SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

ROCKING THE CRADLE

A Report into Childbirth Procedures

DECEMBER 1999

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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

CHAPTER 1

INTRODUCTION

Terms of reference

1.1 The matter was referred to the Committee on 30 June 1999 for inquiry and report by 30 December 1999.

1.2 The complete terms of reference are:

To inquire into and report by 30 December 1999 on childbirth procedures, with particular reference to:

(a) the range and provision of antenatal care services to ascertain whether interventions can be minimised through the development of best practice in antenatal screening standards;

(b) the variation in childbirth practices between different hospitals and different States, particularly with respect to the level of interventions such as caesarean birth, episiotomy and epidural anaesthetics;

(c) the variation in such procedures between public and private patients;

(d) any variations in clinical outcomes associated with the variation in intervention rates, including perinatal and maternal mortality and morbidity indicators;

(e) the best practices for safe and effective births being demonstrated in particular locations and models of care and the desirability of more general application;

(f) early discharge programs, to ensure their appropriateness;

(g) the adequacy of access, choice, models of care and clinical outcomes for rural and remote Australians, for Aboriginal and Torres Strait Islander women and for women of non-English speaking backgrounds;

(h) whether best practice guidelines are desirable, and, if so, how they should be developed and implemented;

(i) the adequacy of information provided to expectant mothers and their families in relation to the choices for safe practice available to them; and

(j) the impact of the new Medicare rebate provided for complex births, including the use of the term ‘qualified and unqualified neonates’ for funding purposes, and the impact that this has had on improved patient care and reduction of average gap payments.

Conduct of the inquiry

1.3 The inquiry was advertised in *The Weekend Australian* on 3 July 1999 and through the Internet. Submissions were also invited from Federal, State and Territory Governments, hospitals, professional organisations and other groups and individuals involved with childbirth in Australia. The closing date for submissions was originally 6 August 1999, although the Committee continued to receive submissions throughout the course of the inquiry.

1.4 The inquiry attracted wide interest throughout Australia with the Committee receiving 190 public submissions and 5 confidential submissions. The Committee also received a substantial amount of additional material from witnesses. Submissions were received from a wide range of organisations and individuals including hospitals and health services, practitioners, independent and hospital based midwives, welfare and peak organisations, and individual mothers. The list of submissions and other written material received by the Committee and for which publication was authorised is at Appendix 1.

1.5 The Committee held six days of public hearings in Canberra, Melbourne, Sydney, Adelaide, Brisbane and Perth. Some hearings were held in hospitals: the Royal Women's Hospital, Melbourne; the Women's and Children's Hospital, North Adelaide; the King Edward Memorial Hospital for Women, Perth; and the Mater Misericordiae Mothers' Hospital, Brisbane. While at these hospitals, the Committee took the opportunity to inspect the maternity facilities available. The Committee also inspected maternity facilities at the Mercy Hospital for Women in Melbourne and Queen Elizabeth Hospital in Adelaide. On behalf of the Committee, the Chair visited the Kirwan Hospital for Women, Townsville and inspected the maternity facilities including the telemedicine project. Details of the public hearings and the witnesses who gave evidence are listed in Appendix 2.

Acknowledgments

1.6 The Committee expresses its appreciation to the individuals and organisations who made submissions to the Committee or gave evidence to the inquiry. As always, the Committee places great value on the submissions it receives as primary sources of information. Many witnesses provided additional written information and copies of published articles. This material was most helpful to the Committee during its deliberations on the inquiry.

1.7 The Committee would like to thank all the hospitals that opened their facilities for the Committee's use and also the hospital and medical staff who generously gave their time to accompany Committee members on the inspections of maternity facilities. In particular the Committee would like to thank Ms Therese Sampson from the Mercy Hospital, Ms Ro Hogan and Ms Julie Webber from the Royal Women's Hospital, Dr Ross Sweet and Ms Joanne Harrison from the Women's and Children's Hospital, Dr Brian Pridmore from the Queen Elizabeth Hospital, Ms Robyn Collins from the King Edward Memorial Hospital, Mrs Jennifer Skinner and Professors

Jeremy Oats and David Tudehope from the Mater Misericordiae Mothers' Hospital, and Mr John Whitehall from the Kirwan Hospital.

1.8 The Committee's inquiry was greatly assisted through being able to discuss issues with Hospital staff and to see first hand the services provided and the developments that are occurring within hospitals.

1.9 The Committee would particularly like to thank Mr Paul Mackey from the Social Policy Group of the Department of the Parliamentary Library for the provision of material used by the Committee in the preparation of this report.

1.10 A Bibliography has been included at the end of the report. While not being comprehensive on the subject, it lists recent reports, research outcomes and other source material used by the Committee in the preparation of this report.

Consultancy

1.11 During the inquiry, the Committee received conflicting evidence in relation to medical indemnity, including the impact of escalating premiums for obstetricians, their fear of litigation and subsequent loss to the profession. The Committee had minimal success in attempting to obtain current data on medical indemnity to clarify the situation.

1.12 The Committee engaged Ms Fiona Tito to supply recent data on medical indemnity, including litigation in obstetrics, and to provide an analysis of this data with observations and recommendations relating to the escalation in litigation and costs. Ms Tito had previously chaired the 1995 Review of Professional Indemnity Arrangements for Health Care Professionals, which produced the report *Compensation and Professional Indemnity in Health Care*.

1.13 Ms Tito's paper has been incorporated, with some minor alterations and additions, as Chapter 10 of this report. The Committee would like to thank Ms Tito for undertaking this work at short notice and so late in the Committee's inquiry.

CHAPTER 2

ANTENATAL CARE

The nature and content of antenatal care

2.1 Antenatal programs vary greatly in their approach, content and the ways in which they are provided. The following discussion relates to antenatal care for the majority of pregnant women - those at low risk. The Committee was advised that they constitute about 80% of all pregnant women. They are healthy, neither very young nor close to the end of their fertile life and have no history of problems in pregnancy or childbirth. Women deemed to be at high risk because of their own health status, previous problems in pregnancy or childbirth or because of concerns about foetal abnormalities require, and normally receive, a different antenatal regime. This will vary for each woman.

2.2 Antenatal care usually has three distinct elements:

- the provision of information about pregnancy and childbirth generally and about arrangements for the birth of individual babies;
- antenatal classes; and
- screening of pregnant mothers.

Each of these elements is discussed later in this chapter and in the following chapter.

2.3 While antenatal screening is normally provided by doctors and specialists in hospitals and surgeries, antenatal education and information are provided by midwives, childbirth educators and other health professionals such as physiotherapists.

2.4 The frequency of antenatal visits also varies greatly. No agreement exists in Australia on the optimum frequency of antenatal visits nor has any link been established between visit schedules and outcomes. Women's Hospitals Australia is currently analysing the variations in visit schedules within its own hospitals to try to reach consensus on best practice.[1]

2.5 Notwithstanding the variations in practice, evidence to the Committee suggests that a typical schedule of antenatal care visits is:

- first consultation during the first 8 weeks of pregnancy;
- monthly visits until 28 weeks gestation;

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1 Submission No. 69, p.7 (Women's Hospitals Australia and Australian Healthcare Association).

- fortnightly visits from 28 weeks to 36 weeks gestation; and
- weekly visits from 36 weeks until birth.

2.6 The purpose of these visits is to monitor the wellbeing of the mother and child during pregnancy. The doctor or midwife records physical signs and doctors order tests as required. They can then act upon any symptoms of illness or abnormality detected in this process.

2.7 An area of increasing concern is the frequency and extent of some sophisticated antenatal screening, and especially ultrasound. This issue is discussed in the next chapter.

Range and provision of services

2.8 Antenatal care may be provided by:

- general practitioners;
- midwives in public hospital clinics or birth centres attached to hospitals;
- midwives in private practice (independent midwives) at the woman's home, for women who will normally deliver at home, at a birthing centre or, more rarely, in a labour ward with the same midwife in attendance;
- obstetricians;
- junior obstetric staff;
- a team which may include people from several of the above groups; and
- a team which may include Aboriginal health workers, for services targetted to indigenous women.

2.9 A range of antenatal care services is available in each State and Territory. The nature of the antenatal care provided to an individual will depend upon the model of care which she accesses, her insured status and the State in which she lives.

2.10 Once a woman has her pregnancy confirmed, normally by her general practitioner, he/she will generally advise her to book into a hospital for the birth. Certain models of antenatal care are unlikely to be available to women without private insurance, for example antenatal care provided by the same obstetrician throughout the pregnancy.

2.11 Women with private insurance are often referred by their general practitioners directly to obstetricians. The general practitioners and specialists may be unaware of other antenatal services. Some submissions argued therefore that women with private insurance in fact have fewer choices than those who do not.

> It should be noted that in many instances public patients [are] better served with choices in models of care generally, while these choices are not denied to private patients they may not be offered as currently happens to public

> patients. Women who elect to be treated by the public hospital have access to Family Birth Centre; midwife care, Team Midwifery model of care, Shared Care Programs with community GPs. Especially for those women who fit into the low risk category. Women with private insurance attending consultant Obstetricians for their care may not always be aware of the choices available to them. Many women attending Private practices fit the low risk category and could well be cared for by GP and midwifery models of care developed specifically to fit the private sector needs.[2]

2.12 Antenatal care provided by an independent midwife is restricted to those who can afford to pay for it, since it is not covered by Medicare and very few private health funds cover the costs.

2.13 Other factors limiting access to the full range of models of care include cost, geographic location and social and cultural appropriateness of services. Women at high risk may be directed to specific services and may therefore not be able to access locally provided services.

2.14 Some antenatal care services formerly funded by State governments have had their funding withdrawn or reduced and they are restricted now to those who can pay for them. This is particularly the case for antenatal classes (known as child birth education in some States) and will be discussed in greater detail in that context.

2.15 There has been considerable interest by consumers, health professionals and administrators in models of 'shared antenatal care,' the objective of which is to ensure that women enjoy continuity of care and/or carer throughout the pregnancy and birth and into the post natal period. It was claimed that such an arrangement is beneficial to women, who have an opportunity to develop rapport with, and confidence in, their carer. As the carer is present at the birth they do not have to give birth surrounded by people they have never seen before.

2.16 Shared care may involve individuals from different professional groups, such as general practitioners and midwives, or a number of people from within the same professional group. Variations on the shared care model are extensive. The Committee was told, for example, that in Victoria alone there are currently 18 models of shared antenatal care.[3]

2.17 The Committee received a number of submissions providing details of existing shared care models of antenatal care and generally extolling their virtues. The following excerpt is from the Team Midwives Model of care based at the John Hunter Hospital in Newcastle, which has since been replicated in a number of other hospitals, including Liverpool Hospital, Cairns Base Hospital and Geelong Hospital.

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2 Submission No. 46, p.5 (The Royal Women's Hospital, Vic).

3 *Committee Hansard*, 27.8.99, p.9 (Department of Health and Aged Care).

> The team functions with seven midwives (5.6FTE's) i.e. four fulltime midwives with three part time midwives.
>
> …One of our main objectives is to provide care in labour with a midwife whom the woman has come to know during the antenatal period. Our latest survey shows that 83% of our clients were supported in labour by a midwife known to them.
>
> …One to one care during labour has been an objective of the team since its beginning. Our latest figures show that 71% of our clients are supported by the same midwife for the entire duration of labour.
>
> The team provides continuity of care across the spectrum of antenatal care, with three clinics provided over morning, afternoon and evening providing flexibility of appointment times on three different days through out the week. This flexibility is not offered by other local service providers. During the antental visits rapport is built, the length of these visits is greater than eight minutes giving the women the opportunity to ask questions and discuss issues of importance to them as individuals. The woman and her family then have with them a midwife that they have come to know when labour begins.[4]

2.18 The merits of continuity of antenatal care provided by a single care giver were described in a number of submissions. These claimed that it was particularly valuable if the same care giver also attended the woman during birth and post natally. In South Australia, for example, the Community Midwifery Program in the Northern Metropolitan Area (funded through the Alternative Birthing Services Program described later in this chapter) provides continuity of carer through pregnancy, birth and the post natal period.

> Each woman will be allocated a primary midwife who will provide her care throughout pregnancy, labour, birth and post natal period, supported by a second midwife providing back-up. A midwife will be available for contact 24 hours a day.[5]

2.19 A similar approach has been adopted at St George Hospital in south Sydney where midwives provide antenatal care from community centres (an early childhood centre, a community centre and a family planning clinic).

> …those women received all their antenatal care in the community with these two teams of midwives and obstetricians. When they came to birth their babies, they came to the hospital and the same midwives came in and cared for them. They were on a 24-hour rotation roster. After the babies were born

4 Submission No. 165, pp.7-8 and pp.1-2 (Team Midwives, John Hunter Hospital).

5 Additional information, 24.9.99 (Community Midwifery Program, SA).

> they went to the postnatal ward or they went home, and they were still cared for by those same midwives.[6]

2.20 Some submissions differentiated between continuity of care and continuity of care giver. Implicitly, if not explicitly, they made the case for a shared care approach.

> I think there are a number of misconceptions and aberrant usages of the term "continuity of care" and my way of getting around this is to differentiate continuity of care from continuity of care giver. The way that I perceive this issue is that continuity of care can occur in a major obstetric unit where policies and clinical paths have been devised by consensus amongst the various care givers to provide a clear and consistent frame of management for the care of maternity patients. This means that every time a new medical officer sees the patient or a new midwife sees the patient they are aware of what has gone before and what is considered the unit policy within that hospital.
>
> Continuity of care giver on the other hand, refers to the same person providing care throughout the whole pregnancy delivery and post natal period. In order to provide continuity of care giver, requires that the obstetrician, GP or independent midwife see the patient for each of their antenatal visits, remain available for 24 hours per day 7 days per week should this patient come into labour at a non scheduled time, then be available for the total duration of their labour which may be up to 36 hours without any breaks and then to regularly see the patient during the post natal period.[7]

2.21 The following excerpt extolling the virtues of continuity of care giver is from a mother who received pregnancy care from the Childhood Information Service, a home birth group in Tasmania. The Committee received many supportive submissions from women associated with this group.

> …the midwife may be able to conduct antenatal visits at the woman's own home. This is an aspect of the service which is rarely available through hospitals, but which can be very convenient late in pregnancy. Certainly, such an arrangement is preferable to a woman failing to appear for her antenatal checks during the final weeks of pregnancy, when complications such as pre-eclampsia may arise and require immediate attention.
>
> The continuity of care provided by the midwife throughout the pregnancy, combined with long appointment times (often up to one hour) facilitates the development of a personal relationship…Under the CIS model, the midwife is able to build familiarity and knowledge of the woman and her family, including their values and preferences.[8]

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6 *Committee Hansard*, 14.9.99, p.434 (Midwifery Practice and Research Centre).

7 Submission No. 8, p.2 (Dr Andrew Child, King George V Memorial Hospital, Sydney).

8 Submission No. 36, p.4 (Ms Clarissa Cook, Tas).

2.22 The Committee strongly supports the concepts of shared care and continuity of care. It notes that a number of State and national reports have also supported them. The *Final Report of the Ministerial Review of Birthing Services in Victoria* and the *Final Report of the* Ministerial *Task Force on Obstetric Services in New South Wales* (the Shearman Report)[9] made a number of recommendations concerning the desirability of extending shared care models of antenatal care. So did the National Health and Medical Research Council (NHMRC) Report *Options for effective care in childbirth.* These were Recommendations 5.1 – 5.4, which read:

- Public hospital clinics should be adapted to enable links to be developed with general practitioner obstetricians and midwives to improve shared care.
- Public antenatal clinics should take all steps necessary to enable most women to have continuity of care and carer, in hospital or with a medical practitioner.
- Shared care involving small teams of general practitioners obstetricians and midwives should be encouraged. This should promote satisfaction for both the woman and the service providers.
- Guidelines for shared care should be drawn up locally having regard to State and National guidelines.

2.23 The Committee notes with concern the failure of governments, hospitals and professional groups to act upon the recommendations of these reports. Given the Commonwealth's role in providing national leadership and consistency across States in the provision of services the Committee considers it appropriate that the Commonwealth Government take a leadership role in implementing the recommendations of earlier reports.

Recommendation

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.

2.24 While most evidence to the Committee was generally supportive of the shared care model of antenatal care and emphasised the importance of continuity of care, a note of caution was expressed by Women's Hospitals Australia and the Australian Healthcare Association. They pointed out the lack of Australian data on the impact of transferring antenatal care from hospital clinics to other centres and the need for a proper evaluation of different models of shared care in different settings throughout Australia.[10]

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9 National Health and Medical Research Council. *Options for effective care in childbirth,* 1996; Health Department of Victoria. *Having a Baby in Victoria,* 1990; *Final Report of the Ministerial Taskforce on Obstetric Services, NSW, 1989.*

10 Submission No. 69, pp.8-9 (Women's Hospitals Australia and Australian Healthcare Australia).

2.25 Dissatisfaction with some models of shared care has also been expressed by Victorian consumers.

> Women indicated a low level of satisfaction with Shared Care in the 1993 Victorian Survey of Recent Mothers (Centre for the Study of Mothers' and Children's Health). In this survey 33% of women receiving Shared Care rated their antenatal care as very good compared with 72% of women attending a private obstetrician, 46% attending a public clinic and 80% who received team midwifery care in a birth centre.[11]

2.26 Even team midwifery care in a birth centre can fail a woman who has chosen it, as was the experience of one witness in Melbourne.

> I blame the system, actually. Even though they are offering you a team of midwives, in reality it really means discontinuity of carer. This girl, this midwife, was on my team but because of the way my antenatal appointments were organised, when it came time for me being in labour she was the one who was there and I had never met her before. She had no idea who I was…So I blame the system. I do not blame her or that team of midwives.[12]

2.27 Potential problems with the shared care model include the possibility of duplication of services or gaps in the provision of services and of test results being lost or not followed up. To overcome these difficulties it has been suggested that antenatal records should be held by the individual woman to whom they refer. A number of witnesses before the Committee supported this recommendation.[13]

> I think a patient held record which involves a multidisciplinary approach and puts the woman at the centre is absolutely the right way to go.[14]

* * *

> That is the beauty of the South Australian woman-held pregnancy record card because each provider potentially provides it to the woman at her first visit so that the range of information that is being provided at that initial visit is the same whether you are visiting a hospital or a GP.[15]

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11 Submission No. 163, p.6 (Department of Human Services, Vic). Refers to 1993 '*Survey of Recent Mothers*' conducted in Victoria by Stephanie Brown and Judith Lumley.

12 *Committee Hansard*, 6.9.99, p.134 (Maternity Coalition, Vic).

13 For example by the NHMRC Report *Options for effective care in childbirth*, Canberra,1996, p. xii.

14 *Committee Hansard*, 6.9.99, p.156 (Royal Women's Hospital, Vic).

15 *Committee Hansard*, 7.6.99, p.254 (Department of Human Services, SA).

2.28 The Committee is aware that patient[16] held maternity records are provided to women in some Australian hospitals and that their use is well established in a number of European countries.

Recommendation

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.

Access to antenatal care

2.29 Antenatal services are widely available, (at least in metropolitan areas), but take up rates are very variable. Access to antenatal care is an issue, where there are language difficulties or where culturally appropriate services are not available. Take up rates are low among some groups such as Aboriginal and Torres Strait Islander women, women from non English speaking backgrounds and adolescent women. Such groups include women, whose health status is poor, so that they could derive significant benefit from antenatal care.

Access for women in rural and remote areas

2.30 Residents of rural and remote areas are significantly disadvantaged compared with residents of metropolitan areas in respect to access to, and choice of, health care services generally. This is also the case for antenatal services. There is a significant shortage of general practitioners, midwives and specialists outside major regional centres. In 1997, 16% of all medical practitioners worked in rural and remote areas in their main job, but 28.8% of the total population lived there. For obstetricians and gynaecologists the figure was 15.3% and for midwives it was 23.7%. In remote areas there is one medical practitioner per 1,395 of the population. This compares with 1 per 824 of the population in capital cities. Only seven obstetricians and gynaecologists had their main job in a remote area.[17]

2.31 The situation is expected to deteriorate with the ageing of the specialist medical workforce (the average age of obstetricians is now 51.1 years) and the reluctance of general practitioners to undertake obstetric work because of fears and costs associated with litigation as well as more general lifestyle considerations.

