of neonates being readmitted to hospital for failure to thrive after early discharge led to the introduction of the Newborns' and

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16 See Submission No. 111, p.3 (Royal District Nursing Service, Vic).

17 See Submission No. 69, p.27 (Women's Hospitals Australia & Australian Healthcare Association).

18 See Submission No. 155, p.6 (King Edward Memorial Hospital, WA).

> Mothers' Protection Act of 1996. This Act enforces health insurers to cover the client for a minimum stay of 48 hours.[19]

8.26 As noted, some post natal services are funded by hospitals and provided by hospital based outreach staff. This is the position at Mater Misericordiae Mothers' Hospitals in Brisbane, for example, where 57% of mothers are discharged early and all are visited at home by hospital based midwives, usually for five visits.[20]

8.27 At Queen Elizabeth Hospital in Adelaide funds saved through closure of a ward were redirected into a domiciliary service for women discharged early.

> Our own hospital some years ago was able to close a ward and use the money we saved by sending women home early to set up a domiciliary service – and women are at least followed through. They get a minimum of one visit up to a maximum of about 10, depending on what they need.[21]

8.28 Early discharge care is provided by hospital based midwives or by community based midwives. In either case, the women who provide it are often not those who have tended the woman during the antenatal period and during the birth. They are therefore not familiar with the woman (and she with them), which puts them at a disadvantage in tailoring their care to the needs of the individual woman and her child. In this respect, privately insured women with a midwife as principal carer are much more favourably placed. They have obviously developed a rapport with the midwife and she, in turn, is well aware of the particular concerns of the woman involved and can act accordingly.

8.29 One problem with hospital based early discharge programs is the position of women discharged early who fall outside the hospital 'catchment area' and are therefore deemed ineligible for its outreach programs. Women in this position must rely on local community based services. It seems that a number receive no follow up support at all.

> Some women, who birth at Westmead Hospital but do not live in their "area", are being subjected to a lottery of follow-up after discharge from hospital. If their neighbourhood hospital refuses them their service, they are either left to their own devices or referred to community health staff who do not necessarily have the specialist skills to give the best post-partum care.[22]

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> The EDP [early discharge program] offered within our community can only be given to those within the Kalgoorlie-Boulder City proper. Midwives from the Maternity Unit, which gives a continuum of care, service it. Clients who

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19 Submission No. 73, p.3 (Australian College of Midwives, Qld Branch).

20 See Submission No. 78, p.28 (Mater Misericordiae Mothers' Hospital, Brisbane).

21 *Committee Hansard*, 7.9.99, p.281 (Dr B.R. Pridmore, Queen Elizabeth Hospital, Adelaide).

22 Submission No. 21, p.4 (Westmead Hospital).

live in areas outside our City (ie Kambalda, Coolgardie) are referred to the Community Health Service…A concern is that some of these health providers may not have a midwifery background and thus could be unaware of the total health aspects of a post partum woman and her baby.[23]

8.30 Nevertheless, the Committee was advised of a number of very successful hospital based early discharge programs. One was in the New England Area Health Service region.

There is only one formal **Early Discharge Program** operating within the NEAHS. This service operates from the Tamworth Base Hospital within a 20 km radius. Usage varies from 30-39% of those women living within the catchment area. Client satisfaction is high and readmission rates ranged from 1-3.8% over a three year period. Breastfeeding rates at discharge from the program are generally equal to, or above, the rate for inpatients.[24]

8.31 Another was at Royal North Shore Hospital.

Midwife supported Early Discharge Programmes have been evaluated and accepted as a safe voluntary option of postnatal care. The appropriateness of this service has been demonstrated by:

- Positive patient satisfaction questionnaires
- Low hospital readmission rates
- Positive outcomes for the successful initiation of breastfeeding
- Appropriate admission to an M.E.D.P. [midwife early discharge program] due to careful assessment and screening of women and their babies prior to discharge from hospital…
- Women elect M.E.D.P. with their subsequent babies
- Positive midwife satisfaction in providing this model of postnatal care
- Demonstrated reduction of inpatient postnatal length of stay.[25]

The advantages of early discharge

8.32 While the widespread adoption of early discharge programs may have been precipitated by economic considerations there is no doubt that well run, adequately resourced programs have many benefits. Provided participants are assessed for health and social problems, have adequate support at home and, most importantly, are allowed to choose this option, then the available evidence suggests that outcomes are comparable or superior to those for women and babies with longer hospital stays.