2.32 The Commonwealth Government is attempting to address the problem through the Rural Incentives Program which provides initiatives funded under the

16 The Committee recognises that the majority of pregnant women are not ill and that use of the term 'patient' is therefore problematic. It is used here, and occasionally elsewhere in the Report, where it clarifies the issues being discussed.

17 Figures are from Australian Institute of Health and Welfare. *Medical labour force 1997*, Canberra 1999, p.3 and p.29, Australian Medical Workforce Advisory Committee. *The Obstetrics and Gynaecology Work Force in Australia: Supply and Requirements 1997-2008*, Sydney 1998, p.8 and Australian Institute of Health and Welfare. *Nursing labour force 1998*, Canberra 1999, p.58.

National Rural Health Strategy. These include payments designed to encourage general practitioners to relocate to rural areas and to support those already practising there. It has also negotiated with each State and the Northern Territory to provide for the establishment of 37 specialist positions in major provincial and rural centres during 1999. It is anticipated that these positions will provide the selected centres with access to advanced trainee obstetricians and at the same time expose the trainees to the special issues facing women giving birth in rural areas.[18] The Committee considers that while these initiatives may go some way to addressing the shortage they are most unlikely to overcome it.

2.33 Some rural residents are therefore obliged to travel long distances to access services. This is especially difficult for women in the later stages of pregnancy, those with small children and those without their own transport.

2.34 Some major teaching hospitals provide satellite clinics with visiting specialist medical teams to rural and remote communities. They travel to regional centres and examine women referred to them by local general practitioners. At present they reach only a small proportion of those who could benefit from them. When problems are identified, treatment is normally available only at major centres. The Committee considers that satellite clinics with visiting teams of obstetricians have the potential to overcome many of the disadvantages faced by women in rural and remote locations in accessing specialist obstetrical care.

2.35 Mater Misericordiae Mother's Hospital in Brisbane provided information about a successful pilot project in foetal ultrasound telemedicine which it conducted in conjunction with Kirwan Hospital for Women in Townsville in 1998.

> The project, the first of its kind in Australia, demonstrated that realtime fetal ultasound consultations could be performed using high quality video conferencing systems network interface units and ISDN access…The majority of these consultations were completed in 30 minutes at a line cost of approximately $70 per consultation.[19]

2.36 While the service received strong support from the women using it and from clinicians in North Queensland, Mater advised the Committee that the number of consultations performed to date had been too small to determine the true costs of a consultation. Initial set up costs were high and the extension of the system to other hospitals may be limited by the type and quality of video conferencing equipment in use in these hospitals. A further concern for Mater was the difficulty of calculating factors such as the costs of additional clinician time, and costs borne by the woman and her family, including the costs of travelling to Townsville.

2.37 Despite these concerns and the fact that rural women are still obliged to travel to a major regional centre for antenatal screening, the Committee believes the model

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18 See Submission No. 97, p.31 (Department of Health and Aged Care).

19 Submission No. 78, p.31 (Mater Misericordiae Mothers' Hospital, Qld).

warrants further study and application in order to increase rural women's access to antenatal obstetrical services.

Recommendation

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.

Access for Aboriginal and Torres Strait Islander Women

2.38 While morbidity and mortality rates for Australian mothers and babies generally are among the lowest in the world, this is not the case for indigenous mothers and babies. The Aboriginal and Torres Strait Islander Commission indicated that:

- Infant mortality rates [for indigenous babies] are still three to five times as high as the rates for other Australians.
- The mean birthweight of babies born to indigenous mothers was 3,140 grams, compared with 3,370 grams for babies born to non-indigenous mothers.
- Babies born to indigenous women were more than twice as likely to be of low birthweight (12.6% compared with 6.2%).[20]

2.39 The reasons for the higher incidence of maternal and infant health problems in the Aboriginal and Torres Strait Islander population are complex. They relate, at a macro level, to poverty and social disadvantage. Furthermore, indigenous mothers tend to give birth at younger ages, to have more children and to have them more closely spaced than does the non indigenous population. Their own health is likely to be significantly worse than that of women of equivalent age in the general population and they are more likely to engage in high risk behaviour that can be damaging to them and their babies during pregnancy.

2.40 In the Northern Territory in 1995, for example, 4.1% of Aboriginal mothers aged 20-29 were diagnosed with gestational diabetes compared with 2.3% of non Aboriginal mothers. The equivalent figures for anaemia were even more disturbing: 18.9% for Aboriginal mothers, and 3% for non Aboriginal mothers.[21]

2.41 A greater percentage of indigenous babies are born prematurely, and with low birthweight. Their perinatal[22] death rate is high. The New South Wales Midwives Data

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20 Submission No. 156, p.3 (Aboriginal and Torres Strait Islander Commission). Figures issued by the Australian Bureau of Statistics in November 1999 show the infant mortality rate for indigenous Australians was at least three times the Australian rate in 1998.

21 *Trends in the health of mothers and babies, Northern Territory 1986-95,* Northern Territory Midwives Collection, Territory Health Services, 1998, pp.16-18.

22 A perinatal death is a still birth plus a death of a baby within 28 days of birth.

Collection estimates that the death rate is 13.8 per 1,000 births to indigenous mothers, compared with 6.8 per 1,000 for non indigenous mothers.[23]

2.42 The picture is not uniformly bleak. There have been some significant improvements in the last 15 years, especially in perinatal mortality rates for babies of indigenous mothers.

> In Western Australia, for example, the perinatal mortality rate for babies of Indigenous mothers fell from 23.3 per 1,000 births in 1986 to 17.2 in 1995, although the rates remain more than double the non-Indigenous figure of 6.8 per 1,000 in 1995…In the Northern Territory, the perinatal mortality rates per 1,000 births for babies born to indigenous mothers fell even more dramatically, from 48.9 in 1986 to 26.4 in 1995.[24]

2.43 These improvements result from a general improvement in health and nutrition among indigenous mothers and from specific initiatives designed to reduce morbidity and mortality among indigenous mothers and babies.

2.44 Appropriate antenatal care is a significant contributor to improved health outcomes for indigenous mothers and babies, yet Aboriginal and Torres Strait Islander women have significantly fewer antenatal visits and generally have their first visit later in pregnancy than do non indigenous mothers.

> Almost 38% of Aboriginal women present after 20 weeks gestation for their first antenatal visit, compared with 15% in NSW overall.[25]

* * *

> The Aboriginal women were generally younger at delivery…made their first antenatal visit later (Aboriginal 49% after 20 weeks vs non Aboriginal 10%) and made fewer antenatal visits (Aboriginal 43% fewer than 4 visits vs non Aboriginal 2% fewer than 4 visits).[26]

2.45 Factors identified as inhibiting access to antenatal services by indigenous women were cost, lack of transport, the culturally inappropriate nature of the services offered and lack of appreciation of the value of antenatal care. The Koori Health Unit in Victoria, for example, commented that:

> One of the greatest difficulties in getting Koori women to attend antenatal classes and check-ups was that pregnancy was seen as normal and most

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23 NSW Department of Health, *NSW Midwives Data Collection*, 1995.

24 Australian Bureau of Statistics and Australian Institute of Health and Welfare. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 1999, p.88.

25 Submission No. 45, p.18 (Australian Midwifery Action Project, NSW).

26 Powell J. and Dugdale A.E. *Obstetric Outcomes in an Aboriginal Community. A Comparison with the Surrounding Rural Area.* Australian Journal of Rural Health, Feb 1999, 7, pp.13-17.

> women did not feel sick. As a result, they did not see the need for antenatal care or for changes to their lifestyle.[27]

2.46 A number of antenatal programs for indigenous mothers are currently being trialled. They are designed to overcome the difficulties referred to above and some have been very successful. The Committee was particularly impressed by the evidence it received on the *Strong Women, Strong Babies, Strong Culture* program in the Northern Territory.

2.47 This program began in 1993 in three communities in the Northern Territory where low birthweight was a problem causing community concern. The program is run by Aboriginal women and supported by Territory Health Services. The women were carefully selected and trained. Their role is to encourage a range of practices including regular antenatal visits, compliance with medications and proper nutrition. They work within a traditional framework and so have gained the confidence of the women concerned and of the wider community.

2.48 The program was adopted by a further seven communities in 1997. It was evaluated in 1998. The main findings of the evaluation were:

> In the three pilot communites, the mean birthweight increased by 171 grams between 1990-91 and 1994-96 (from 2,915 grams to 3,086 grams), and the proportion of babies who weighed less than 2,500 grams decreased from 19.8% to 11.3%. There were improvements over the same period in communities that did not have the program, but they were not as large… Other changes in health services occurred in the pilot communities, and these may have had an effect on birthweight, but the evaluation team concluded that it was likely that the program had been beneficial.[28]

2.49 An antenatal program targetted to indigenous women in a metropolitan areas is the Daruk Aboriginal Medical Services Antenatal Program in Mt Druitt, west Sydney. This program employs a full time midwife and an Aboriginal health worker. They work in conjunction with a general practitioner from the Aboriginal Medical Service and obstetricians at Nepean Hospital, providing antenatal care, birth support, transport, home visits, social and family support and education. The program has significantly increased the number of indigenous women accessing antenatal care and encouraged them to seek this care early in pregnancy.

> The program evaluation compared outcomes for Aboriginal women who accessed the Daruk service with those of Aboriginal women who accessed mainstream antenatal care at Nepean and Blacktown Hospitals. Thirty six percent of Daruk women had their first antenatal visit in the first trimester of pregnancy compared with 21% at Nepean and 25% at Blacktown. Despite Daruk women having a higher burden of antenatal risk factors than

27 Department of Human Services, Koori Health Unit, 1996.

28 Australian Bureau of Statistics and Australian Institute of Health and Welfare. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples,* 1999, p.87.

> Aboriginal women at Blacktown and Nepean hospitals, there was no concurrent increase in perinatal morbidity or mortality.[29]

2.50 In Alice Springs, Congress Alukura was established under the Alternative Birthing Services Program. This is a Commonwealth Government funded program designed to promote greater choice for women giving birth and to encourage State health services to carry out trials of a range of care models. Congress Alukura provides antenatal, birthing and post natal services to Aboriginal women using culturally appropriate approaches including the employment of a grandmother educator/ traditional birth attendant. It has been very successful in encouraging Aboriginal women to access antenatal care.

> During 1994 the Alice Springs Urban area had the highest rate of Aboriginal presentation for antenatal visits before 13 weeks gestation than any other centre in the NT…The figures for 1994 showed 122 Aboriginal women presented for antenatal care in the Alice springs urban area, of these 119 (98%) attended congress Alukura.[30]

2.51 A very diverse range of programs has now been conducted aimed at improving access to, and quality of, antenatal programs for indigenous women. Others are currently being established, for example through the *Healthy Women Strong Families Program* funded by the Commonwealth Government through the Office for Aboriginal and Torres Strait Islander Health. Many programs have been carefully evaluated. As a result it is possible to identify elements common to successful programs. Such elements include:

- consultation with Aboriginal communities, especially women, at every stage of development, implementation and evaluation;
- the provision of culturally appropriate services;
- the training of indigenous health workers and midwives to provide such services;
- training in cultural issues for non indigenous staff involved in programs;
- a team approach involving the Aboriginal Medical Service general practitioners and rural GPs as well as community midwives and health workers;
- links with hospitals, especially through Aboriginal outreach and liaison workers;
- links to broader health services;
- adequate transport; and
- continuity of program funding for successful projects, through provision of Commonwealth and State funds.

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29 Submission No. 38, p. 15 (NSW Midwives Association).

30 Territory Health Services, Women's Health Unit. *Evaluation of the Alternative Birthing Service Program in the Northern Territory,* 1997, p.11.

2.52 None of these findings are new. Similar conclusions have been reached in a range of publications and reports such as the National Aboriginal Health Strategy of 1989 (currently in the process of modification), the NHMRC Report on *Options for effective are in childbirth*, the Report of the Ministerial Review of Birthing Services in Victoria, *Having a Baby in Victoria* and the *Review of Birthing Services in the Northern Territory of Australia*.

2.53 The Committee is therefore extremely disappointed to note that a number of pilot programs targetted to improving the care of Aboriginal and Torres Strait Island women and babies have had to close through lack of funding, despite their successful outcomes. Several submissions, for example, drew the Committee's attention to a series of pilot programs in Victoria funded by the Commonwealth through the Alternative Birthing Services Program, which closed upon cessation of Commonwealth funding.

2.54 Work funded by the Alternative Birthing Services Program as well as through programs funded directly by the Aboriginal and Torres Strait Islander Commission and, more recently, by the Office of Aboriginal and Torres Strait Islander Health, has established the elements which contribute to the success of antenatal programs. What is needed now is not further pilot programs but for existing pilot programs to be made permanent and for new antenatal care services to be established incorporating the elements demonstrated to be critical to the success of such programs.

Recommendation

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.

Access for women from non English speaking background

2.55 The importance of providing culturally and linguistically appropriate antenatal services for women from non English speaking backgrounds has been well recognised, for example in *Having a Baby in Victoria,* in *Options for effective care in childbirth* and in the Turnbull Report.[31] The issue is a complex one. The social isolation and poverty experienced by some women from this group are undoubtedly contributing factors to their lower take up rates of antenatal services but language barriers, practices which they find culturally inappropriate and ignorance of Australian services undoubtedly deter some women from seeking antenatal care or fully benefitting from it they when they do so.

2.56 Following concerns expressed in the Shearman Report of 1989 the New South Wales Government funded a number of initiatives designed to improve access to

31 Health Department of Victoria. Final Report of the Ministerial Review of Birthing Services in Victoria, *Having a Baby in Victoria, 1990; NHMRC. Options for effective care in childbirth*, 1996; Legislative Assembly of Western Australia. *Report of Select Committee on Intervention in Childbirth, 1995.*

antenatal care for women from non English speaking backgrounds.[32] As a result, hospitals and area health services in areas of New South Wales with high concentrations of women from non English speaking backgrounds employed ethnic obstetric liaison teams and bilingual midwives and expanded interpreter services. These initiatives were successful in improving access to antenatal services.

> The lack of access to interpreter services can deny women adequate and timely health care. The ethnic obstetric liaison program has been very effective in meeting this need, particularly for antenatal care.[33]

2.57 It appears however that despite the success of these programs their funding has been reduced.

> Ethnic Obstetric Liaison Officers were introduced into a number of Sydney hospitals following the *Shearman Report* (Shearman 1989). The funding for these have since been reduced, or removed in some centres, and many of these positions no longer exist.[34]

2.58 Nor have funding cuts been restricted to services operating in New South Wales.

> Because of budgetary reductions that have been imposed on all maternity health care centres in Australia, interpreter services have been severely restricted and in many cases withdrawn.[35]

2.59 Given that the programs were introduced in response to the findings of the Shearman report, that they have been well supported in the community and that they are relatively inexpensive, the Committee finds it extraordinary that they have been defunded.

Recommendation

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.

Access for adolescent women

2.60 The Committee's attention has been drawn to the particular difficulties faced by adolescent women in obtaining appropriate antenatal care. Some large maternity hospitals do run programs targetted to this group.

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32 Shearman, R. *Final Report of the Ministerial Task Force on Obstetric Services in New South Wales,* New South Wales Health Department, 1989.

33 Submission No. 104, p.1 (Central Sydney Area Health Service).

34 Submission No. 51, p.11 (Midwifery Practice and Research Centre, NSW).

35 Submission No. 69, p. 32 (Women's Hospitals Australia and Australian Healthcare Association).

> We also have clinics for young pregnant women, with peer support workers and other teenage mothers to help them.[36]

2.61 However, little is done for those outside metropolitan areas, despite the greater likelihood of their suffering significant disadvantage such as lower education levels, poorer nutrition and a greater likelihood of high risk behaviours.

2.62 The Committee is concerned that very few programs currently address the needs of adolescent mothers.

Recommendation

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

Antenatal information and education

2.63 Antenatal information is provided to Australian women in a variety of ways. The most usual of these are:

- by hospital based midwives and/or nurses in hospital clinics;
- by community based midwives in community health centres;
- by childbirth educators in hospital clinics or community health centres;
- by a team consisting of midwives, general practitioners, obstetricians, and sometimes other health professionals such as physiotherapists, normally but not necessarily held in a hospital clinic;
- by independent midwives in a woman's own home; and
- by general practitioners or obstetricians.

2.64 For many women, the type of antenatal information they receive, as well as its quality, is largely determined by their general practitioner, who in the majority of cases will be the person confirming the pregnancy. On the first visit the general practitioner may herself/himself provide information on choices for the birth, conduct preliminary tests to ascertain the woman's health status, provide some preliminary antenatal information and direct the woman to other sources of information. The general practitioner's awareness of sources of information and assessment of their value is a critical factor for many women in the information they access.

2.65 As noted earlier, some women considered their general practitioners were ill informed about the range of birthing options available or failed to mention those options they did not support. This lack of information curtailed women's choices, an issue of particular concern to women who favoured home birth. This option was rarely

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36 *Committee Hansard*, 7.9.99, pp.195-196 (Professor Keirse, Flinders Medical Centre).

supported by general practitioners and obstetricians and in many cases it seems they do not advise women that it is a possibility.

> In discussions about initial antenatal practices, we believe two items should be paramount:
>
> 1. Women who attend their first antenatal visit should be well informed…Information about the option to birth at home should be provided to all women, along with all other options.
>
> 2. The practitioners who see women for their first antenatal visit should be well informed about the practice of homebirth as a safe birthing option.[37]

2.66 A similar position applied with respect to advice on birthing centres.

> …the majority of women, when they first believe that they are pregnant, have their pregnancy confirmed by a medical practitioner. At that visit, the medical practitioner decides with the woman who she will visit for the rest of her pregnancy. With few exceptions, the birth centre here at King Edward, homebirth or other midwifery managed services are not mentioned. Doctors tend to refer to other doctors. Many GPs tend to refer to obstetricians if they are not going to practise obstetrics themselves.[38]
>
> * * *
>
> I believe that GPs who are often the first "port of call" for a pregnant woman exploring her options, need access to high quality information about birth options and their relative safety.[39]

2.67 Similarly, many women who have their first antenatal visit at a hospital clinic are advised only of the services available at that hospital, for antenatal care, for birth and for post natal care.

Access to information

2.68 Some women will independently access sources of information not suggested or not known by their general practitioners. This is likely to be particularly the case for middle class, well educated women with the skills and training to seek out information. Other women may find additional information through family and friends or from community based midwives where they operate successful outreach programs. The Community Based Midwives Program in Western Australia, funded through the Alternative Birthing Services Program, is an example of such a service.

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37 Submission No. 30, p.1 (Homebirth Network of South Australia).

38 *Committee Hansard*, 8.9.99, p.364 (Australian College of Midwives, WA).

39 Submission No.110, p.20 (Dr Sarah Buckley, Qld).

> The program aims to empower and assist birthing women by supporting their right to choose the most appropriate care for the individual circumstances…The program also aims to ensure that women are made aware of all their options with regard to pregnancy and childbirth and assist women in making their personal choice based on sound and unbiased information. Whilst we actively promote home birth as an alternative option among the choices available, we do not encourage home birthing to the exclusion of other models of care.[40]

2.69 Another is the Pregnancy and Childbirth Resources Centre in Fremantle, with which the Community Based Midwives are closely associated.

> Importantly for us, we have a partnership with the Pregnancy and Childbirth Resource Centre, which is also funded through the Alternative Birthing Services program and operates out of East Fremantle. That centre essentially provides women with resources such as books, videos and all sorts of information in terms of choices on childbirth and the process of childbirth. It also provides a network not only for women who use our program but also for women in the broader community to create their own networks and community groups.[41]

2.70 Some antenatal hospital clinics also have very successful outreach information programs. Many of these are targetted to groups thought to be in greatest need of information, and to have the most difficulty in obtaining it, such as adolescents and women from non English speaking backgrounds.

> We are the only hospital in the state that runs morning, afternoon and evening clinics, as well. We do two evening clinics a week. We are also the only one that delivers antenatal care for public patients off-location, 20 kilometres to the south, where there is an area of greater need.[42]

2.71 However, the Committee also heard from a number of consumer groups about some 'user unfriendly' antenatal clinics. A problem raised consistently was the extended delays experienced in many clinics.

> There are problems in the management of antenatal clinics in hospitals. Women often report extended delays that can regularly run well more than an hour past their appointed time. There are no incentives to change existing practices in this area and Maternity Alliance strongly recommends that strategies be implemented to improve performance.[43]

2.72 Aboriginal women generally face significantly more difficulty than the general population in accessing antenatal information because most of the information

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40 *Committee Hansard*, 8.9.99, p.314 (Community Based Midwifery Program, WA).

41 Ibid, p.318.

42 *Committee Hansard*, 7.9.99, p.195 (Professor Keirse, Flinders Medical Centre).

43 Submission No. 153, p.3 (Maternity Alliance, NSW).

available is not culturally sensitive to their needs. As noted, Aboriginal women tend to begin their antenatal visits later in pregnancy and to have fewer visits overall. This reduces their opportunities to access the information available to them.

2.73 Some recent programs have been very successful in presenting culturally appropriate information for Aboriginal and Torres Strait Islander women. These include the *Strong Women, Strong Babies, Strong Culture* program and the Congress Alukura program, already described.

2.74 Other programs with a particular focus on the provision of antenatal information to Aboriginal women include the Wurli Wurlinga project at Katherine and the Darwin rural maternal health project which is developing an antenatal care model for women in the Oenpelli area. Both projects are funded through the Alternative Birthing Services Program. The Oenpelli project has only recently started but the Wurli Wurlinga project:

> …although in its early stages, has already begun to document an increase in the number of Aboriginal women in the Katherine area receiving ante natal care prior to 28 weeks, and improved early presentation figures.[44]

2.75 Women living in rural and remote areas may also be disadvantaged in accessing antenatal information, but this is not always the case. Some excellent programs exist in rural and remote areas. However, because they have fewer sources of information, women in rural and remote Australia are more dependent on their general practitioners to refer them to appropriate sources and may have more difficulty in obtaining information in cases in which their general practitioner is ill informed about the options available.

2.76 The Committee concluded, on the basis of the evidence received during its Inquiry, that availability of antenatal information, and access to it, varied greatly. Factors influencing availability and access included:

- knowledge of information sources on the part of the professional primarily responsible for a woman's care;
- education and skill of the woman concerned;
- general practitioner's knowledge and referring practice;
- geographical location;
- familiarity with the English language;
- Commonwealth and State health department commitment to the provision of information, and concomitant allocation of resources; and

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44 Territory Health Services, Women's Health Unit. *Evaluation of the Alternative Birthing Services Program in the Northern Territory*, 1997, p.16.

- successful promotion of existing sources of information.

2.77 The quality and relevance of the information provided are also significant factors affecting the take up of available information and its impact.

Quality of antenatal information

2.78 The quality of antenatal information and its timeliness were issues raised repeatedly by both practitioners and consumers. It is perhaps more critical now than ever before, partly because the range of possible interventions and other 'treatments' is so much greater than previously and also because, with small families, most women have minimal experience of pregnancy and childbirth in their immediate families.

2.79 A concerted effort has been made in Western Australia to address these issues, in part in response to the Turnbull Report of 1995, which raised concerns about the inadequacy of information available to most women during pregnancy.[45] In 1998 the Health Department of Western Australia, with input from consumers and professional groups, published a booklet available to all pregnant women (from general practitioners, antenatal clinics, chemists etc) outlining **all** their birth options, suggesting questions they might like to raise, covering issues of informed consent and providing a comprehensive list of service providers throughout the State.[46]

2.80 One of the aims of the booklet is to inform women at low risk of the feasibility and benefits of a natural birth.

> All mothers need assistance in going through the pregnancy process. This booklet reassures them that, if they are a low risk patient, they are safe to be delivered by a midwife or a general practitioner/obstetrician. That is part of the objective of this book. The objective is to get out the news to people that safe delivery for low risk patients can occur in any one of these establishments in the whole of Western Australia. Your guarantee of having a good delivery of a baby that is as perfect as can possibly be managed in our society is excellent in any one of these facilities throughout the whole of Western Australia.[47]

2.81 The Committee was advised that almost all of the 35,000 copies originally printed have been distributed and a revised edition is planned.[48] The Committee considers that the West Australian example is deserving of wider emulation.

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45 Dr Hilda Turnbull MLA. *Select Committee on Intervention in Childbirth,* Perth, 1995.

46 *Your Birth Choice. Planning Ahead for Birth.* Health Department of West Australia, 1998.

47 *Committee Hansard,* 8.9.99, pp.289-90 (Dr Turnbull MLA).

48 By the West Australian Department of Health. See *Committee Hansard*, 8.9.99, p.352.

Recommendation

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.

Recommendation

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.

Recommendation

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.

Recommendation

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.

2.82 Concern focussed on the quality, accuracy and depth of information provided to women on the procedures available during the antenatal period and during the birth itself. Both consumers and practitioners repeatedly stated that without the provision of quality, current information and advice it was not possible to guarantee that a woman was in fact giving informed consent to the interventions proposed. In the case of interventions possible at birth, advice and information obviously needed to be provided well ahead of the event and not, as is often the case, at the point when they are needed.

> Women need to be given information about childbirth procedures in a timely way - preferably during pregnancy, but better explanations should be given before procedures are commenced. Women need to know the reasons for an intervention, what is involved and the potential consequences for themselves and their baby(s).[49]

49 Submission No. 153, p.15 (Maternity Alliance, NSW).

2.83 One witness questioned the whole concept of informed consent at the time of birth, given the unequal power relationship existing at that time between the woman in labour and her clinician.

> In my opinion, I cannot imagine people being in more different positions of power than a woman who is naked, in labour, prone on a hospital bed and someone who is a clinical care provider who is in a position of responsibility. I find it very hard to accept that you can give fully informed consent in such circumstances, which is not to say that we should not try to give it. I do not think we should pretend, though, that such a thing is possible.
>
> I believe that it is in fact very difficult for women to give informed refusal in such circumstances, because they are very fearful that care will be withdrawn if they refuse recommendations that their baby's life is in danger or their own life is in danger and that these procedures are necessary. So my other concern is that we need to look very carefully at the ethics of decision making in these fairly extreme circumstances.[50]

2.84 An issue of major concern was the quality of information provided to women on the possible adverse consequences of some of the antenatal screening procedures now routinely offered. It appears that many women are very ill informed about such consequences. They do not appreciate that screening tests cannot determine with certainty the health status of the foetus, so that uncertainty and anxiety might well follow, for example an unclear ultrasound. Nor do they understand that where ultrasound tests suggest irregularities they will then be required to undertake further tests such as amniocentesis, which carries a risk of miscarriage, thus prolonging the uncertainty.

> Antenatal tests particularly in regard to pregnancy screening are an example which misunderstandings can occur. The opportunity to view an image of their unborn baby at their 18-week diagnostic ultrasound is a special occasion for many women and their families. Few women understand that the primary clinical purpose of the test is to diagnose foetal anomalies. The consequence of an adverse finding [may] be not only devastating but completely unexpected. Limits in the sensitivity of obstetric ultrasound are also not well understood or explained.[51]

2.85 These concerns are most marked in the case of ultrasound because that is the most widely used of the screening tests, but they are not confined to that test.

2.86 The Committee acknowledges the importance of these screening measures. However, it is persuaded that currently too many scans are carried out without adequate knowledge and counselling of the women concerned about their possible consequences.

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50 *Committee Hansard*, 6.9.99, p.87 (Dr Jane Fisher, University of Melbourne).

51 Submission No. 153, p.3 (Maternity Alliance, NSW).

2.87 Clinicians are certainly concerned about the problem. Guidelines for antenatal screening issued by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, for example, are emphatic about the need for counselling and information on all antenatal screening tests before they are performed.

> Such screening tests should only be undertaken with the informed consent of the patient after adequate and appropriate counselling as to the implications, limitations and consequences of such screening.[52]

2.88 However, evidence to the Committee and to complaints bodies such as the Victorian Health Services Commissioner and the Health Care Complaints Commission in New South Wales suggests that in practice such counselling is not universally offered and certainly is not always understood.

> Women felt that they were not adequately advised of their choices about the risks and benefits of interventions and not sufficiently involved in the choice of whether or not these should take place.[53]

2.89 The Victorian Health Services Commissioner stated that, in her view, if informed consent were obtained from women for any intervention performed on them they would be much less likely to resort to litigation in the event of any adverse outcome. The Committee shares this view.

> All I can tell you is that our experience is that, where proper explanations are provided, people are unlikely to go to law. We see that over and over again. That is what the [medical indemnity] insurers are telling their members.[54]

2.90 The issue of informed consent to interventions performed during birth was also a major concern to consumers and clinicians. The risk of problems occurring in childbirth is low. There is a general expectation of a successful outcome for mothers and babies. It appears that many women are ill advised about the possible adverse consequences of interventions at birth. They are not advised that the interventions can be painful and that, although each type of intervention has merit in certain circumstances, each also has inherent disadvantages. Women may therefore be totally unprepared on those occasions on which the outcome is less than ideal.

2.91 Lack of adequate advice and information on the experience of childbirth in general, and the impact of a range of interventions in particular, has been pinpointed by complaints commissioners as the basis for many complaints, and perhaps for litigation. In the experience of the Victorian Complaints Commissioner, as noted, when such information is provided following an adverse outcome, many complaints

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52 Submission No. 17, Appendix 1 (Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

53 *Committee Hansard*, 6.9.99, p.121 (Health Services Commissioner, Vic).

54 *Committee Hansard*, 6.9.99, p.123 (Health Services Commissioner, Vic).

are withdrawn or conciliated. Provision of the information before the event therefore could be expected to greatly reduce the number of complaints and cases of litigation, as well as reducing anxiety and trauma for the family.

Recommendation

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.

Recommendation

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.

2.92 The issue of informed consent to interventions during childbirth is discussed in greater detail in chapters 5 and 6.

Antenatal Education Classes

2.93 Antenatal education classes are an important means of overcoming some of the problems described above, for example those relating to informed consent. A woman who is well informed about pregnancy and birth is better able to make the choices facing her, and to understand the implications of these choices. She is likely to be less passive and to feel more empowered.

2.94 A complaint frequently made to the Committee during the Inquiry, by women and by midwives in particular, was that pregnancy and childbirth, both perfectly natural processes, have become unnecessarily medicalised. They are now the province of doctors and hospitals rather than of the women themselves. Education was seen as a means by which women might reduce the medical dominance of birth.

2.95 As with other aspects of antenatal information, the content of antenatal classes, their quality and their accessibility are very variable. Most provide information to pregnant women and their partners on the development of the baby in utero, maternal health during pregnancy, the process of birth and parenting skills. Antenatal classes are usually held in hospital clinics or community health centres but sometimes take place in schools or other educational or community facilities such as public libraries. Most are run by midwives or nurses although they increasingly include segments provided by other professionals and associations such as the nursing mothers' associations, nutritionists, physiotherapists and obstetricians.

2.96 The move away from midwife run antenatal education has been deplored by some.

> Teaching is an integral part of a midwife's practice, and as a midwife I have always believed that the midwife is the best health professional to provide antenatal education. I have looked on in despair as yet another area of midwifery practice has been gradually eroded, with physiotherapists and childbirth educators 'taking over' what was once the domain of the midwife.[55]

2.97 The very variable quality of antenatal education and information in Australia may be partly explained by the fact that there are no nationally or State agreed standards for childbirth educators or for the content of the courses they run.

> Our concern is that anyone can call themselves a childbirth educator without any specific training and that many maternity units still roster midwives untrained in group processes to conduct these educational courses.[56]

2.98 Antenatal classes are usually funded by the institutions which run them. However, they may be held in hospital clinics and run by hospital based staff (usually midwives) but funded from non hospital sources. This is the position at the Queen Elizabeth Hospital in Adelaide, for example.

2.99 Classes may be funded from the general health budget or from education budgets. The Committee was concerned to learn that in the Northern Territory, Victoria and New South Wales, State government funding for antenatal education was being cut. Consequently, classes that were formerly free now attract a fee. In Victoria for example, this was said to be approximately $200 for eight classes.[57] In south east Sydney it was $170 for seven classes. The result is that women on low incomes are increasingly unable to attend antenatal classes.

Recommendation

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.

2.100 Other concerns about antenatal classes raised during the Inquiry related to their accessibility. Classes were said to be held at times when working women and their partners could not attend, and in locations which could not be reached by public transport.

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55 Gilkison A. *Antenatal Education – Whose Purposes Does it Serve?* New Zealand College of Midwives Journal, May 1991, p.13.

56 *Committee Hansard,* 14.9.99, p.398 (National Association of Childbirth Educators).

57 See *Committee Hansard*, 6.6.99, p.140 (Maternity Coalition, Vic).

> The difficulty faced by many in our community arises from an inability to attend groups or information sessions because of the cost. Often working, as long as possible, is a priority for some women, in our present climate. This situation, coupled with the partner's work means that they are unable to attend free programs, which if available, are usually offered during the daytime.[58]

2.101 The presentation of antenatal classes was also an issue for some. They were said to be too formal and technical for some potential participants, especially adolescents although, as noted, some centres have designed particular programs to meet their needs. There is certainly a case for more targetted antenatal classes which can better meet the needs of the groups concerned. In fact however, the trend is in the other direction. As funding is reduced, antenatal classes become increasingly the preserve of middle class, English speaking urban dwellers. These are precisely the women best able to access the range of information on offer outside the classes.

2.102 Some overseas commentators have suggested that where hospitals both fund and run antenatal classes these classes may be designed to accommodate the requirements of the institution rather than those of the women concerned.

> The institution which offers the classes has a high level of control over them; deciding for whom the classes will be provided, what should be taught, who should teach it and the nature of the evaluation.
>
> …Much of the material covered in classes aims to "prepare" women for childbirth in that particular institution.
>
> …Women are encouraged to ask questions about the procedures, and offered "choices" within certain boundaries, but to question the status quo or to challenge the system is definitely not a part of most antenatal classes.[59]

2.103 This Committee heard that a similar situation existed in Australia.

> In the [last] 10 or 15 years…childbirth education pretty well exclusively happens within the hospitals where the care is provided. Childbirth education then becomes the dissemination of information about what happens in that particular hospital, what the routines are and what women can expect in that situation, rather than a broad range…I think that childbirth education in general is in a very sorry state because it is exclusively happening within the hospitals and fairly well under the control of the dominant medical system about what is being disseminated.[60]

2.104 The extent of hospital control was illustrated by a Brisbane witness.

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58 Submission No.37, p.1 (Ms Pauline Green, National Association of Childbirth Educators).

59 Gilkison A. *Antenatal Education – Whose Purposes Does it Serve?* New Zealand College of Midwives Journal, May 1991, pp.13-14.

60 *Committee Hansard*, 6.6.99, p.139 (Maternity Coalition, Vic).

> The antenatal information that women are given is so poor, because midwives are controlled by the organisations for which they work, when they try to give information to women they are often severely criticised. I am sure some burn out because of it.
>
> Very recently somebody gave information to women about the side effects of epidural blocks…and she was absolutely prevented from saying that any more in her classes. She was stopped from doing it.[61]

2.105 Some exceptions to this rather dismal picture were also brought to the Committee's attention.

> The QEH antenatal class actually starts from the premise that you will deliver your baby naturally without drugs…From day one it is based on the premise that you are going to have a healthy pregnancy and you are also going to deliver your baby naturally.[62]

2.106 While some evidence to the Committee was critical of certain aspects of antenatal classes, as noted, none was as savage as the criticism made of antenatal classes in some other countries.

> Because the antenatal education most women receive is a product of the system which effectively deprived women of freedom and choice in childbirth, its agenda has generally been narrow, conformist, patronizing and disempowering. There have been many studies of its effectiveness, but few have been able to report positively on its outcomes.[63]

2.107 Evidence to the Committee suggests that information and education are relatively neglected areas of antenatal care in Australia. The Turnbull Report, for example, made a series of recommendations for improvements in this area. A number have since been adopted by the West Australian Government, most notably through publication of *Your Birth Choice*, discussed earlier in this chapter. The Committee considers there is scope for publications along similar lines to be produced in those States which lack a comprehensive and current directory of maternity services

2.108 The Committee concludes, on the basis of the evidence it received during the course of the Inquiry, that antenatal care and information can make a difference to birth outcomes for mothers and babies. The Committee strongly supports the provision of high quality, accessible antenatal care and information for all pregnant women.

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61 *Committee Hansard,* 15.9.99, p.590 (Dr Fahy, University of Southern Queensland).

62 *Committee Hansard*, 7.9.99, p.235 (Keep the Queen Elizabeth Hospital Delivering Community Action Group).

63 Nolan M. L. *Antenatal education – where next?* Journal of Advanced Nursing, London,1997, 25, p.1200.

CHAPTER 3

ANTENATAL SCREENING SERVICES

Scope of antenatal screening

3.1 The antenatal screening of women and foetuses is an issue generating considerable interest and concern among consumers, clinicians and health administrators. This interest was reflected in evidence to the Committee. Major concerns consistently raised in the evidence relate to the increasing range of screening tests offered to women and the frequency with which they are performed, the concomitant growth in expenditure on screening and lack of evidence on the efficacy of many of the tests now performed. Each of these concerns is discussed in this chapter.

3.2 There is no agreement on the basic elements of antenatal screening. Some witnesses interpreted antenatal screening quite narrowly.

> Best practice in antenatal (pre-natal) screening standards is simple and natural. In a healthy woman there is little need for pre-natal screening - there is no reason to suspect that anything is wrong. At the very most, women may feel more secure that all is well by conducting checks on urine contents, blood pressure, weight gain, uterine shape and growth, foetal heart beat, movement and position, and general nutrition and well-being. Further screening is unnecessary unless a problem is indicated.[1]

3.3 Others defined it more explicitly, to encompass psychosocial as well as purely medical risks.

> Antenatal screening does not only encompass pathology and ultrasound testing, but also screening for example domestic violence, psychosocial conditions, that have major implications for not only the pregnancy but for the family unit as a whole.[2]

3.4 There is no agreement on the optimal range and number of screening tests for low risk women.

> Currently, no Australian antenatal screening standards exist. Recommendations regarding screening tests in pregnancy exist, but it appears from the early work of the Women's Hospitals of Australia Group, that those recommendations are interpreted differently across Australia. Medical and midwifery literature related to antenatal screening tests appears

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1 Submission No. 94, p.3 (Home Midwifery Association, Qld Inc).

2 Submission No. 69, p.9 (Women's Hospitals Australia and Australian Healthcare Association).

> to be inconclusive and most certainly has not been validated to the Australian population.[3]

3.5 A number of witnesses focussed on more recent, technological advances in screening, especially ultrasound. One witness saw screening as extending to in utero treatment of damaged foetuses. He chided the Committee for what he saw as its preoccupation with birth procedures rather than the potentially more rewarding study of in utero treatment.

> Labour and birth are not much of a biological event for the child. Birth is not an event for the foetal brain. The foetal brain does not really acknowledge the moment of birth. The foetal brain development has proceeded a long time before birth and it will proceed a long time after birth – birth is just another day in its life…we need to appreciate that labour is not the whole game...
>
> What I am trying to get across is that we need some lateral thinking. Instead of having an entire inquiry based on birthing procedures, we need to understand that it is not the main game. The main game from government should be to de-focus off the moment of birth and to start focusing on the amazing opportunities we have to improve the life of our community by steps at earlier times.[4]

3.6 While acknowledging the emergence of foetal research and treatment in utero, the Committee is not persuaded by Professor Newman's claims, neither his assessment of the limits of its Inquiry nor of the insignificance of birth for the foetus.

3.7 The Committee accepts that antenatal screening refers to the tests and examinations offered to pregnant women, which range from straightforward measurement of blood pressure and determination of blood type through to very sophisticated ultrasound screening, for example nuchal fold screening.