23 Submission No. 48, p.5 (Australian College of Midwives Inc – Goldfields Sub- Branch).

24 Submission No. 22, p.3 (New England Area Health Service).

25 Submission No. 150, p.11 (Royal North Shore Hospital, Sydney).

8.33 Some submissions stressed the importance of early discharge in reinforcing the view of birth as a normal life event rather than a medical crisis.

> The advantages of early discharge from Maternity Hospitals particularly amongst some of those who would otherwise choose home delivery are that it promotes the concept of normalisation of the birthing process for non-complex obstetric births.[26]
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> Early discharge is becoming accepted as the norm by the general public in relation to obstetrical admissions. The perception of birthing as a normal life occurrence, and one not requiring long-term hospitalisation is becoming more predominant.[27]

8.34 Others however felt that the pendulum had swung too much in the other direction so that women were being deprived of the additional support they need in the immediate post natal period.

> Unfortunately extreme radical feminism has promoted the notion that childbirth is a mere incident in women's lives with no recognition of the huge physical & emotional demands made on a woman at this time. Consequently the distress among new mothers has been kept private and hidden.[28]

8.35 Those who support hospital rather than home birth see early discharge as a means of encouraging those women who might otherwise have opted for home birth to deliver in hospital. Certainly mothers who deliver in birthing centres are generally discharged very early.

> The option for women to have access to an early discharge program can be a key factor in the decision making process in the election of her model of care and could encourage mothers to birth in the hospital setting rather than at home. When mother knows she is not captive for a long period of time, she may be more likely to agree to deliver in a hospital setting, where it is easier to deal promptly with maternal or neonatal complications.[29]

8.36 Early discharge is helpful in integrating the new baby into the existing family structure and reducing the potential for the development of sibling rivalry.

8.37 Women discharged early from hospital have a greater chance of establishing and maintaining successful breastfeeding. This is said to be because they tend to receive one to one advice from the same midwife when they are at home whereas in

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26 Submission No. 78, p.25 (Mater Misericordiae Mothers' Hospital, Brisbane).

27 Submission No. 16, p.14 (Royal Women's Hospital Health Service District, Brisbane).

28 Submission No. 79, p.2 (Women's Action Alliance (Australia) Inc).

29 Submission No. 78, p.25 (Mater Misericordiae Mothers' Hospital, Brisbane).

hospital they often receive conflicting advice from a range of midwives. Furthermore, some common hospital practices are not conducive to early establishment of breastfeeding, despite all hospitals' stated commitment to this goal.

> Conflicting advice from different members of hospital staff has been repeatedly identified as a problem for the new mother. A considerable number of previously common hospital practices, such as routine separation of mother and baby at birth for observation, nursery care for babies, supplementing the intake of breastfed babies with cows milk formulas or water, using artificial teats and dummies, and enforced schedules for feeding have been shown to have a negative impact on breastfeeding rates.[30]
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> Without exception, all of the women [12 women from Birth Matters, South Australia] who stayed in hospital for the post partum period (that is, except for home births and one birthing centre birth with early discharge) felt VERY confused by different advice given on breastfeeding techniques.[31]

8.38 A questionnaire of 1,336 women conducted in Victoria in 1993 provides one of the few sources of information on the broad impact of early discharge policies in this country.[32] Questionnaires were mailed to a representative sample of women who gave birth in a two–week period in September 1993 in all Victorian hospitals. The questionnaires were completed six months after the birth. They were designed to compare the outcomes for women discharged early from hospital with those who were not.

8.39 Most women in the sample (80%) were happy with their length of stay. However, 13% described it as too short and 7% as too long. These findings support the view expressed to the Committee during the Inquiry that most women who participate in early discharge programs do so from choice. Where they do not make the choice themselves, but their length of stay is dictated by hospital policy, they are more likely to consider they were discharged too early. The study noted that:

> One in four women who went home within four days of the birth indicated that hospital or birth center policy was a major factor in determining how long they stayed. These women were considerably more likely to believe their stay had been too short than other women who left hospital early.[33]

8.40 This study indicated that early and late discharge were both associated with the successful establishment and maintenance of breastfeeding. While the women

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30 Submission No. 14, p.13 (Australian College of Midwives Inc, Vic Branch).

31 Attachment to Submission No. 84 (Birth Matters, South Australia).

32 Brown, Stephanie and Lumley, Judith. *Reasons to Stay, Reasons to Go: Results of an Australian Population-Based Survey,* Birth 24: 3 September 1997, pp.148-158. Since this study was conducted post natal length of stay has decreased significantly in Victoria, as in other States.

33 Ibid, p.154.

discharged on or after day five were slightly more likely to begin breastfeeding than others (93% compared with 87%), women who left hospital within 48 hours and those who left on day five or later both had significantly higher rates of breastfeeding at six weeks, three months and six months than those discharged on day three or four.

Concerns about early discharge

8.41 Concerns expressed to the Committee about early discharge relate to its implementation rather than to the concept as such. In this respect witnesses are reflecting general community concerns about aspects of early discharge programs as they currently operate, and particularly the lack of adequate back up services for women and babies discharged early from hospital following delivery.

> …we are sending women home from hospital two or three days after they have had a baby, not necessarily with any community based support and, increasingly, following operative delivery. So they are going home with a new baby, recovering from major surgery, trying to take on mothering and establish breastfeeding, very often without any professional care or support whatsoever.[34]

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> On the issue of postnatal care, one of the issues that we wish to draw to your attention is the lack of facilities, support, recognition and understanding of long-term consequences of postnatal care. It arises when we talk about early discharge. In actual fact all our member hospitals are concerned that the social consequences of women being isolated or families being isolated or children being isolated by incapacitated mothers in the early period after birth are enormous and have long-term impacts on the community in terms of social welfare, crime and various other things.[35]

8.42 One of these concerns is the adequacy of screening mechanisms to ensure that early discharge is not extended to women for whom it is inappropriate. When this happens the woman and her child are at enhanced risk of ill health and social isolation. Post natal problems might not be quickly recognised, resulting in later disruptive and costly readmission to hospital. This is a particular risk where follow up services are inadequate. It was raised by some witnesses in connection with the discharge of drug dependent mothers and their babies.

> Part of the problem now with the early discharge program, with a lot of people going home within a few hours of delivery, is that, if it is not identified before delivery, these babies are going home and then exhibiting their withdrawal symptoms out in the community where people are not

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34 *Committee Hansard*, 14.9.99, p.425 (Health Advisory Committee, NHMRC).

35 *Committee Hansard*, 27.8.99, p.76 (Women's Hospitals Australia).

> trained to realise that is what is happening or how to manage them. That is another concern that we have with the early discharge program.[36]

8.43 A major concern with early discharge was said to be the increased likelihood that post natal depression would not be diagnosed in its early stages, especially where support services are under resourced. However, as with so many aspects of antenatal, intrapartum and post natal care, there is little firm evidence on which to base this widely held supposition.

> We have little information about post natal depression rates which we surmise would have increased as length of stay together with support services decrease. A number of studies have looked at the incidence of post natal depression and it was estimated at between 10% and 17% at six to seven months post partum. Indeed some hospitals have looked at the relationship between postnatal depression and length of stay. One study found that there was a strong relationship between the two, while another study found that if there were good support services in place then postnatal depression is unlikely to be a complication as a result of early discharge. Thus there is a strong correlation between length of stay, good support services (such as domiciliary services) and postnatal depression.[37]

8.44 The Brown and Lumley study referred to above found no association between early discharge and subsequent rates of post natal depression. Other studies have claimed that there is such an association. A study conducted at the Nepean Hospital in Sydney, for example claimed that women discharged within 72 hours of delivery had almost twice the risk of post natal depression as those with a standard length of stay.[38] The authors commented that 'While health services are having to cut costs, early discharge may result in short-term cost savings. However, the consequences of post natal depression could lead to escalating health care costs in the long term'.

8.45 Views differ also on the association between early discharge and establishment and maintenance of breastfeeding. As noted, Brown and Lumley found that breasfeeding rates were higher among those with early and late discharge from hospital compared with those discharged three or four days after the birth. Other witnesses questioned these findings.

> The establishment of breastfeeding does not usually occur before 3 to 4 days and the effect that a shorter length of postnatal care has on infant feeding decisions is unclear.[39]

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36 *Committee Hansard,* 27.8.99, p.72 (Women's Hospitals Australia).

37 Submission No. 69, pp. 27-28 (Women's Hospitals Australia and Australian Healthcare Association).

38 Hickey A. R. et al. *Early discharge and risk for postnatal depression.* Medical Journal of Australia 1997; 167, pp. 244-247.