3.8 Despite the range of views on antenatal screening procedures however, there was substantial agreement, at least among clinicians, on routine procedures to establish health status, enabling corrective action to be taken where appropriate. The Royal Australian College of General Practitioners, for example, advised:

> Generally accepted antenatal screening procedures include:
>
> Routine blood and urine tests for blood group, anaemia, tests for preventable or treatable conditions such as rubella, syphilis, Hepatitis B and

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3 Submission No. 150, p.3 (Royal North Shore Hospital, NSW).

4 *Committee Hansard*, 8.9.99, pp.303-304 (Professor Newman, King Edward Memorial Hospital, WA).

5 Submission No. 150, p.3 (Royal North Shore Hospital, NSW).

6 Submission No. 94, p.3 (Home Midwifery Association, Qld Inc).

7 *Committee Hansard*, 8.9.99, p.303 (Professor Newman, King Edward Memorial Hospital, WA).

> identification of diseases such as HIV or Hepatitis C. Routine anatomy ultrasound at 18 weeks gestation is accepted practice.[8]

3.9 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists suggested the following (broadly similar) base line investigations in apparently normal pregnancies, to be carried out at the first antenatal visit.

> *Tests at first antenatal visit:*
>
> 1. Blood group and antibody screen
> 2. Full blood picture
> 3. Rubella antibody status
> 4. Syphilis serology
> 5. Hepatitis B serology
> 6. Hepatitis C serology
> 7. HIV serology
> 8. Cervical cytology[9]

3.10 Despite the guidelines issued by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, referred to above, which recommend that screening for HIV should be universally provided to pregnant women, it is not routine practice to provide it. Practice varies from one institution to another and from one practitioner to another. Women's Hospitals Australia, for example, advised of significant variations between its member hospitals.[10]

3.11 There was much less agreement on a range of other tests such as short glucose tolerance tests for gestational diabetes, as indicated in the following excerpts from submissions to the Committee.

> An entire medical history has grown up around diagnosing and treating gestational diabetics in the belief that in doing so it will improve outcomes for mothers and their babies. The exact reverse may in fact be the reality. We need to challenge the gestational diabetes 'gravy train' and accurately reveal the costs of routine screening. 'Large amounts of money and resources that are tied up in diagnosing and treating this 'condition' could be diverted into areas where they might be more effective'.[11]

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8 Submission No. 70, p. 2 (Royal Australian College of General Practitioners).

9 Submission No. 17, Appendix 1 (Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

10 See *Committee Hansard*, 27.8.99, p.71 (Women's Hospitals Australia).

11 Submission No. 38, p.4 (NSW Midwives Association).

> A review of antenatal screening was performed at Monash Medical Centre and certain recommendations were made, including the removal of screening for gestational diabetes on **all**. It was proposed to screen only those women considered at high risk for gestational diabetes and those women showing glucose in their urine…The policy for screening all women [for gestational diabetes] was in situ and as the senior obstetricians had opposing viewpoints the policy in situ remained. This suggests that it is easy to introduce policies that increase interventions but more difficult to show evidence to remove them.[12]

3.12 Witnesses from Women's Health Australia advised that screening for gestational diabetes is currently the subject of a comprehensive National Institute of Health (America) study which may provide more definite answers to the unresolved question of whether this intervention can be justified as part of routine screening.[13]

3.13 The Committee was advised that at present there was considerable variation in the usage of tests for gestational diabetes, whereas the routine tests referred to earlier were offered almost universally to pregnant women.

3.14 Several witnesses pointed out that non standard tests were more beneficial if selectively applied to at risk populations rather than universally applied.

> The decision to implement or suspend antenatal screening is related to the setting of the antenatal care. Whilst all women must have equal access to quality care, regardless of their geographic location or insurance status, what defines that quality may vary depending on the local incidence of disease, the ethnic mix of the local population, and whether the intervention used is Medicare rebatable.[14]

3.15 Widely different views were also presented to the Committee on the value of antenatal screening of any kind for low risk women. Some witnesses considered it unnecessary, as indicated in the submission from the Queensland Home Midwifery Association quoted earlier in this chapter.

3.16 Others believed antenatal screening an essential contributor to Australia's enviable record on childbirth outcomes.

> Current data suggests that there is correlation between the provision of antenatal services and screening with improved childbirth outcomes. (indicated by morbidity and mortality figures). Whilst it is widely accepted that there is benefit derived from the provision of antenatal care and

12 Submission No. 47, p.4 (Ms Carole Gilmour, NSW).

13 See *Committee Hansard*, 27.8.99, p.73 (Women's Health Australia).

14 Submission No. 104, p.4 (Central Sydney Area Health Service).

> screening, there is not, as yet, a consensus as to what constitutes "best practice".[15]

3.17 The Committee supports a definition of antenatal screening which includes basic, routine tests and measurements such as blood pressure and haemoglobin counts as well as more sophisticated tests such as ultrasound. The Committee is convinced of the importance of screening in improving outcomes for mothers and babies.

3.18 In evidence to the Committee, and in the literature generally, most concerns about antenatal screening have focussed on ultrasound scanning.

Ultrasound scanning

3.19 Ultrasound techniques were first developed in the 1950s to examine babies in utero. Their use has since become almost universal in Australia.

> In a 1994 Australia's Parents survey, 99.5% of respondents reported having at least one ultrasound in their last pregnancy.[16]

3.20 They absorb a significant proportion of the medical costs associated with childbirth. The Committee received many comments on this issue.

> Ultrasound is like a vast, bottomless pit.[17]
>
> * * *
>
> We spend more on taking pictures of babies than we do on delivering them.[18]
>
> * * *
>
> It does concern me that too much ultrasound is undertaken in pregnancy… diagnostic ultrasound HIC costs more than the whole of obstetric services – not just antenatal care, but antenatal care, confinement and postnatal care. That was two years ago.[19]
>
> * * *
>
> Figures from the Health Insurance Commission show the cost of obstetric ultrasound for 1997/8 was $39 million. Total number of obstetric ultrasounds 472 026 for 280 000 births. Cost of all other obstetric care from MBS obstetric items was $54 million. On top of this there will be

15 Submission No 16, p.3 (Royal Women's Hospital Health Service District, Brisbane).

16 Buckley S. *Ultrasound – Reasons for Caution.* First published in Australia's Parents, Summer 1999, as *All about Ultrasound.*

17 *Committee Hansard*, 6.9.99, p.158 (Royal Women's Hospital, Vic).

18 *Committee Hansard*, 8.9.99, p.325 (Royal Australian College of General Practitioners).

19 *Committee Hansard*, 8.9.99, p.340 (Professor Michael, St John of God Health Care).

> underestimates, as they do not include the private fee on top of medicare which can be the same again, or more.[20]

3.21 The most recent figures from the Health Insurance Commission, which exclude services provided by hospital doctors to public patients in public hospitals, show that in the period July 1998 to June 1999 expenditure was:

- $38.6 million on ultrasound (almost all of it routine scanning);
- $27.6 million on labour and delivery (including complex births, Caesarean sections and immediate post natal care); and
- $30 million on antenatal visits.[21]

3.22 The increase in the number of ultrasound tests performed, and the concomitant rise in costs, is especially troubling to some.

> Of particular concern is the cost of numerous ultrasound examinations. It is our current experience that it is not unusual for women to have undergone three ultrasound examinations before their pregnancy reaches twenty weeks of gestation.[22]

3.23 There is no clear evidence of what has caused the dramatic increase in ultrasound screening. Fear of litigation on the part of clinicians seems to be a significant contributing factor.

> Of particular concern to all parents is the risk of an abnormality in their baby. Consumer demand for reassurance in this regard is becoming overwhelming and the birth of an undetected abnormal child may often be followed by attempts at litigation. Failure to perform an ultrasound, cardiotocograph or other medical tests at an appropriate time are commonly cited in writs against doctors, midwives and hospitals.
>
> The adverse medico-legal climate in Australia has created a drift to a much more defensive style of medical practice with a greater need to demonstrate reassuring negative test results to consumers.[23]

3.24 The increasing use of diagnostic ultrasound in pregnancy parallels its increasing use more generally.

> There has been continuous (nominal) growth in the use of ultrasound. In 1990-91, 77 ultrasound services were claimed for every 1000 persons, by 1996-97 this rate had increased to 139 per 1000 persons. For the last seven years (1990-91 to 1996-97), there has been an average annual growth rate of

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20 Submission No. 38, p.3 (NSW Midwives Association).

21 Health Insurance Commission Medicare Benefits Schedule Item statistics generated 5 October 1999.

22 Submission No. 150, p.3 (Royal North Shore Hospital, NSW).

23 Submission No. 17, p.3 (Royal Australian and New Zealand College of Obstetricians & Gynaecologists).

> 10.4 per cent in ultrasound services per 1000 population compared with a rate of 2.7 per cent for all diagnostic imaging services [including radiology, nuclear medicine etc].[24]

3.25 The growth in routine ultrasound screening is of particular concern given the lack of consensus on its value.

3.26 There is no doubt that ultrasound is beneficial where difficulties are identified or suspected, for example when bleeding occurs early in pregnancy or a breech position is suspected. Accurate dating through ultrasound may be helpful in preventing unnecessary induction of birth and in ensuring that other screening tests are performed at a time when they will provide the most accurate results.

3.27 The value of routine ultrasound scanning is more controversial. Some witnesses before the Committee believed ultrasounds are no more accurate in determining due date than are women themselves, or their doctors or midwives. Others questioned their accuracy in detecting foetal abnormalities. Whilst 'ultrasound is regarded as the gold standard for the establishment of the viability of pregnancy' its accuracy in determining physical abnormalities is very questionable.[25] Scans do not generally identify intellectual disabilities.

> While many women are reassured by a normal scan, in fact RPU [routine prenatal ultrasound] detects only between 17% and 80% of the 1 in 50 babies that have major abnormalities at birth. A recent Brisbane study showed that ultrasound at a major women's hospital missed around 40% of abnormalities, with many of these being difficult or impossible to detect.[26]

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> Despite this epidemic of ultrasound examinations, which are supposed to give reassurance, at least one in five perinatal deaths are associated with lethal anomalies, many – if not most of which – are diagnosable by ultrasound.[27]

3.28 In the view of the Australian Health Technology Advisory Committee the accuracy of the ultrasound test is related to the training and expertise of the operator (normally a radiologist) in conducting the test and the skill and practice of the physician in interpreting it. Staff in major centres with high exposure to foetal abnormalities have greater detection rates than staff in centres conducting fewer

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24 Australian Health Technology Advisory Committee. *Diagnostic Ultrasound. Discussion Paper – Forum on Ultrasound,* Sydney, 13-14 June 1998, p.v. These figures are based on data from the MBS, which excludes public patients in the public health system.

25 Ibid, p.46.

26 Buckley S. *Ultrasound – Reasons for Caution.* First published in Australia's Parents, summer 1999, as *All about Ultrasound.*

27 *Committee Hansard,* 15.9.99, p.513 (Professor James King).

tests.[28] The Committee was concerned to learn that there are currently no standards governing the training of those who operate ultrasound equipment, a situation which it considers unacceptable given the number of tests performed, their cost and the impact on women and their families of inaccurate diagnoses.

3.29 Inaccuracy in determining abnormalities is not the only concern. Another is the fact that for the majority of abnormalities detected, there is no possibility of remedial treatment. A further concern is that in a small number of cases false positive diagnoses are made, where the baby is said to be damaged when it is in fact normal. In a greater number of cases, (possibly up to 10%)[29] scans are unclear. In each of these situations families must endure months of needless anxiety. In some instances normal babies have been aborted because of false-positive diagnoses.

> We generate an enormous amount of anxiety by some of these screening tests and I am not sure that all of them are actually worth while.[30]

* * *

> Most women choose to have prenatal diagnosis, because they want the reassurance that their baby is normal. However our current tests cannot give this guarantee. Perhaps we are expecting too much of this technology, and in our striving for the perfect baby, we are producing a system that has its own share of heartache.[31]

3.30 A more realistic expectation of what can be achieved, and its costs as well as its benefits, would assist in considering future priorities and directions for antenatal screening.

3.31 There appears to be inadequate counselling of women about the nature of a screening test. Women are often not aware of the possible adverse consequences of routine scanning, and the difficult decisions they may face as a result of it.

> I find that most women, once aware of the likelihood of false positive or false negative results with regard to ultrasound do not want the screening. My impression of the general public is that they are very poorly informed about ultrasound and that it is becoming a part of culture that there is a photo of the baby before birth.[32]

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28 Australian Health Technology Advisory Committee. *Diagnostic Ultrasound, Discussion Paper – Forum on Ultrasound,* Sydney 13-14 June 1998, p.42.

29 See Sparling J. W. et al. *The relationship of obstetrical ultrasound to parent and infant behaviour.* Obstetrical Gynaecology 1988, vol. 72, no. 6, pp.902-7.

30 *Committee Hansard*, 7.9.99, p.202 (Professor Marshall, Flinders Medical Centre).

31 Buckley S, *What's new in prenatal diagnosis,* p.3, 1998. Attachment to Submission No. 110.

32 Submission No. 7, p.1 (Ms Jenny Parratt, Vic).

3.32 Evidence to the Committee suggests that the position in Australia is fast approaching that in the United States where a 1993 editorial in *U.S.A. Today* proclaimed:

> Baby's first picture…a $200 sonogram shot in the womb…is a nice addition to any family album.[33]

3.33 There are growing concerns in the medical profession about the safety of ultrasound for mother and baby, although there is no conclusive evidence to support the case for suspension or limitation of routine tests. Concerns are heightened by the absence of standards in Australia governing the level of the dose used in ultrasound scans (which may vary by up to 5,000 times according to the machine used) and the training of operators. Since the level of the dose used does not affect the accuracy of ultrasound results, the Committee considers that standards governing the safety of ultrasound equipment should be introduced without delay.

3.34 Despite these concerns, routine ultrasound scanning (one scan at 18 weeks) remains almost universal. Evidence to the Committee suggested few variations in this practice between hospitals, States, or public and private patients. However, there is a much greater variation in the multiple use of ultrasound scans and in the use of more sophisticated ultrasound scans.

3.35 A very large randomised study in the United States (the RADIUS trial) involving 15,151 pregnant women at low risk for perinatal problems, to determine the impact of ultrasound screening on perinatal outcomes concluded:

> Potential benefits such as satisfying patients' desires for assurance that there are no fetal anomalies must be weighed against the unnecessary anxiety entailed in the examinations and the risks of overtreatment due to false positive diagnoses. The adoption of routine ultrasound screening in the United States would add considerably to the cost of care in pregnancy, with no impact on perinatal outcome.[34]

3.36 An analysis of nine trials undertaken through the Cochrane Pregnancy and Childbirth Group trials concluded:

> Routine ultrasound in early pregnancy appears to enable better gestational age assessment, earlier detection of multiple pregnancy and earlier detection of clinically unsuspected fetal malformation at a time when termination of pregnancy is possible. However the benefits for other substantive outcomes are less clear.[35]

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33 From Wagner M. *Ultrasound: More Harm than Good?* ACE Graphics, 2 November 1998, p.1.

34 Ewigman B.G. et al. *The Effect of Prenatal Ultrasound Screening on Perinatal Outcome.* New England Journal of Medicine, 16 September 1993: 329, pp.821-827.

35 Neilson J. P. *Ultrasound for fetal assessment in early pregnancy*. Cochrane Review. In Cochrane Library, Issue 3, 1999, Oxford: Update Software.

3.37 The only large, randomised study undertaken in Australia, the Raine study, compared the effects on children of mothers who had had a single ultrasound at 18 weeks with the children of those mothers who had had five ultrasounds. It showed no long term, demonstrable adverse effects.

> It was the world's only randomised trial of multiple ultrasounds in pregnancy that has ever been performed. It showed that there were no deleterious effects on the children whatsoever, apart from a one per cent shift in the birth weigh curve to the left in the babies that had had frequent ultrasounds. In other words, about a 30 gram overall reduction…By one year of age, the effect had gone.[36]

3.38 The Committee considers that routine ultrasound screening in pregnancy is an obvious area for the development of evidence based guidelines which will minimise unnecessary testing without compromising maternal or foetal health and ensure that funds are directed to areas of maximum benefit to the health of mother and child. Many submissions pointed to the need for such guidelines, and for further research on which to base them. This issue will be discussed in a later chapter, as one aspect of best practice guidelines in antenatal care.

Recommendation

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.

Recommendation

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

Recommendation

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.

3.39 Although most evidence to the Committee on high technology antenatal screening focussed on routine ultrasound screening, other antenatal tests were also discussed. Those receiving most attention are described below.

Nuchal fold test

3.40 The nuchal fold test, also known as the nuchal translucency test, is a relatively new, specialised ultrasound screening test, performed at 11 – 13 weeks, to measure the

36 *Committee Hansard*, 8.9.99, p.308 (Professor Newnham, King Edward Memorial Hospital, WA).

fluid level at the back of the neck of the foetus. Babies with extra fluid have a higher risk of Down's Syndrome. In cases where this is suspected after ultrasound, mothers may be offered amniocentesis or chorionic villus sampling (CVS) for chromosomal analysis.

3.41 Similar concerns have been raised in connection with the nucal translucency test as with ultrasound. These include: inaccuracies in results; insufficient training of those who operate the equipment and those who interpret the results; the impact on women of false positive diagnoses, especially for those women who have received inadequate counselling and information before undertaking the procedure; and its costs. All of these concerns were raised in a submission from the NSW Midwives Association.

> More recently, the widespread use of ultrasound for screening women for Down Syndrome using the Nuchal Translucency test has emerged. This is increasingly being offered to women regardless of their age or risk factors. Often they are not adequately informed of the subsequent investigations that may need to follow, such as amniocentesis with its inherent complications. The high false positive rate of Nuchal Translucency testing is well known. Many untrained practitioners are beginning to use this technique because of the potential financial gains. Once again, we are not evaluating a technology before implementing it and like so many interventions in childbirth, once the procedure is established it is impossible to withdraw it.[37]

3.42 The disturbingly high rate of false positive results from nuchal translucency testing, and its deleterious consequences for the women and families concerned, were highlighted in a recent article by Dr Sarah Buckley.

> With Nuchal translucency, for example, 19 out of 20 women who get a "positive" result will not have been carrying an affected baby, but will go through counselling and amniocentesis (with a 1% risk of miscarriage), and then wait for days or weeks before reassuring results are back. Some women who have been through this experience report that they felt anxious about their baby even after this reassurance, and others believe that it has permanently affected their relationship with their child.[38]

3.43 Suggestions for controlling the growth in nucal fold screening were made in a submission from the Director of Obstetrics and Gynaecology at Queen Elizabeth Hospital in South Australia.

> There should be support for an Australian multicentre trial of nuchal fold screening; otherwise it will creep in by stealth with no adequate quality

37 Submission No. 38, pp.3-4 (NSW Midwives Association).

38 Buckley S. *What's new in prenatal diagnosis,* 1998. Attachment to Submission No. 110.

> control. One could mount an argument for certified training in the technique (which is available) before allowing a charge on Medicare to be made.[39]

3.44 The Committee believes there is merit in this suggestion and that it should be further investigated.

3.45 The nuchal translucency test, because it requires sophisticated equipment, is generally not available to women outside major metropolitan centres.

> This latest form of screening [nuchal fold] has been introduced and now appears to be a part of "routine screening". It appears that this sophisticated screening tool is primarily available to women in most urban areas. The question that must be asked, is whether there is equity of access to this screening for the majority of women in Australia?[40]

Recommendation

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.

Recommendation

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.

Maternal serum screening (MSS)

3.46 This is a blood test undertaken at 15-18 weeks of gestation and designed to detect babies at high risk of Down's Syndrome and neural tube defects such as spina bifida. The accuracy of the test is severely compromised in cases in which exact gestational age is in doubt. This is one reason given as justification for the increasing number of ultrasounds being performed early in pregnancy. Accurate determination of foetal age, it is claimed, can ensure that other tests are performed at a time when their accuracy is maximised.

3.47 The tests were developed as one means of ensuring that only those babies most likely to have an abnormality would be subjected to amniocentesis and CVS tests, which carry a chance of miscarriage. (There is a 1% chance in the case of amniocentesis, for example). Again, similar concerns were raised with the Committee as in the case of the other screening tests discussed. Inadequate information to women undertaking the test was a particular concern for MSS.