39 Submission No. 51, p.10 (Midwifery Practice and Research Centre, NSW).

> Problems have been reported in the area of breast-feeding, an extremely important natural process but for many mothers [it] is a painful and difficult learning process at the beginning. A reduced length of stay does not provide the time to provide the education and support to the mother to assist in the breast feeding process.[40]

8.46 The move to early discharge has placed greater responsibility on general practitioners for monitoring and care of new born babies. Often they are not trained or resourced to undertake this role.[41]

> General practitioners were very ill-prepared for the transition of care in the neonate from hospital to the community. It happened in a very short transition period. Many of the cares of the neonate that we thought were hospital – the peak of jaundice, for instance, and excluding a whole lot of birth defects in the discharge examination – have now firmly fallen in the lap of the general practitioner.
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> General practitioners were in no way prepared for this. Our expectations of general practitioners is much higher than they were ready for.[42]

8.47 Most concerns, in the literature generally and in evidence to the Committee, focus on the inadequacy of support services provided to mothers and babies after early discharge from hospital. In the Brown and Lumley study, for example, only a third of women who returned home within four days of the birth received even one visit from a midwife. For those leaving within 48 hours, 66% received such a visit(s). One must assume that the remainder had no midwifery support in the immediate post natal period.

8.48 These concerns were highlighted by the Women's Action Alliance.

> To ascertain the impact on maternity patients of these funding cutbacks and reduced hospital stays we consulted widely with mothers, nurses, doctors, breast feeding consultants and the Maternal and Child Health Consumers Group. These investigations indicated a widespread level of dissatisfaction and disquiet about early discharge, lack of follow up support and changes to Maternal and Child Health Service in Victoria. We became aware of much hidden distress as mothers were re-admitted to hospital with infections and babies admitted with jaundice. Successful breastfeeding was difficult as many women were discharged before their milk supply was established and ongoing help at home was often not available leading women to abandon their efforts to breastfeed.[43]

8.49 Funding cutbacks have not been confined to Victoria.

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40 Submission No. 78, p.26 (Mater Misericordiae Mothers' Hospital, Brisbane).

41 This issue is discussed in Submission No. 78, pp.25-27.

42 *Committee Hansard*, 15.9.99, p.544 (Mater Misericordiae Mothers' Hospital, Brisbane).

43 Submission No. 79, p.1 (Women's Action Alliance (Australia) Inc)

> Ten years ago most women who had an uncomplicated childbirth in this country stayed in hospital for 5-7 days and were provided with domiciliary midwifery care if they were discharged ‘early’ (ie less than three days from birth). Today, with the average length of stay reducing significantly, ‘early discharge’ has been redefined. Seven of Sydney’s 17 metropolitan hospitals now only provide domiciliary midwifery care to women who are discharged within 48 hours of childbirth.[44]

8.50 As noted, post natal care, like other aspects of care in pregnancy and childbirth, is adversely affected by fragmentation in funding arrangements. Fragmentation in responsibility for service provision is one consequence of this.

> In the case of obstetric early discharge, the period immediately following childbirth seems to fall into a ‘black hole’ when health and family policies are formulated at State and Commonwealth level. The need for a hospital to monitor mother and baby postnatally is effectively removed by discharging early. Yet because the immediate post-partum period is generally seen as a health system responsibility, other family policies and programs which begin at birth rarely include provision for formal linking and handover mechanisms.[45]

8.51 The recently introduced Families First program in New South Wales is an attempt to overcome these gaps in service provision. Currently being trialled in three health areas, it pays for early childhood health visitors to make regular home visits to families with young babies. It is intended that they will have links to hospital midwives involved in early discharge programs to ensure continuity of care, in much the same way as this is provided in the United Kingdom (where however, the program is long established and much better resourced).

8.52 While most concerns have focussed on inadequate back up for mothers and babies discharged early this is not the only problem with post natal care in the period immediately following birth. The nature and quality of hospital care during this period were also questioned by a number of witnesses.

> You get more quality time at home than you do in hospital. On the second day, you are probably allocated something like four hours of a midwife’s time if you are in the hospital environment, but that time is full of interruptions. We practise in a terrible way in the hospital environment. So if the women are at home and there is just one person giving advice, they do so much better than when they are in hospital.[46]

8.53 This issue was also raised in the Brown and Lumley study which found that:

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44 Submission No. 51, p.10 (Midwifery Practice and Research Centre, NSW)

45 Attachment to Submission No. 109 (NSW Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research)

46 *Committee Hansard*, 6.9.99, p.108 (Australian College of Midwives Inc, Vic Branch)

> Over 80 percent of women rated their postnatal care [in hospital] as good or very good, but many also described problems obtaining adequate rest, time for recovery, and assistance with their baby. Forty percent thought their hospital stay could have been improved by reducing the amount of noise and constant interruptions, restricting the number of visitors, more continuity of staffing so that the same midwife or group of midwives helped with each feed, and staff being less busy and spending more time with each new mother.[47]

Conclusion

8.54 The distinction between early discharge and post natal care is an artificial one. Both are important. The need for each is increasing as societal changes weaken the supports traditionally available to young mothers and babies, especially through their extended families.

8.55 While the picture is very varied, by hospital rather than by State, the general level of care provided to women in Australia in the immediate post natal period is inadequate in the opinion of many witnesses to the Inquiry. They claimed that it compares unfavourably with that provided in many other countries including Holland, the United Kingdom, New Zealand and even some states of America.

8.56 Early discharge programs have evolved in an ad hoc fashion across the country, generally but not always in response to pressure on hospital beds. Most of the practices associated with early discharge programs have never been evaluated. This is a feature of many aspects of antenatal and intrapartum care too, but it is particularly evident in post natal care. We do not know what constitutes best practice for post natal care and very limited research exists (either in Australia or overseas) on which to develop best practice guidelines. Even the Cochrane Collaboration, for example, has evidence of only three radomised trials relating to early discharge programs.

> This [early discharge] is one of these areas where there is a wholesale change of substantial magnitude occurring without any monitoring, without any standard and with no oversight about what is appropriate or not.[48]

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> More research needs to be conducted into postnatal care and the effect that different models of care have on longer term outcomes. We do not have a good understanding about the impact of different models of postnatal care (for example, hospital stay, domiciliary care), nor do we fully comprehend the essential elements and content of quality postnatal care.[49]

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47 Brown, Stephanie and Lumley, Judith. *Reasons to Stay, Reasons to Go: Results of an Australian Population- Based Survey,* Birth 24: 3 September 1997, pp.155-156

48 *Committee Hansard,* 14.9.99, p.439 (Midwifery Practice and Research Centre, Sydney)

49 Submission No. 51, p.10 (Midwifery Practice and Research Centre, Sydney)

> There is not one particular model that stands out as one that is best practice. It is possible in any model that a woman could cease breastfeeding, and suffer from postnatal depression and the system be unaware or be unable to detect any problems. Indicators of the success of the early discharge programs are not available, such as breastfeeding rates, postnatal depression rates, satisfaction rates, and cost effectiveness.[50]

8.57 Discussion of early discharge programs has tended to focus on length of hospital stay, the optimal duration of which is not known, much less agreed upon. This has skewed the debate away from the much more important issue of what constitutes optimal post natal care, who should provide it and what factors hinder its provision. It has also focussed attention upon the role of hospitals in providing post natal care (either in the hospital setting or through hospital based outreach programs to women after early discharge).

8.58 Experience in Australia and overseas shows quite clearly that the most effective post natal care is that based in the community and provided by maternal and child health nurses. The need for such services is increasing as family and community supports are reduced. The Committee considers therefore that development and implementation of community based approaches to post natal care is a high priority.

Recommendation

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.

8.59 The Committee considers that funding of domiciliary support services for women discharged early from hospital following childbirth should be available through the Commonwealth National Demonstration Hospitals Program, which has received more than $24 million since its inception in 1998. The objectives of the Program include ‘achieving early discharge with better integration of hospital and community care, more seamless transfer of care between hospital and community and lower overall cost to the health sector and community’.[51] Given that the greatest number of admissions to hospitals and the highest number of occupied bed days are pregnancy and birth related the Committee considers community support following obstetrical early discharge deserves inclusion in this program.

Recommendation

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.

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50 Submission No. 69, p.29 (Women’s Hospitals Australia and Australian Healthcare Association)

51 Information in this section was provided as an attachment to Submission No. 109 (New South Wales Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research)

8.60 As noted, little research has been conducted into post natal depression. Mental health generally has been recognised as a major public health issue. As a result the NHMRC received more than $24 million for mental health research in 1998. The Committee considers that some of these funds could be spent on research into post natal depression.

Recommendation

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