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

40 Submission No. 150, p.4 (Royal North Shore Hospital, NSW).

> Many of the informed consent problems with Ultrasound apply to prenatal diagnosis, and particularly MSS, where the blood test may be taken as part of the standard pregnancy screen, without the necessary counselling and discussion.[41]

3.48 Rates of MSS are very variable between States.

> Each State coordinates its own blood testing, or maternal serum screening (MSS), and rates vary from state to state – eg around 75% in S.A. and about 20% in Victoria, depending on the enthusiasm of the institution involved.[42]

Amniocentesis and chorionic villus sampling (CVS)

3.49 These are diagnostic tests rather than screening tests like ultrasound. They can therefore determine with certainty whether the foetus has the abnormality for which it is being tested.

3.50 Each of these tests is used to determine whether the foetus has Down's Syndrome or other chromosomal abnormalities. In the case of amniocentesis, a sample of the amniotic fluid which surrounds the baby is withdrawn for examination. In the case of CVS a small fragment of the placenta is removed. This test is preferred by some women because it can be conducted at 10-12 weeks when, in the event of a positive diagnosis, an early termination is possible.

3.51 This discussion of antenatal screening has been confined to the tests in common use, and about which the greatest concern has been expressed. The Committee received little information on other tests, such as genetic tests for families at risk of specific inherited conditions.

41 Submission No. 110, p.4 (Dr Sarah Buckley, Qld).

42 Ibid, p.4.

CHAPTER 4

CARE DURING BIRTH

The birth setting

4.1 Almost all Australian babies are born in hospital. Most are born in traditional labour wards, now generally known by the more politically correct term 'delivery suites'. A small percentage of hospital births take place in alternative birthing centres the majority of which are located either within hospitals or very close to them.[1] The Australian Institute of Health and Welfare estimated that in 1996 birth centres accounted for 2.5% of all births, but the figures do not include Victoria and Tasmania, where confinements in birth centres are not separately enumerated.[2]

4.2 A very small number of Australian babies is born at home. The figure was 0.3% in 1996, although the Australian Institute of Health and Welfare cautions that home births 'are underascertained in some State and Territory perinatal collections'.[3]

4.3 This pattern does not vary significantly between States. Nor is it greatly influenced by the ethnic background or health insurance status of the mother.

4.4 Irrespective of birth setting, mortality outcomes are exceptionally good for Australian mothers and babies by world standards (although this is not the case for Aboriginal mothers and babies for whom mortality rates are double those of the non indigenous population, as noted in chapter 2). Appendices 3 and 4 give international comparisons.

4.5 In the period 1991-93 there were 3.5 maternal deaths per 100,000 confinements directly related to childbirth.[4] However, the underlying rate is higher than this. In 1994 the rate was 7.0 deaths per 100,000 births. Averaged over the period 1990-1994 it was 5.3.[5] The safety of childbirth in Australia is reflected in Australian Bureau of Statistics figures on deaths from complications in pregnancy, childbirth and

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1 The Committee notes the reservations expressed by the NHMRC on the use of this term (ie that it may encourage the view that maternity services are a set of alternative systems run by competing professional groups rather than an integrated set of options.) However, it considers the term is in such general use and so widely understood as to justify its use in this Report.

2 Australian Institute of Health and Welfare. *Australia's mothers and babies 1996*, p.5.

3 Ibid, p.5.

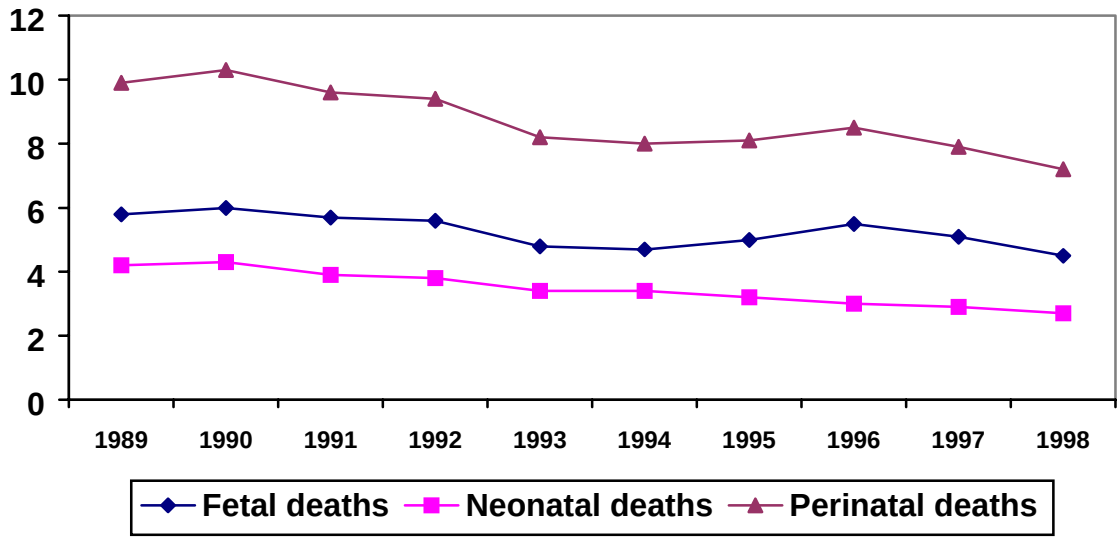
4 Submission No. 97, p.5 (Department of Health and Aged Care).

5 de Looper M. Kuldeep B. *International health – how Australia compares,* Australian Institute of Health and Welfare, Canberra, 1999, p.25.

the puerperium: 13 in 1989 and 1991, 15 in 1993, 24 in 1995, 11 in 1997 and 7 in 1998.[6]

4.6 Foetal, neonatal and perinatal death rates were 5.5, 3.0, and 8.5 per 1000 births in 1996. By 1998 the foetal death rate had dropped to 4.5, the neonatal rate to 2.7 and the perinatal rate to 7.2 per 1000 births.[7]

Foetal, Neonatal and Perinatal Deaths



Rates are per 1,000 total relevant births.

Source: ABS, *Causes of Death Australia*, Cat No 3303.0, Table 3.1 p.60.

4.7 Australian women value safety for their babies and themselves above everything when making choices about birth settings. For this reason the vast majority choose to birth in hospitals where perinatal and maternal mortality rates are very low.

4.8 But while women may be happy with the outcomes achieved, in terms of perinatal and maternal mortality, they are generally not impressed by the measures adopted to achieve them. The evidence suggests that they resent the way in which childbirth has been taken over by the medical profession rather than treated as a natural process, with a concomitant increase in the level of interventions and consequent morbidity outcomes (described in the following chapters) and in the disempowerment of the women giving birth. While acknowledging that the medical approach may be necessary in a small number of cases they consider it inappropriate

6 Australian Bureau of Statistics, 1999 *Causes of Death, Australia.*

7 Australian Institute of Health and Welfare. A*ustralia's mothers and babies 1996*, p.xiv and Australian Bureau of Statistics 1999. *Causes of Death, Australia*. Perinatal deaths are stillbirths plus neonatal deaths. Neonatal deaths are those of babies within 28 days of birth. Foetal, neonatal and perinatal deaths are normally given per 1,000 births. Maternal deaths are given per 100,000 births because total numbers are so small.

for most women compelled or persuaded to submit to it without any medical justification. They are further alienated by a system which too often fails to provide continuity of carer so that they may be tended during birth by total strangers.

4.9 Hospitals have been slow to respond to community pressure for a more holistc approach to birth, as have governments and some elements of the medical profession. Some initiatives have been adopted as noted. The Alternative Birthing Services Program has been an important catalyst in this respect. But much remains to be done. Possible future directions will be considered in connection with discussion of the development of best practice guidelines for care during birth.

Birth in a hospital delivery suite

4.10 Although most maternity hospitals (and maternity units within general hospitals) are relatively small (half had fewer than 100 births in 1996), many births occur in large units. In 1996 more than 42% of all births were in hospitals conducting more than 2,000 confinements annually.[8] Arrangements are normally made during pregnancy for women deemed at risk of complications during birth to be admitted to large hospitals where obstetrical specialists and a range of services are available. This policy has been a major contributor to Australia's current very low rates of maternal, and more especially perinatal, morbidity and mortality.

4.11 Just over 30% of mothers giving birth are privately insured. The figure ranges from 30.2% in Western Australia to 35.5% in the Australian Capital Territory.[9] (Figures were not recorded in Victoria and the Northern Territory at this time and were not available for Tasmania.)

4.12 During birth in a hospital delivery suite, a woman may be in the care of midwives, of a general practitioner, of a registrar, of a specialist obstetrician or of any combination of these. Usually she is cared for by midwives during labour, with an obstetrician or registrar on call who then attends at the birth, at least in the case of privately insured women. General practitioners rarely have the right to attend hospital births in urban centres. A woman is more likely to be attended by a specialist obstetrician during labour and birth if she is privately insured or if she or her baby are deemed at risk of developing complications.

4.13 Even healthy women who give birth in traditional hospital labour wards and have uncomplicated labours run a high risk of some form of intervention (as discussed in the following two chapters). They may or may not be familiar with the midwives attending them in labour, depending upon the extent to which shared care arrangements are in place which extend through pregnancy into birth and beyond into the post natal period. (Shared care arrangements are discussed in chapter 2.)

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8 Ibid, p.6.

9 Ibid, p.13.

4.14 Women who enjoy continuity of carer right through pregnancy and birth express greater satisfaction with their care than do women assisted by a range of professionals. A study by Brown and Lumley suggested that while consumer satisfaction was highest among privately insured women attended by a specialist during their antenatal care, women in this group were no more or less likely to be happy with their care during birth than women receiving standard public hospital or general practitioner care.[10] This is because in the former situation it is rare for an obstetrician to be present throughout labour. So women must rely on midwives or registrars with whom they are unfamiliar, and who are not familiar with their histories and particular concerns.

4.15 Dissatisfaction with the medical emphasis of hospital births and with discontinuity of care were major factors driving consumer demand for alternative, more woman centred approaches to birth, with midwives as the primary care givers. Some traditional hospitals have responded to this demand by establishing team midwifery programs for healthy women. Westmead hospital is one.

> 7% of women giving birth [at Westmead] in 1998 enrolled in this programme. Though an obstetrician is ultimately responsible for these patients, they are seen in a separate clinic and cared for by a team midwife in labour ward. Team midwives only rarely need to care for more than one woman at a time in labour ward because the numbers of women booked for this model of care are limited to a number which makes this feasible. Women receiving team midwifery care have a greater degree of continuity of care than other public obstetric patients.[11]

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> At the *John Hunter Hospital* in Newcastle, NSW, continuity of care provided by midwives was demonstrated through a randomised, controlled study with 814 women to be as safe as routine care. It also reduced the need for medical interventions including induction of labour, analgesia use and need for neonatal resuscitation. Women receiving team care were significantly more satisfied with their experience and there was a significant reduction in cost. This model of care has now become part of the routine options of care available for women who choose to birth at this hospital.[12]

4.16 The Committee received many submissions supporting the work of team midwives at John Hunter, whose system has been adopted by many other hospitals.

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10 Brown Stephanie, Lumley Janet. *Changing childbirth: lessons from an Australian survey of 1330 women,* British Journal of Obstetrics and Gynaecology, February 1998, vol. 105, p.152.

11 Submission No. 34, p.1 (Westmead Hospital, NSW).

12 Submission No. 38, p.10 (NSW Midwives Association).

The Committee was therefore dismayed to learn that the program is now under threat, with its funding to be diverted to other hospital programs.[13]

4.17 The team midwifery approach is only one of a range adopted by hospitals in response to consumer demand for a less interventionist medical approach to childbirth for healthy women. Others include the midwifery case load model and variations on the shared care model. Aspects of the midwifery case load model were explained by a Victorian witness.

> There are different midwifery models that provide total continuity of care. An example is a caseload model. The midwives actually take a caseload of about four women throughout their pregnancies and provide the antenatal, intrapartum and postnatal care.[14]

Birth in an 'alternative' birthing centre

4.18 Although originally established as alternatives to standard hospital models of birth care, birthing centres are now accepted as mainstream services. They are therefore generally referred to in the following discussion simply as 'birth centres'.

4.19 A birth centre may be housed in a self contained area within a maternity hospital. It may be a free standing building in hospital grounds or adjacent to a hospital or, more rarely, it may be located totally independently of a hospital.

4.20 Birth centres are a deliberate attempt to move away from the medical model of care provided in labour wards, and to replicate the atmosphere prevailing at home, while ensuring immediate access to medical attention and services should they be required. Ideally, they are designed to provide a home like atmosphere with rooms furnished like bedrooms rather than hospital wards, for example with a double bed rather than the usual hospital variety. They have ready access to shower and bath facilities and some are completely self contained units. This is the position at the Queen Elizabeth Hospital in Adelaide, for example, and at the King Edward Memorial Hospital for Women in Perth. Many regular labour wards are moving in the same direction.

4.21 Where hospitals or health services have had no real commitment to them, the centres may in fact be no more than a room at the end of a labour ward with no special facilities and no attempt to introduce a non medical approach to birth.

> The concept of birth centres has become murky in Australia as many traditional labour wards have been decorated with curtains and bedspreads

13 See for example Submission No. 165, p.5 (Team Midwives, John Hunter Hospital) and Submission No.180, p.1 (Ms Katrina Maranik, NSW).

14 *Committee Hansard*, 6.9.99, p.103 (Australian College of Midwives Inc, Vic Branch).

> and renamed birth centres without any fundamental change to the medical protocols that still control woman and midwives. [15]

4.22 Birth centres are staffed and run by midwives. Although obstetricians and registrars (or general practitioners in some centres) may be on call they do not assist at labour or birth unless requested by the midwives to do so. In some birth centres (and some labour wards) where a team approach has been adopted midwives and general practitioner-obstetricians both may be present during labour and birth.

4.23 Access to birth centres is limited to women deemed at low risk. In most birth centres strict admittance protocols apply. Women who are accepted by birth centres early in their pregnancy will be transferred to regular hospital labour wards if they develop complications during pregnancy. Similarly, low risk women who develop complications during labour are immediately transferred to 'mainstream' hospital labour wards. Transfer rates are quite high. At the birth centre at the King Edward Memorial Hospital for Women in Perth, for example, in the year to January 1997 approximately 29% of women were transferred prior to the onset of labour and a further 17% were transferred during labour.[16] 'Nearly 30% of women who planned a birth centre birth in NSW in 1997 were transferred to the labour ward for the delivery'.[17]

4.24 Although protocols govern both admittance to birth centres and transfer out of them in the event of complications, there is great variety in their content. In Melbourne, for example, a woman who has had a previous Caesarean section is not permitted to book into a birth centre. In Sydney she may be accepted.[18] In South Australia the position varies from hospital to hospital.

> We have produced guidelines for South Australia of the people who should be in a birthing centre, or should be informed about birthing centres, and who could go to a birthing centre. Individual hospitals interpret those guidelines differently. For example, the Queen Elizabeth Hospital allows women who have had a previous caesarean section to go to their birthing centre, whereas this hospital [the Women's and Children's in Adelaide] does not.[19]

4.25 More research, especially research using randomised trials, is needed on which to base best practice guidelines governing the content of these protocols.

4.26 The earliest birth centres were established in the 1980s, in response to consumer demand. They were funded by State health departments. Later the

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15 Submission No. 15, p.13 (Dr Kathleen Fahy and Dr Karen Lane, University of Queensland).

16 See Submission No. 62, p.9 (Australian College of Midwives, WA).

17 Submission No. 153, p.10 (Maternity Alliance, NSW).

18 See Submission No. 14, p.12 (Australian College of Midwives Inc, Vic).

19 *Committee Hansard*, 7.9.99, p.206 (Perinatal Society of Australia and New Zealand).

Commonwealth, reacting to the same pressures, funded the Alternative Birthing Services Program (ABSP). It began in 1989 and provided funds for the establishment of birth centres in the public health system and for the payment of midwives attending at home births or in birth centres. It has also funded a range of innovative outreach and antenatal services. Commonwealth funding for the program in the period 1989-90 to 1996-97 was $15.4 million. Since 1997-98 ABSP funding has been broadbanded with general public health funding provided to the States under the Public Health Outcome Funding Agreements.

4.27 Birth centres account for only a small proportion of total births. In 1996 there were 4,652 such births (2.5% of all births), an increase from the 2,405 recorded in 1992. These figures exclude Victoria and Tasmania where birth centre births were not separately recorded.[20]

4.28 The objective of the ABSP was to promote greater choice for women giving birth. It aimed to promote a philosophy of care which emphasised the role of the midwife as a primary carer and pregnancy and birth as normal life events for most women. It was also intended to encourage State health services to trial a range of models of care.

4.29 The ABSP had a strong emphasis on the provision of alternative services for Aboriginal and Torres Strait Islander women. During its first phase, 25% of its funds were targetted to this group. The focus has been on antenatal and post natal care rather than birth, although Aboriginal programs include, for example, a community based birthing service for Koori women in metropolitan Victoria, run by the Victorian Aboriginal Health Services Cooperative and a similar project in Adelaide run by the Northern Metropolitan Area Health Service. Both of these services provide continuity of care for Aboriginal women through the antenatal period, the birth and into the post natal period.

4.30 The birth centres have been an outstanding success. Their maternal and perinatal morbidity and mortality rates are comparable to, or better than, those of hospital labour wards. Even though their client group is restricted to women in the low risk category, while that of major centres includes most women considered at high risk, their results are impressive, both in terms of medical outcome and in terms of consumer satisfaction.

4.31 The cost of births at birth centres is comparable to, or slightly higher than, the cost of uncomplicated vaginal deliveries at public hospitals, at least in those centres for which figures were supplied to the Committee. Queensland Health, for example, advised that the cost of an uncomplicated vaginal delivery of a public patient at Mackay Hospital was $1,473 in 1999. The cost at Mackay Birth Centre was $1,840.[21]

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20 Figures are from Australian Institute of Health and Welfare. *Australia's mothers and babies 1996,* p.5.

21 Additional information, 30.10.99 (Queensland Health).

4.32 Birth centres have lower intervention rates than labour wards and much higher levels of consumer satisfaction. Women particularly report greater feelings of empowerment in birth centres. Women in the centres are given greater flexibility than the hospitals generally permit in the manner in which they give birth, and report that they have more input to decisions taken during labour and birth.

4.33 Support for birth centres is widespread. Demand exceeds supply in most centres.

> The birthing centres are overfull in Adelaide and cannot provide enough places for the women who want them.[22]

4.34 In the centre at the Royal Women's Hospital in Brisbane potential clients are selected by ballot every month, with applications approximately double the centre's capacity to respond.

4.35 Facilities have not been expanded to keep pace with this demand. In fact, some very well supported centres have recently closed, or are threatened with closure.

> The average number of babies born every year in Western Australia is 25,000. The state has only two Birth Centres in the Metropolitan Area, a total of only five (5) beds…The only rural Birth Centre in Mandurah was closed when the public hospital was privatised. This means that there are no Birthing Centres outside the Metropolitan Area.[23]

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> As I understand it, the birth centre at Swan District was an Alternative Birthing Services project and it was funded for the length of time covered by the Alternative Birthing Services Program. I think the funding is just about over.[24]

4.36 The Health Department of Western Australia disputed this, claiming that 'since 1994/95, Western Australia has received over $230,000 annually from the ABSP, with broadbanding under the Public Health Agreement having no effect on the ABSP allocation'.[25]

4.37 This is in part a funding issue. The position was succinctly stated in a Northern Territory evaluation of the ABSP.

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22 *Committee Hansard,* 7.9.99, p.226 (Birth Matters, SA).

23 Submission No. 62, p.8 (Australian College of Midwives, WA).

24 *Committee Hansard,* 8.9.99, p.364 (Australian College of Midwives).

25 Additional information 21.10.99 (Health Department of Western Australia).

> The ability of the Alternative Birthing Services Program to promote birthing as a normal life event is hindered by the lack of funds available compared to those available to parties with an interest in keeping it medicalised.[26]

4.38 The Commonwealth Alternative Birthing Services Program was a pilot program. The intention was that projects established by the program which proved successful in terms of safe outcomes and consumer support would continue with State funding. While this intention is certainly being fulfilled in some area health services the practice is by no means uniform.

4.39 Funding considerations are not the only barrier. Some midwives and consumer groups pointed to opposition from obstetricians to establishment, retention or expansion of birth centres.

> **In 1995** consulting obstetricians at KEMH prevented the establishment of a Commonwealth Alternative Birthing Services Programme under the auspices of the hospital, by threatening to withdraw their clinical services from all women, after hours and on weekends.[27]

4.40 The success of birth centres extends beyond the centres themselves. They have had an impact on attitudes and practice in traditional labour wards.

> …the birth centre culture has filtered out through the rest of the practice of midwifery…I see the sorts of philosophies that the birth centre brought in going through what one used to call labour wards – we call them delivery suites these days.[28]

4.41 Their impact on the general community can be expected to increase among groups not so far touched by their development, according to some evidence to the Committee.

> I think the multicultural society which we have may well increase our numbers in the family birth centre. I think it is just the beginning of perhaps a much larger input into and interest in the family birth centre type of situation when the multicultural and perhaps the less educated or informed people are becoming more and more informed of that option.
>
> …I think that up to now the birth centre philosophy and birth centre facility have not been exploited as much as they should have been with some of the ethnic groups which we now have. There is a lot of potential for that to become a very much more used option.[29]

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26 Territory Health Services, Women's Health Unit. *Evaluation of the Alternative Birthing Services Program in the Northern Territory*, 1997, p.iv.

27 Submission No. 62, p.12 (Australian College of Midwives, WA).

28 *Committee Hansard*, 6.9.99, p.145 (Royal Women's Hospital, Vic).

29 Ibid, p.145.

4.42 Many recent reports[30] have favoured the further development of birth centres provided they continue to attract consumer support and continue to provide services that are equally safe to those provided by hospital labour wards. The NHMRC did not support the expansion of birth centres remote from hospitals, on safety grounds.

4.43 The Committee favours the continuation and expansion of birth centres. As noted, they have received support in many recent reports. Support was also expressed consistently in evidence provided to the Committee by consumer and midwife groups. The Committee considers that birth centres have demonstrated that they have community support, are safe and are cost effective. They are now a widely accepted mainstream component of birthing services in Australia rather than a fringe alternative. It is therefore appropriate that they be maintained and extended by hospitals, through hospital budgets, rather than through the Alternative Birthing Services Program, which is now part of Public Health Outcome funding.

Recommendation

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

Home birth

4.44 Home birth represents a very small proportion of total births in Australia. As noted, they accounted for only 0.3% of total births in 1996.[31] The number has been fairly consistent over recent years, although supporters claim that more women would birth at home if current financial and other constraints were removed.

4.45 The Australian Institute of Health and Welfare suggested that women who favoured the non medical approach of home birth were turning increasingly to birth centres and that this accounted for the fact that there had been no increase in home births despite increased consumer concerns over the medicalisation of pregnancy and childbirth.

> Women who sought to avoid what they would regard as unnecessary intervention and may have chosen home birth for that reason and for the type of care that they get are increasingly using birthing services linked to hospitals for their care. So we are not seeing an increase in home births in Australia.[32]

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30 These include: NHMRC. *Options for effective care in childbirth*, 1996. Health Department of Victoria. *Having a Baby in Victoria*, 1990. West Australian Legislative Assembly. *Report of Select Committee on Intervention in Childbirth*, 1995. NSW Health Department. *Final Report of Ministerial Taskforce on Obstetrical Services in New South Wales*, 1989.

31 Throughout this Report the term home birth is used only to indicate **planned** home births, whether they are completed there or in a hospital setting.

32 *Committee Hansard*, 27.8.99, p.26 (Australian Institute of Health and Welfare).

4.46 A major inhibitor to growth in the number of home births is concern about rapid access to medical expertise and facilities in the event of unforeseen complications. Although most home birth midwives accept only healthy women at low risk of developing complications, such risks can never be totally predicted. This is borne out by the fact that a significant number of women who begin their labour at home are eventually delivered in hospital. The figure was said to be 12.9% in 1988-90.[33]

4.47 The medical risks of home birth are cited by the medical profession as the reason for their opposition to it.

> With infant and maternal mortality the lowest it has ever been, people have begun to believe that childbirth is totally without risk, and that all the medical intervention is both invasive and unnecessary. They advocate a return to home-delivery, without medical management, and often without any medical support. The end result of this can be deduced by comparison with the situation in the Third World, where no woman has the chance of a hospital delivery, and where 9 women in every 1000 die during or after labour.
>
> …Home delivery survives only as an atavism. It can only be justified in terms of personal gratification, and it has nothing to do with best practice, or indeed any form of professional standard.[34]

4.48 The Royal Australian College of Obstetricians and Gynaecologists is opposed to home birth on safety grounds but, in recognition of the fact that it does occur, has developed best practice guidelines to assist women contemplating this option.

> The College recognises that a small number of women will chose domiciliary confinement. While considering that homebirth exposes the mother and child to unacceptable risks, the College has recommendations to guide persons seeking home delivery.[35]

4.49 Another factor restricting the appeal of home birth is its cost. This ranges from $1,500 to $2,500 according to evidence provided to the Committee. These costs are not met by Medicare and must therefore be borne by the woman and her family. For this reason home birth is not an option for many women who might otherwise choose it. Few private health funds cover the costs of home birth either.

> Failure to make midwifery fees claimable through Medicare discriminates against the midwife and the women who wish to choose this model of care. With the WHO recommending the midwife as the most appropriate carer for normal healthy women in pregnancy and birth, it is ironic that their fees are

33 See Submission No. 15, p.9 (Dr Kathleen Fahy and Dr Karen Lane, University of Queensland).

34 Submission No.18, pp.2-3 (Dr Ron Chang and other medical specialists, Qld).

35 Submission No. 17, p.7 (Royal Australian College of Obstetricians and Gynaecologists).

> the only ones *not* claimable either through Medicare or most private health insurance funds.[36]
>
> * * *
>
> Midwifery care for homebirths should attract an equitable medicare rebate. Many women from lower socio-economic areas are extremely disadvantaged and discriminated by the lack of a medicare rebate for the services of independent midwives. A more general application would see homebirth made free to **all** women through medicare taking up its public responsibility in rebating the care provided by midwives.[37]

4.50 Women birthing at home therefore tend to be of higher socio economic status than those who give birth in hospital.

> A SA study in 1990 found women who had planned homebirths were older and of a higher socioeconomic group than women who gave birth in hospital.[38]

4.51 Because of the small number of women birthing at home, there is not enough work available to the independent midwives who assist them. Such midwives have therefore to seek work in hospitals or community based centres (where these institutions will accept them - often will not). Here they have less responsibility and autonomy and may lose some of their skills. Many of them are uncomfortable with the medical approach adopted in hospitals where, they consider, their skills are undervalued.

4.52 Midwives are leaving the profession and recruitment of new midwives is insufficient to replace them. High attrition rates place great pressure on those remaining. There are parallels here with the situation facing specialist obstetricians.

> The general public is being swayed to think that the hospital is more safe because of the technology, but many authors assert that the use of technology is actually deskilling the midwives in this "technobirthing" environment. The midwives are no longer 'with' women but are minders of machines and reporters to doctors.[39]

4.53 The threat of litigation is also a factor adversely impacting on the recruitment and retention of independent midwives.

> …medical insurance is having quite an impact on the way - at least in the private sector - the options are available to women. Because there is still an

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36 Submission No. 20, p.7 (Ms Robin Payne, Choices for Childbirth, Vic).

37 Submission No. 30, p.4 (Homebirth Network of South Australia).

38 Mardi Chapman. *Homebirth Control.* Australian Doctor, 29 January 1999, p.34. The findings of the study referred to were published in the Medical Journal of Australia 1990, 153: pp.664-71.

39 Submission No. 81, p.4 (Launceston Birth Centre Inc).

> attitude by organisations such as the Medical Defence Union that doctors and midwives should not be working together. Doctors should not be providing backup for visiting midwives. This causes a problem, because it is difficult for midwives to get the required amount of insurance in order to have access to visiting rights in hospital.[40]

4.54 Home birth may be viewed as one manifestation of the widespread reaction by women against the medicalisation of pregnancy and birth. They resent the way in which hospitals treat healthy women in labour as if they were sick and require medical intervention.

4.55 The Committee heard from many advocates of home birth. Most had themselves given birth at home and were keen to extend the benefits which they had received to other women. The following excerpts are typical of many received by the Committee.

> The degree of medical intervention practised in hospitals is unnecessary and frightening and this led me to a search for different approaches for the birth of my daughters…I wish to share these experiences with the Committee to highlight the importance of informed choice, continuity of care and respecting the normality of pregnancy and childbirth.[41]

* * *

> From our experience, we know that birthing at home is good for women, babies, families, communities and cultures and it is also cost effective when compared to the expense of giving birth in hospital.[42]

4.56 Most advocates of home birth recognised that it was not an option for women at risk of developing complications during labour or delivery.

> I wish to point out that I do not believe that giving birth at home is somehow inherently 'better' than giving birth in hospital. I am well aware of the fact that some women and babies require the type of medical care only possible in a hospital setting, and I do not underestimate the importance of such care. I am also aware of the fact that many women feel safer and more comfortable labouring and giving birth at hospital than they would at home. However, there are a number of women with low-risk pregnancies who, if given the choice, would prefer to give birth at home and who could do so safely if the type of care provided under the CIS [Childbirth Information Service] model was more widely available.[43]

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40 *Committee Hansard*, 15.9.99, p.561 (Association for Improvement in the Maternity Services, Qld).

41 Submission No. 123, p.2 (Ms Lisa Joseph, NSW).

42 Submission No. 171, p.6 (Birthplace Support Group Inc, WA).

43 Submission No. 36, p.6 (Ms Clarissa Cook, Tas).

4.57 Home birth supporters considered that the risks of home birth were exaggerated by the medical profession, which saw it as a threat to their authority.

> When I decided on birth at home, most medical practitioners I spoke with abhorred my decision, branding it as unsafe and foolish. I felt that I had made the right decision and set about informing myself about the practice of home birth. What I discovered was that claims about the dangers of home birth are based on opinion, not facts. These claims are also perpetuated by those with the least motivation for encouraging women to access this model of care. Their motivation is less about safety and more about politics, power and money.
>
> …I believe the silence on these issues [safety of home birth] is testimony to the power of the medical profession generally in sustaining the medical model of birth and suppressing the development of superior woman-centred midwifery care.[44]

4.58 Independent research on the safety of home birth in Australia is not conclusive. Where the numbers are so small it is difficult to draw definitive conclusions. Some overseas studies have shown that home births are not inherently less safe than hospital births.

> It is concluded that no empirical evidence exists to support the view that it is less safe for most low-risk women to plan a home birth, provided that the pregnant woman is motivated and, furthermore, selected and assisted by an experienced home birth practitioner, and provided that the home birth practitioner, in turn, is backed up by a modern hospital system should a transfer be needed. It is further concluded that home birth as managed in the included studies may well have other advantages compared with standard hospital care.[45]

4.59 Other studies dispute this. A study by Hilda Bastian and others which compared data on 7,002 planned home births in Australia during 1985-90 with national data on perinatal deaths and outcomes of home births concluded that Australian home births carried a high death rate compared with both all Australian births and home births elsewhere. The largest contributors to the excess mortality were underestimation of the risks associated with post–term birth, twin pregnancy and breech presentation, and a lack of response to foetal distress.[46]

4.60 In view of these findings the authors stated that:

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44 Submission No. 20, pp.7-8 and 11 (Ms Robin Payne, Choices for Childbirth, Vic).

45 Olsen Ole. *Meta-analysis of the Safety of Home Birth.* Birth, 24: 1 March 1997, p.11. This study examined the birth outcomes for 24,092 primarily low risk women in six controlled, observational studies.

46 Bastian H. Keirse J. N. C. Lancaster P. A. L. *Perinatal deaths associated with planned home birth in Australia: population based study.* British Medical Journal, vol. 317, 8 August 1998, pp. 384-387.

> While home birth for low risk women can compare favourably with hospital birth, high risk home birth is inadvisable and experimental.[47]

4.61 Certainly, women birthing at home undergo fewer invasive procedures so the morbidity rates associated with these procedures are lower.

> Women birthing at home between 1988-90 experienced mainly spontaneous birth (86%) and only 12.9% were transferred to hospital during labour or in the postnatal period…Of those women who birthed at home, 93% required only non-medical or social support by the midwife and support persons; 1.5% required Pethidine and further 5% used acupuncture or homeopathy and herbal remedies.[48]

4.62 Home birth pilot programs were developed by some States using Commonwealth funding provided through the Alternative Birthing Services Program (ABSP). This funding was used to pay the fees of independent midwives attending low risk births. It has been suggested that in States which did not take up these funds and where therefore, there were fewer constraints on the women accepted for home birth, there has been an increase in high risk births at home.

> States which did not use the opportunity of developing a home birth program based on low risk criteria (NSW, Victoria and Queensland) have seen an increasing trend of midwives taking on women with high risk pregnancies for delivery at home…The ABSP homebirth pilot programs have ensured safe home birth practices with good access to hospitals. It is regrettable that no States have taken up the challenge of on-going funding of home birth services.[49]

4.63 Home births are favoured by only a small number of women in Australia. In other countries the situation is quite different. In Holland, to which the Committee's attention was repeatedly directed, over a third of babies are born at home and perinatal and maternal morbidity and mortality rates are low. The reasons for the difference in approach are complex. Cultural and social factors are important.

4.64 Holland has a much more integrated health system than does Australia, and provides greater continuity of care through the antenatal period, birth and into the post natal period. Home birth is much more widely accepted there, by the population generally and by the medical profession. Midwives undergo a more rigorous training in Holland than they do in Australia. Finally, because Holland is a small and densely populated country, women giving birth at home are never far from hospital support should this become necessary.

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47 Ibid.

48 Submission No. 15, p.9 (Dr Kathleen Fahy and Dr Karen Lane, University of Qld) Figures quoted are from Bastian H. and Lancaster P. A. L. *Home Births in Australia 1998-1990.* AIHW National Perinatal Statistics Unit, Sydney, 1992.

49 Submission No. 153, p.11 (Maternity Alliance, NSW).

4.65 It seems likely that home birth will remain the preferred choice for a minority of Australian women. Its proponents suggest that their greatest impact will not be to increase the number of home births but rather to 'humanise' hospital births by influencing hospital staff to adopt a less interventionist, more holistic and woman centred approach to birth. Moves in this direction are already evident in some hospitals, although they have not gone nearly far enough in the view of many witnesses before the Committee.

> I have had discussions with a very prominent homebirth midwife – I do not see any reason not to name her – Maggie Lecky-Thompson. I enjoyed my discussion with her and she herself volunteered that the impact of the homebirth movement was not going to be to move birth to the home but to civilise hospital births. I think she is absolutely right. I think that in the last 10 to 15 years, since it has become very apparent to any obstetrician that obstetrics was being practised in a way which was not necessarily either beneficial to mothers or making them happy, obstetricians have been changing their practice.[50]

4.66 The Committee supports the continuation of this option for healthy women. It considers that the available evidence, both in Australia or overseas, is such as to justify its retention and notes that in Holland, for example, where a third of all births take place at home, morbidity and mortality rates are comparable to those in Australia.

Recommendation

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.

Birth in rural and remote locations

4.67 Women living in rural and remote areas have fewer local options for care during birth than do those in urban centres. Basically they can either give birth at their local hospital, attended by a midwife and a general practitioner or, if there is no local hospital, transfer to a regional or other urban centre offering the range of services outlined earlier. Few women have access to the services of a specialist obstetrician. Home birth is problematic in rural areas because of the distance and time involved in transferring a woman to a major centre should complications develop during labour.

4.68 Women with health problems or considered at risk of complications during birth are normally encouraged to give birth at a metropolitan or regional centre where specialist staff and facilities are available if required. For women in remote communities this requires transfer to urban centres well before the anticipated date of birth. This practice, which is in place in all States and Territories, has been a major contributor to Australia's current very low rates of perinatal and maternal morbidity and mortality.

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50 *Committee Hansard*, 14.9.99, p.497 (Dr A.F.Pesce, Westmead Hospital).

> …the regionalisation of perinatal care, whereby high risk mothers and babies are transferred from smaller units to tertiary care centres, has probably been the predominant factor in reducing perinatal death rates.[51]

4.69 Some evidence to the Committee suggested that despite women's reduced choices in rural areas, outcomes are not compromised.

> Clearly, it is not possible to have a range of options for women in rural areas doing only 20 deliveries per year. On the other hand, the doctors and hospital midwives in those districts offer a level of continuity of care that city dwellers could only dream of.[52]

* * *

> Although access to obstetric facilities for rural and remote women is often limited, health outcomes for women choosing to deliver in rural and remote locations are not necessarily worse than for metropolitan teaching hospitals.
>
> **In fact, the converse is true. Perinatal mortality and morbidity statistics from GP obstetric units in rural areas in NSW and rural Canada have been identified as being among the best in the world.**[53]

4.70 Other evidence suggested that high skill levels could not be maintained by staff in hospitals carrying out only a small number of births each year. As noted, half of the maternity units in Australia have fewer than 100 births a year. Almost all of these are in country areas.

4.71 For healthy women giving birth with the assistance of a midwife and a general practitioner in a country hospital outcomes are comparable with those in metropolitan areas. It has been suggested that in part this is because country general practitioners are skilled at identifying possible problems in pregnancy and arranging for the transfer of women at risk to metropolitan services.

> The reasons for this [comparable outcomes for rural general practitioner care] are complex but it is believed that experienced rural GP obstetricians are good at identifying potential problems promptly and transferring patients to a larger centre in a timely and appropriate fashion.[54]

4.72 There are generally lower intervention rates in country areas than in metropolitan centres for comparable populations. This may in part be because fewer options for intervention are available. Anaesthetists are in short supply, for example,

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51 *Committee Hansard*, 27.8.99, p.25 (Australian Institute of Health and Welfare).

52 Submission No. 5, p.2 (Dr B.R. Pridmore, Queen Elizabeth Hospital, Adelaide).

53 Submission No. 70, p.4 (Royal Australian College of General Practitioners). The study referred to is by Hogg W. E. et al. *The Case for Small Rural Hospital Obstetrics*. Canadian Family Physician 32: pp.2135-38, October 1986.

54 Submission No. 70, p.4 (Royal Australian College of General Practitioners).

so that epidural anaesthetic may not be available (and because women are less likely to have their labour artificially initiated it may be less necessary). In these circumstances there is greater need for alternative, less interventionist approaches to pain relief and greater knowledge and skill in their use.

4.73 In country hospitals staffing arrangements tend to be less hierarchical than in urban areas. Midwives and general practitioners work as a team. The woman giving birth is likely to have received her antenatal care from the midwife and/or general practitioner attending at the birth. This continuity of care and familiarity with the people attending at the birth have been demonstrated in many studies to increase women's confidence and sense of control during the birth, which in turn reduces the need for intervention.

> The best examples of the whole of the shared care model are in the country…I refer, for example, to Geraldton…Kalgoorlie, and Collie, which is where I come from. We have a population of only 10,000. We do not have a resident specialist, but we have three GP obstetricians, a general surgeon and anaesthetists and our intervention rate is low. It is currently about 10 per cent…So it can be done, and it can be safely done.[55]

4.74 This pattern is not uniform. The Committee was advised of a number of country hospitals with very high intervention rates. They included, for example, the Coff's Harbour Hospital (23.8%), Tamworth Base Hospital (23.7%) and Lithgow (27.1%).[56]

4.75 While giving birth in country hospitals is in many respects a more satisfying experience than giving birth in metropolitan hospitals (at least for healthy women) there are significant problems. Rationalisation of services in rural areas threatens the existence of small country hospitals. Without them, healthy women in rural areas will be forced to travel to major urban centres for their births and will lose the benefits of giving birth close to their homes and families. The National Health and Medical Research Council has cautioned against further centralisation of hospital services.

> While it is imperative that there is sufficient centralisation of services to ensure that expertise can be maintained in each region, attempts to reduce local services for healthy women with normal pregnancies should be resisted unless clear and unequivocal advantages can be demonstrated.[57]

4.76 The Royal Australian College of General Practitioners also pointed out that:

> Once you close those units [obstetrical units in country hospitals] you get this incredible downward spiral. Closing acute services in a small rural

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55 *Committee Hansard*, 8.9.99, p.293 (Dr Turnbull, MLA).

56 New South Wales Health Department. *New South Wales Mothers and Babies 1997*, Sydney 1998, p.88.

57 National Health and Medical Research Council. *Options for effective care in childbirth*, p.12, Canberra 1996.

> hospital is a disaster because, once you lose your acute services, you effectively turn many of these small rural hospitals into nursing homes.[58]

4.77 In country hospitals which have closed their obstetrics units, but where births still occur, perinatal morbidity and mortality outcomes have deteriorated.

> The New South Wales study found that deliveries continue to occur in hospitals *without* an obstetric unit and will still present unbooked and often in preterm labour. This often occurs in small towns where the units have been closed because of low numbers of deliveries, lack of support services or proximity to larger hospitals. Without the professional expertise of a functioning obstetric and midwifery service, perinatal mortality and morbidity figures tend to be suboptimal.
>
> **This highlights the need to keep small rural obstetric units open and to staff them adequately. Rural women will continue to want care closer to home and have every right to expect a safe, accessible service.[59]**

4.78 The greatest threat to the quality and safety of the birth experience for country women is the shortage of general practitioners qualified in obstetrics. Many of them are leaving country practices. Of those who remain, many are refusing to undertake obstetrical work. And new entrants are not moving to country areas in sufficient numbers to replace them, despite Commonwealth incentives to encourage them (as described in chapter 2).

4.79 Litigation or the perceived fear of litigation, and the associated costs of insurance are major issues for general practitioner obstetricians in country areas (although State governments subsidise the costs of their insurance). They have contributed to the virtual elimination of specialist obstetricians in rural areas.

> The costs of indemnity for specialist obstetricians is predicated on their seeing enough patients and earning enough income to cover these costs. Especially, away from the big cities, specialist obstetric practice rapidly becomes non-viable. The simple solution for Obstetricians is to limit themselves to only Gynaecology, which is lucrative, has better hours and smaller indemnity bills. This is not the best outcome for the community.[60]

4.80 However, a recent Victorian study suggested that lifestyle issues were an equally important factor in the drift of general practitioners with obstetric training from the country.

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58 *Committee Hansard*, 8.9.99, p.323 (Royal Australian College of General Practitioners).

59 Submission No. 70, p.5 (Royal Australian College of General Practitioners). The NSW study referred to is by Woollard L. A. and Hays R. *Rural Obstetrics in NSW***.** Australian and New Zealand Journal of Obstetrics and Gynaecology, 33:3 pp.240-42, 1993.

60 Submission No. 65, p.1 (Dr Joanna McCubbin, Vic).

> Personal/family reasons or interference with lifestyle were chosen by 36% of respondents as the most important reason for ceasing obstetrics. Rising insurance premiums was the reason for 16%, concern regarding the management of unexpected emergencies for 10% and lack of remuneration for 8%…Both rural GPs and urban/provincial GPs considered personal, family and lifestyle issues as the most important (29% v 40%).[61]

4.81 This view was supported by general practitioners in submissions and public hearings.

> Rural Obstetricians may not have the lifestyle, financial and continuing educational opportunities of their city colleagues, so there need to be incentives to keep them or we run the very real risk of losing these services completely.[62]

* * *

> There were two major reasons why general practitioners drop obstetrics, and they are not what you might think. The first one concerned personal family and lifestyles issues. Obstetric practice is very intrusive; it is intrusive on your personal life, your family life and the rest of your medical practice. So when it is not the core business of your medical practice…you tend to look at things you can get rid of, and obstetrics is one of them. People do obstetrics for the love of it.
>
> The second reason people are looking at ceasing obstetric practice…is the rising insurance premiums. A third reason is the perceived threat of litigation. There was, in fact, another major issue that we looked at: being able to get back-up in an emergency. This fear of being alone with an emergency is something that is very high in the minds of general practitioners. It is not the litigation; it is the fear of not being able to cope with an emergency in an isolated place.[63]

4.82 The impact of litigation on the obstetrical work force in country areas is discussed in chapter 10.

4.83 The number of midwives in country areas is also declining. In the period 1993-1996 the percentage of midwives in capital cities increased from 65.8% to 69.2%. In all other geographical locations it declined during this period.[64]

> There are significant problems facing rural and remote Australia in the growing shortage of midwives which places pressure on the continued provision of rural obstetric services.[65]

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61 Innes, Kathleen M. *Why are general practitioners ceasing obstetrics?* Medical Journal of Australia, vol. 166, 3 March 1997.

62 Ibid, p.2.

63 *Committee Hansard*, 8.9.99, p.330 (Royal Australian College of General Practitioners).

64 Australian Institute of Health and Welfare. *Nursing labour force 1998*, Canberra 1999, p.58.

4.84 Commonwealth and State governments have a number of initiatives in place to address this problem and the related problem of ensuring that rural midwives maintain their skills. They include the Commonwealth funded Midwives Upskilling Program, begun earlier this year, through which the Commonwealth will pay State and Northern Territory governments $3,000 per rural/remote midwife so that they can undertake retraining for two weeks every two years. Joint programs with the West Australian and Queensland governments also focus on retraining for rural and remote midwives.[66]

4.85 In addition, the Committee was advised of a number of State funded programs designed to develop the skills of rural midwives. The Royal North Shore Hospital, for example, advised of a midwifery exchange program through which midwives from the Far West Area Health Service of New South Wales have worked for three weeks in the North Sydney Area Health Service.[67] Midwives from the Royal North Shore and Manly hospitals have replaced them at Bourke, Walgett, Wilcannia and Broken Hill hospitals.

4.86 The decline in the rural obstetrical work force and the threatened closure of small hospitals jeopardises the opportunity for healthy women in rural areas to give birth close to home. They may be forced to choose between home birth and transfer to major centres. Neither option is desirable. Home birth in rural areas, even for healthy women, carries an inherent risk because of the difficulty of obtaining rapid assistance in an emergency. Transfer to a metropolitan centre is disruptive to the woman and her family. It is costly and may result in a less satisfactory birth experience, given that she will be in an unfamiliar setting and attended by people unknown to her.

Birth in rural and remote areas for Aboriginal and Torres Strait Islander women

4.87 Many of the issues identified above as applying to women in rural and remote locations apply also to Aboriginal and Torres Strait Islander women. For this group however the position is particularly difficult because they live in the remotest areas where the problems discussed above are most acute. Their own health and diet is generally less satisfactory than that of the rural population as a whole. As noted, they tend to be younger, poorer and have more babies more closely spaced than does the non indigenous population. In addition they face language and cultural barriers in accessing services. All these factors contribute to their poorer outcomes in terms of perinatal and maternal morbidity and mortality.

4.88 Because a greater proportion of Aboriginal women are deemed to be at risk than is the case for the general population, more of them are transferred to urban centres for their births. In the Northern Territory in 1994, for example, nearly 30% of Aboriginal women had to travel away from their homes to give birth. While such a

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65 Submission No. 69, p.31 (Women's Hospitals Australia and Australian Healthcare Association).

66 See Submission No. 97, p.31 (Department of Health and Aged Care).

67 In Submission No. 150, pp.11-12.

practice may be justified on purely medical terms, its costs are significant in financial and emotional terms.

> Transferring women from remote locations to hospital to give birth is certainly the safest option from a medical perspective, especially with high-risk pregnancies. Nevertheless this causes significant disruption and anxiety for women and their families, as many women living in remote locations have to travel long distances to the nearest town with birthing services, then wait (sometimes for weeks) for confinement. While birthing in remote locations may not be feasible or safe, provision of more accessible services may be.[68]

* * *

> Let us take the example of Halls Creek in Western Australia, where Aboriginal mothers are shipped out to Derby, which is hundreds of miles away. They go by plane and then the poor things are dumped on a bus with their babies to bring them back to Halls Creek. It is really tragic.[69]

4.89 Some attempts have been made to assist women who are awaiting the birth of their babies far from their homes and families. Each State and the Northern Territory has a 'patient' assistance travel scheme, but this does not usually include travel costs for an accompanying family member. In Cairns, the Commonwealth is funding a special residence for those women, where they can stay with their immediate family, receive culturally appropriate antenatal care and be close to medical attention should they require it. Such an approach is especially helpful for young Aboriginal women, who are particularly vulnerable in large unfamiliar cities.

4.90 For indigenous women at low risk who remain in rural areas to give birth, some innovative approaches to culturally appropriate services were developed under the auspices of the Alternative Birthing Services Program. These include the Alukura Birthing Centre at Alice Springs, referred to earlier, which allows traditional practices within a medically safe environment and the Koori Birthing Support Service at Ballarat, operated by the Ballarat Community Health Centre and the Ballarat and District Aboriginal Cooperative.

4.91 For most healthy Aboriginal women however there are few culturally appropriate services in country areas, or indeed in metropolitan areas. Where there are no qualified general practitioners they are obliged, like women at high risk, to transfer to urban centres.

4.92 One response to the lack of culturally appropriate birthing services is the movement for birth on the homelands. But few Aboriginal women choose this option because no back up health support is currently available for those who do so. In 1996 only 2% of recorded Aboriginal births took place in locations other than hospitals and

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68 Submission No. 97, p.33 (Department of Health and Aged Care).

69 *Committee Hansard*, 8.9.99, p.294 (Dr Hilda Turnbull, MLA).

these were mainly in designated birth centres or in bush clinics in the Northern Territory.[70]

Recommendation

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.

Recommendation

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.

70 See Australian Institute of Health and Welfare. *Indigenous mothers and their babies Australia 1994-1996*, Sydney 1999, p.12.

CHAPTER 5

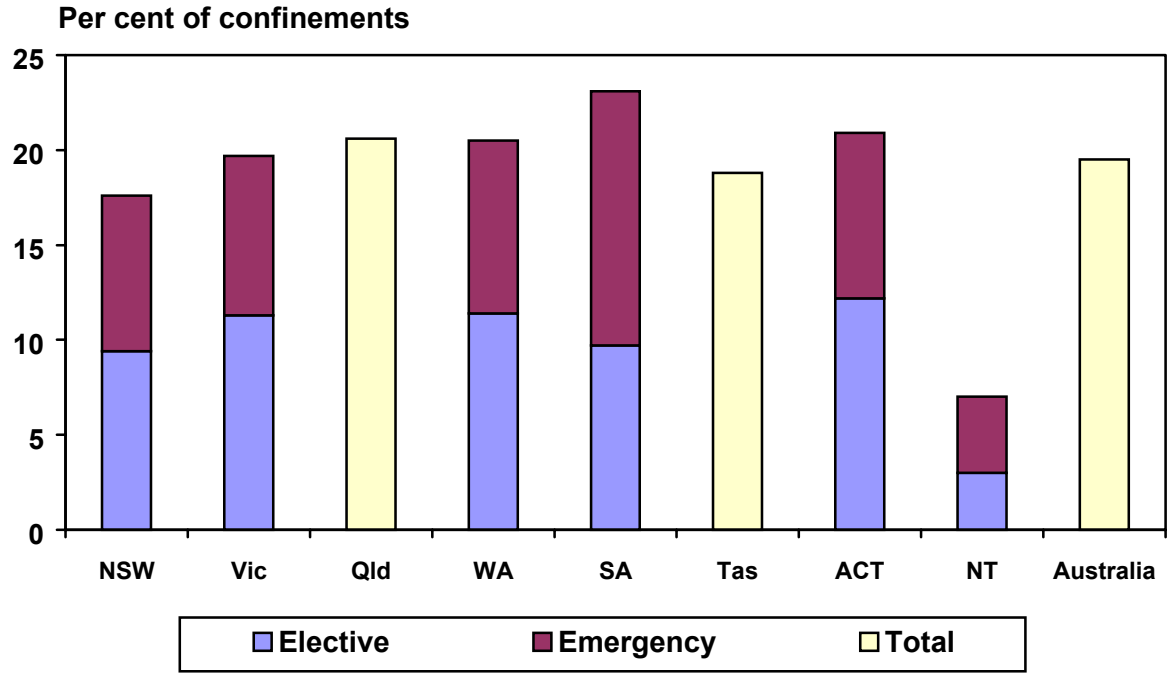
INTERVENTIONS IN CHILDBIRTH – CAESAREAN SECTION

5.1 The Committee is concerned to discover why intervention rates are generally higher in Australia than in most comparable countries, why practices are so variable between institutions and between public and private patients, whether they are justified by improved outcomes for mothers and babies or whether, indeed, they entail adverse consequences for either of these groups.

5.2 The Committee has examined each of the commonly performed childbirth interventions, beginning with Caesarean section, which has aroused the greatest interest and the greatest concern among some members of the general public and some health professionals, especially midwives.

Comparative Caesarean section rates

Caesarean rates, States and Territories, 1996



Note: Elective and emergency caesarean data for Queensland and Tasmania unavailable.

Source: AIHW, *Australia's mothers and babies 1996,* AIHW cat No.PER4, Figure 20, p.20

5.3 The most recent, comprehensive data on Caesarean section in Australia was published by the Australian Institute of Health and Welfare in 1999.[1] It indicated that in 1996 (the year to which its most recent figures apply) 19.5% of all births in

1 Australian Institute of Health and Welfare. *Australia's mothers and babies, 1996,* Canberra, 1999.

Australia were by Caesarean section.[2] There has been a gradual but persistent increase in Caesarean sections over the last thirty years, although the rate of increase has slowed during the last decade.

> …we know that in the early to mid 1960s it was less than five per cent, that it rose to more than 10 per cent in the 1970s, to 15 per cent in the 1980s, and so on…The rate of increase has actually slowed down, if I can put it that way, in the 1990s. I would need to refer to the tables but it was about 16 per cent or 17 per cent in 1991, and it is now 19.5 per cent.[3]

5.4 However, more recent figures from the casemix data base operated by the Commonwealth Department of Health and Aged Care indicate a further increase during 1997-98 to a national rate of 21%.[4]

5.5 There are significant variations between States in the percentage of Caesareans performed. In 1996 the highest rate was in South Australia (23.1%) and the lowest was in New South Wales (17.6%).[5] The casemix data indicates an increase in New South Wales to 18.6% in 1997-98 and a very slight decrease in South Australia to 23%.[6]

5.6 While wide variations between States have historically been a feature of Caesarean rates in Australia, the States with the highest and lowest rates have changed over time. In all States however, the trend has been to increasing levels of Caesarean intervention.

> Caesarean rates varied considerably among the States and Territories – in 1985, the rates ranged between 12.9% in Tasmania and 18.2% in the Australian Capital Territory and, in 1990, between 14.7% in Tasmania and 21.4% in South Australia. Tasmania consistently had the lowest caesarean rate, while the highest rates occurred in South Australia, Queensland and the Australian Capital Territory.[7]

5.7 Australia now has one of the highest Caesarean rates in the world. For the first time it has exceeded the rate in the United States, long regarded by comparable countries (and by the United States itself) as unjustifiably high.

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2 Ibid, p.19.

3 *Committee Hansard,* 27.8.99, p.19 (Australian Institute of Health and Welfare).

4 National Hospital Morbidity (Casemix) Database 1997-98. The Department of Health and Aged Care cautions that the data 'has not yet been subjected to the extensive analysis that has been applied to the data from the AIHW'. See Submission No. 97, p.17 (Department of Health and Aged Care).

5 Australian Institute of Health and Welfare. *Australia's mothers and babies 1996,* Canberra, 1999, p.19.

6 Submission No. 97, p.17 (Department of Health and Aged Care).

7 Lancaster Paul A L & Pedisich Elvis L. *Caesarean births in Australia, 1985-1990*, Australian Institute of Health and Welfare National Perinatal Statistics Unit, Sydney 1993, pp.6-9.

> In fact we have now achieved – if that is the correct term to use – a caesarean rate that is higher than the caesarean rate in the United States…the United States…were very concerned nationally about caesarean rates of 24 or 25 per cent a decade or so ago. In the period since then the caesarean rate has declined to a level of 20.7 per cent, with the latest figures I saw for 1996 of 19 per cent and then slightly up again to 20.8 per cent in 1997 in the United States. But, as I say, on our preliminary figures, we have gone to 21 per cent[8]

5.8 By contrast, Caesarean rates in Holland are 6% and in the United Kingdom 12%.[9] However, in some countries they are much higher than in the United States.

> It is widely believed that the C/S rate should be reduced. However, no acceptable level has been agreed, and values in the developed world vary from 10% in Sweden to 38% in Chile. In some areas of Brazil C/S is considered a modern and acceptable way to have a baby, and 75% of mothers in some areas give birth this way.[10]

5.9 In Australia, Caesarean rates (and rates for some other interventions such as episiotomy) vary markedly between women with private health insurance and those without. There are more older women in the former group, which partly accounts for their higher Caesarean section rates but does not entirely explain it.

> Caesarean section rates differ significantly between patients with public and private admission status. This cannot be entirely explained by the fact that older mothers (who are more likely to have an operative intervention) are also the most likely to have private health insurance.
>
> - In 1997-98, 18% of public patient admissions were delivered by caesarean section against 27% for women with private status.[11]

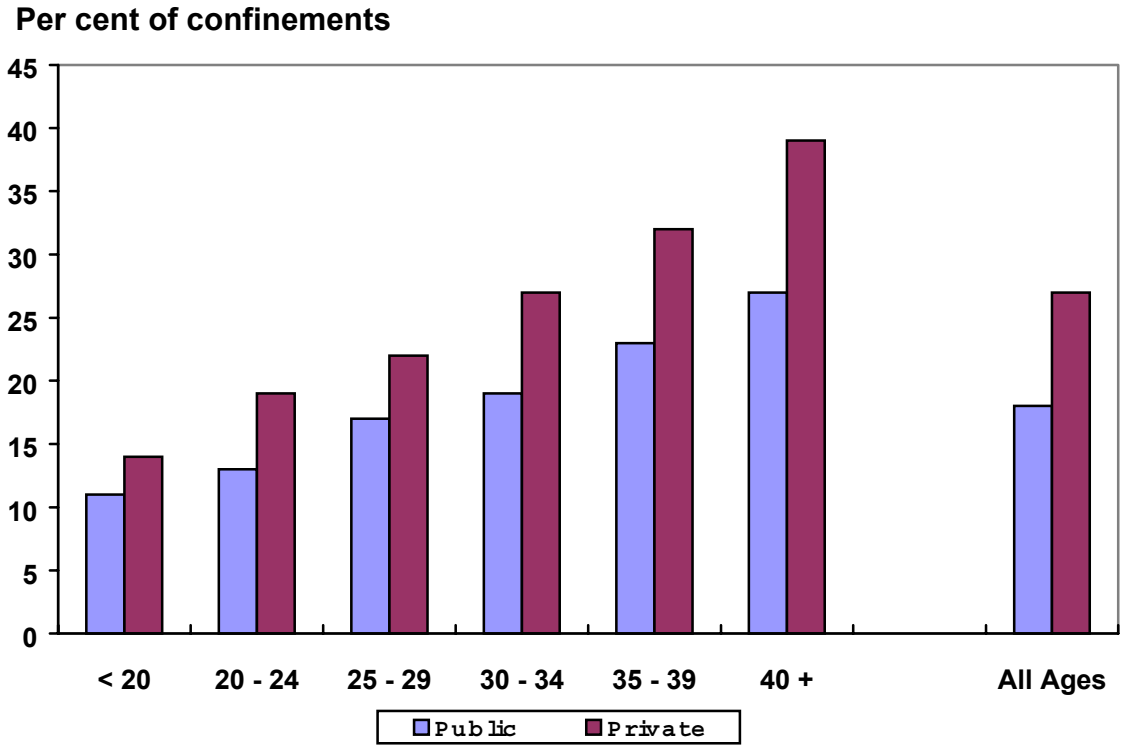
8 *Committee Hansard*, 27.8.99, p.19 (Australian Institute of Health and Welfare).

9 *Committee Hansard*, 6.9.99, p.92 (Dr Jane Fisher, University of Melbourne).

10 Cotzias C, Fisk N. *Patient demand for Caesarean section*. Advances in Obstetrics and Gynaecology, Issue 15, p.9.

11 Submission No. 97, p.20 (Department of Health and Aged Care).

Caesarean rates by maternal age and accommodations status in hospital, selected States and Territories, 1996



Source: AIHW, *Australia's Mothers and Babies 1996,* (AIHW cat. No.PER 4), Figure 21, p.21.

5.10 This again is not a new phenomenon, although the generally declining rates of private insurance cover can be expected to have an effect on the numbers of Caesarean sections being performed in that sector.

> Mothers classified as private had caesarean rates about 40% higher than those classified as public. The greatest difference in rates was in Queensland where the caesarean rates for women admitted to hospital as private patients were 24% and 24.5% in 1989 and 1990, respectively, compared with 15.6% and 15.8%, respectively, for women admitted as public patients. The difference in caesarean rates between private and public patients was least pronounced in the Australian Capital Territory.[12]

5.11 The difference in Caesarean interventions between women with private insurance and women without it is particularly disturbing, given that women in the former group are likely to be healthier and generally at lower risk than those in the latter group.

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12 Lancaster A. L. & Pedisich Elvis L. *Caesarean births in Australia, 1985-1990*. Australian Institute of Health and Welfare National Perinatal Statistics Unit, Sydney, 1993, p.10.

> Private insurance is a very good marker of high socioeconomic status, and we know that high socioeconomic status is also linked with good health and in general with lower obstetric risk. The fact that the rates of use are so high among women who are privately insured is a matter of very serious concern.[13]

5.12 There are also significant variations between hospitals. Again, this can be partly explained by reference to their client group. Women at high risk are much more likely to have a Caesarean section and much more likely to give birth in major metropolitan hospitals with the specialists and equipment required to deal with difficult births. One would expect therefore that these major hospitals would have higher rates of Caesarean section than small country hospitals where clients are more likely to be healthy women at low risk of developing complications. This is in fact the case. But there are very significant differences between individual, large metropolitan hospitals with comparable client groups. At the Queen Elizabeth Hospital in Adelaide, for example, Caesarean section rates have been reduced to 16.6% through the implementation of guidelines by senior and junior staff. This compares with a rate of 25.4% at the Adelaide Women's and Children's Hospital during 1996.

> While caesarean rates for hospitals grouped by size were generally similar, there were still marked variations for individual hospitals. For example, among hospitals with more than 2,000 births per year, one hospital had a caesarean rate of only 9.8% [in 1996] but others had rates in excess of 30%. Such variations depend to some extent on the type of hospital and level of care, the proportion of public and private patients, and maternal age distribution, but policies within a particular hospital may also be a factor.[14]

5.13 Women's Hospitals Australia provided information on 17 of its hospitals (without identifiers) indicating that Caesarean section rates for 1998-99 varied from 15% to more than 30% in these institutions.[15]

5.14 There are also differences in intervention rates for public and private patients within the same hospital. At the Mercy Hospital for Women in Melbourne, for example, 22.03% of public patients had Caesarean sections during calendar year 1998. For privately insured patients the figure was 31.9%[16]. In North Gosford Private Hospital the Caesarean rate was 26.1% in 1997. In Gosford (public) Hospital the rate was 15.8%.[17]

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13 *Committee Hansard*, 6.6.99 p.85 (Dr Jane Fisher, University of Melbourne).

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

15 Additional information 27.8.99 (Women's Hospitals Australia).

16 Additional information 7.9.99 (Mercy Hospital for Women, Melbourne).

17 Submission No. 93. p.5 (Central Coast Midwives Association).

5.15 In these cases and others brought to the Committee's attention the differences were largely in **elective** Caesareans. The figures for **emergency** Caesareans were quite similar. This appears to be the case in all States and Territories.

5.16 Even in smaller hospitals with a predominantly low risk client group there are significant differences in intervention rates. The Caesarean rate at Lithgow for example, as noted earlier, was 27.1% in 1997. In Armidale, with a similar number of births, it was 10.3%.[18]

5.17 Caesarean rates vary according to the professional background of the principal carer. Rates are highest for specialist obstetricians, very much lower for general practitioners and lower again for midwives (who are not qualified to perform Caesarean sections themselves but must refer to medical staff any woman whose condition requires such a procedure). Again, these differences in practice can be largely explained by the client group of each of the professional practitioners. Almost all complex births (which are those most likely to require Caesarean section) are attended by a specialist obstetrician or registrar/general practitioner with obstetric qualifications. Midwives attend low risk births.

5.18 Even here however, there appear to be significant variations in practice between individual obstetricians or groups of obstetricians. This was certainly seen to be the case when individual practitioner rates could be determined through analysis of health insurance data. The data included a separate item for Caesarean section until the late 1980s.

> We do not have current information on practitioner variations in caesarean rates. Unfortunately, the item on caesarean section was taken out of the medical benefits schedule in the late 1980s…[Before that] we actually had access to health insurance data for individual practitioners. And, irrespective of the size of the obstetrician's practice, there were rather large variations in individual caesarean rates, a sixfold variation, say, from six percent to 35 per cent or 40 per cent.[19]

5.19 Some witnesses suggested a direct link between the number of specialist obstetricians and the number of Caesarean sections.

> …if you look at the rates across New South Wales, the places that have the largest numbers of obstetricians have the higher rates [of Caesarean section]…I should qualify that statement in that there are specific obstetricians who are very well versed in evidence based practice who have lower rates as well.[20]

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18 New South Wales Health Department. *New South Wales Mothers and Babies 1997,* Sydney, 1998, pp.88-89.

19 *Committee Hansard,* 27.8.99, p.8 (Australian Institute of Health and Welfare).

20 *Committee Hansard*, 14.9.99, p.397 (Professor M Chamberlain, University of Sydney).

5.20 One might expect that obstetricians who perform a large number of Caesarean sections for complex births and are therefore very skilled and knowledgeable about the procedures would attract as clients women who choose to birth by Caesarean section or those whose health status requires it. Since this information is not generally available it is difficult to determine the extent to which it accounts for the variations in practice between obstetricians.

5.21 Many factors influence elective Caesarean rates at the macro level. The nature of the client group is a major determinant. But anecdotal evidence to the Committee suggests that other factors also have an influence. One of these is the 'institutional culture' of a hospital, which is normally established by a few leading professionals within that organisation. Another is peer pressure.

> …back in the 1980s and into the early 1990s, Tasmania had a lower caesarean rate than all the other states. The perinatal collection in Tasmania was set up by a professor of obstetrics, with a view to obstetric audit of what was going on in the state. He regularly fed the information back for the whole state of Tasmania to individual practitioners. I would like to think that that was a factor in keeping the caesarean section rate down in that state – although I cannot prove it; it is my hypothesis. Since he retired the caesarean rate…has caught up with the national figure.[21]

5.22 In an isolated area the philosophy and practice of an individual specialist or general practitioner/obstetrician can make a difference, as the Committee was advised in Western Australia. In the Geraldton region the Caesarean rate halved (from 16.5% to 7.3%) between 1994-5 and 1998-9 after the appointment of a specialist obstetrician, working with a team of general practitioners and midwives. The number of births remained fairly constant during this period (659-699).[22]

Reasons for growth in rates of Caesarean section

5.23 Many factors may contribute to a woman's decision to undergo a Caesarean section and a doctor's decision to perform one. These may be social/cultural as well as medical. The decision to operate may be made before the onset of labour, in which case it is known as an **elective** Caesarean, or after the onset of labour, in which case it is known as an **emergency** Caesarean section.

5.24 The following paragraphs describe some of the factors contributing to the decision to undergo or to perform a Caesarean section.

(i) Safety

5.25 Caesarean section is now a very safe operation. In the period 1991-93, for example, 14 maternal deaths were directly attributable to Caesarean section and 3 to

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21 *Committee Hansard,* 27.8.99, p.29 (Australian Institute of Health and Welfare).

22 *Committee Hansard*, 8.9.99, pp.321-22 (Royal Australian College of General Practitioners).

anaesthetic. There was a total of 84 maternal deaths for 769,253 confinements.[23] Although it is a major operation with significant adverse consequences for the mother in the short term, such as pain and reduced mobility for up to six weeks following the operation, it has few long term adverse effects on the baby. In the short term it increases the risk of respiratory distress to the newborn but it may improve outcomes for some babies at particular risk, such as those with very small birth weight. It may also reduce the number of unexpected intrauterine deaths. These occur in about 1 in 600 pregnancies which progress beyond 41 weeks gestation.[24]

5.26 Because of its relative safety, Caesarean section is now an option for many births where previously it would never have been considered. However, it remains more risky than vaginal birth, with a maternal mortality rate two to four times higher than for vaginal delivery (although the figures are very low in both cases). Elective Caesarean section is safer for the mother than emergency Caesarean section.

(ii) Availability

5.27 Almost all women in Australia deemed to be at risk of developing complications are advised and assisted to birth in major hospitals where Caesarean section is available at short notice if required. This includes women in rural areas who, as noted, are encouraged to move to urban centres to give birth.

5.28 Healthy women in major centres of population who develop unsuspected complications during labour are usually transported quickly to hospital where they can be operated upon if necessary. The situation is much more difficult in country areas. Healthy women who develop unexpected complications there may have difficulty in obtaining rapid access to Caesarean section and other medical support. The fact that this situation rarely arises is testimony to the skills of the general practitioners and midwives in screening women for possible complications and ensuring that their births take place close to necessary facilities.

5.29 In situations in which a range of other options was likely to have been considered in the first instance, for example in a breech position, the widespread availability of Caesarean section increases the likelihood of its use.

(iii) Increasing age of mothers

5.30 The age of mothers giving birth to their first babies is increasing in Australia. In 1996 the estimated mean age nationally was 28.6. In 1991 it was 27.9. The percentage of older mothers (aged 35 or over) giving birth for the first time increased

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23 National Health and Medical Research Council. *Report on Maternal Deaths in Australia 1991-1993,* Canberra 1998, p.9 and p.68.

24 Hilder L et al. *Prolonged pregnancy: evaluating gestation specific risks of fetal and infant mortality.* British Journal of Obstetrics and Gynaecology, 1998;105: pp.169-173.

from 10.6% in 1991 to 14.3% in 1996.[25] This situation is also occurring in other comparable countries.

5.31 Rates of Caesarean section are considerably higher among older women. The older they are when their first baby is born, the more likely they are to give birth via Caesarean section.

> In 1996, the caesarean rate among mothers in their early 30s was double that of teenage mothers, while for mothers aged 40 years and over the rate was almost three times higher. The national caesarean rates by maternal age were as follows: less than 20 years – 11.1%; 20-24 years – 14.0%; 25-29 years – 18.3%; 30-34 years – 22.0%; 35-39 years – 26.2%; and 40 years and over – 31.8%.[26]

5.32 In addition, Caesarean rates are generally higher for women having their first baby than for others. The comparable figures in 1996 were 20.7% for first time mothers and 18.7% for others.[27]

5.33 There are a number of reasons for this, both medical and social. Older women have a slightly enhanced risk of carrying a baby with foetal abnormalities and a slightly higher risk of developing complications during labour and delivery. They are more likely to be privately insured and more likely to be attended during their antenatal period and during birth by a specialist obstetrician. All of these factors enhance the likelihood of Caesarean section.

5.34 The Committee was told that older women are more likely to be highly educated and assertive. Some of them have careers which they do not want to disrupt. They are therefore said to be disproportionately represented among the group of women 'demanding' Caesarean section (as discussed in the following paragraphs).

5.35 It is impossible to ascertain the importance of each of these factors in contributing to the high Caesarean rate among older mothers but the high rate itself cannot be disputed.

(iv) Medical indications for elective Caesarean section

5.36 Some conditions of the mother or foetus during pregnancy predispose doctors and mothers to the use of Caesarean section. They do not of themselves necessitate this approach and years ago would have been generally managed through vaginal delivery. The major predisposing factors are:

(a) Caesarean section following a previous Caesarean section;

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25 Figures are from Australian Institute of Health and Welfare. *Australia's mothers and babies 1996*, Sydney 1999, p.7.

26 Submission No. 170, p.3 (Australian Institute of Health and Welfare).

27 Ibid, p.3.

(b) breech presentation of the foetus;

(c) multiple birth;

(d) low birth weight of the baby; and

(e) large size of the baby, especially where the mother is small.

5.37 This is an area of some disagreement between midwives and some medical specialists. Midwives consider that many, but not all, of these conditions could be managed by vaginal delivery without adverse consequences for the mother or baby. This was particularly the case when Caesarean section was less routinely resorted to, so that specialists developed skills in, for example, delivering breech babies and in assisting women to deliver vaginally after a previous Caesarean section.

5.38 Now, obstetricians are much more likely to resort to Caesarean section before the labour starts that is, elective Caesarean. This limits their opportunities to develop skills in vaginal delivery of complex births.

5.39 Each of the predisposing factors listed above is briefly discussed below.

(a) Caesarean section following an earlier Caesarean section

5.40 A woman who has given birth by Caesarean section may have difficulty in giving birth vaginally on subsequent occasions. This is because the scar from the original procedure may reopen during labour. For this reason many women who are pregnant for the second time, and whose first birth was by Caesarean section, are advised to be delivered again by Caesarean section.

5.41 Some midwives and medical specialists dispute the necessity for this approach. They suggest that if vaginal labour is allowed to proceed and carefully monitored then a majority of women in this group will be able to give birth by this method without harm to themselves or their babies. In the minority of cases where the previous scar tissue is in danger of rupturing there is sufficient time to perform a Caesarean section.

5.42 Evidence shows that up to 70% of women who opt for vaginal labour in these circumstances (technically described as a 'trial of scar') are successfully delivered without recourse to Caesarean section.[28]

5.43 However, a recently published West Australian study indicated that when women with a previous Caesarean section were advised of the risks and benefits of a

28 See de Costa Caroline M. *Caesarean section: a matter of choice?* Medical Journal of Australia 23.5.99, 170, pp.572-573.

trial of scar as opposed to Caesarean section for a second birth the majority opted for a second Caesarean section.[29]

5.44 As a result of the increase in the number of women delivering their first babies by Caesarean section the number delivering subsequent children by the same method is also increasing. This group constitutes a significant proportion of total Caesarean sections and is continuing to contribute to the rise in rates. Casemix data for 1997-98 showed previous Caesarean section as the principal reason for Caesarean delivery in 23.26% of cases. It was the secondary reason in a further 12.55% of cases.

(b) Breech presentation of the foetus

5.45 Breech presentation of the foetus before birth occurs in approximately 4% of pregnancies.[30] While it is a complicating factor, vaginally delivered breech babies have only marginally worse outcomes than do vaginally delivered babies of normally presented foetuses. A recent study of maternal and neonatal outcomes of 846 single breech deliveries concluded that 'available data was not sufficiently conclusive to justify Caesarean section for the singleton breech infant at term'.[31]

5.46 A multinational, randomised trial of planned Caesarean section versus planned vaginal delivery of breech babies, begun in 1997 and due to conclude in 2000, should provide more definitive answers on the relative safety of each of the methods for both mothers and babies. The trial is being conducted by the University of Toronto in Canada.

5.47 Before Caesarean section was such a safe procedure, almost all breech babies were delivered vaginally. Midwives and medical specialists would develop skills in external rotation of the baby to the head down position before labour commenced and were successful in doing so in about 70% of cases. Where this was not possible, or where the baby returned to its original position before labour began, they would develop skills in assisting during labour and birth and in minimising trauma to the mother and baby. If trial of a breech by vaginal labour were unsuccessful they could resort to Caesarean section at that point.

5.48 Today, specialists are much more likely to resort to Caesarean section before labour begins. Vaginal delivery is now performed in only 13% of cases of breech presentation. There are a number of reasons for this. One, as noted, is that Caesarean section is a relatively safe alternative. Another reason is that young specialists have less practice in managing breech births vaginally and so are more nervous about undertaking them. They may also be concerned about the possibility of litigation if

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29 Quinlivan J. Peterson R. and Nichols C. *Patient Preference the Leading Indication for Elective Caesarean Section in Public Patients – Results of a 2-year prospective audit in a teaching hospital. Australian and New Zealand Journal of Obstetric Gynaecology,* 1999, 392, pp. 207-214.

30 Australian Institute of Health and Welfare. *Australia's mothers and babies 1996,* Sydney 1999, p.18.

31 See Schiff et al. *Maternal and Neonatal Outcomes of 846 Singleton Breech Deliveries.* American Journal of Obstetrics and Gynaecology 1996, 175, pp.18-23.

they do not opt for Caesarean section and there is subsequently a less than optimal outcome. Women themselves may be ill informed about the high success rate for vaginal delivery of breech babies and may exert pressure on obstetricians to perform a Caesarean section. As specialists and midwives become less experienced in performing vaginal delivery for breech presentations they become less skilled at doing so, more reluctant to undertake them and more likely to resort to Caesarean section.

5.49 Breech presentation makes a significant contribution to Australia's high Caesarean rate. It was the principal reason for performing Caesarean sections in 11.06% of cases in 1997-98 and the secondary reason in 4.13% of cases.

(c) Multiple births

5.50 Multiple births are inherently more risky for the babies than single births. The greater the number of babies involved, the greater the risk, especially for the second and subsequent babies born. For this reason Caesarean section rates are higher for multiple births than for single births, and the greater the number of babies the greater the likelihood of Caesarean section. All quadruplets are now born by Caesarean section, as are 75% of all triplets. For twins the rate is 35%.

5.51 For twins the perinatal death rate was 3.7 times higher in 1994-96 than for singleton births. For other multiple births it was 8.6 times higher.[32] Some midwives and obstetricians suggest vaginal delivery of twins where there are no other risk factors. But, through lack of experience, fear of litigation and women's concerns about the safety of the babies, an increasing number prefer to perform a Caesarean section.

5.52 There has been an increase in the number of multiple births associated with IVF and other assisted conception programs. In turn, this has contributed to an increase in the number of Caesarean sections. The casemix data does not include information on multiple births greater than two babies. In 1997-98 it did not show the delivery of twins as a principal reason for Caesarean section although it was cited as the secondary reason in 3.08% of cases.

(d) Low birth weight of the infant

5.53 There is some conflicting evidence that pre term and low birth weight infants have a greater chance of survival and suffer fewer adverse effects if delivered by Caesarean section. In these circumstances therefore birth by Caesarean section may be indicated. However, recent evidence casts doubt on the value of Caesarean sections for low birth weight babies and intervention rates on these grounds have begun to fall during the 1990s.

32 Australian Institute of Health and Welfare. *Australia's mothers and babies 1996,* pp.43-44.

5.54 The position is reversed for babies of normal weight and gestational age. They are more likely to suffer from respiratory complications when delivered by Caesarean section than when delivered vaginally.

5.55 The number of live births of pre term babies and babies of very low birth weight is increasing, as are their survival rates. The increase in live births is partly a result of the more widespread adoption of assisted conception programs (which result in a disproportionate number of pre term births). The increase in survival rates is a direct result of advances in medical knowledge and medical technology.

(e) Large size of the infant, when the mother is small

5.56 The Committee heard conflicting evidence on the extent to which Caesarean sections are performed in these circumstances, and the desirability of performing them for these reasons. One witness suggested this was a particular problem among some ethnic groups.

> If you come to a hospital in any capital city…you will find that at least 47 per cent, and in some hospitals up to 60 per cent, of the women are first generation migrants. Particularly if they marry outside their racial group, they grow babies with body habitus which is different to that of babies born in Vietnam, Somalia or Ethiopia.[33]

5.57 Others suggested that the high Caesarean rate among some ethnic groups was more likely to reflect the distress of mothers during labour in an unfamiliar environment surrounded by strangers with whom they were unable to communicate.

5.58 There are certainly variations in Caesarean rates between ethic groups.

> High caesarean rates occurred among mothers born in the Philippines (27.4%), Malaysia (23.6%) and India (23.2%) and relatively low rates among mothers from Vietnam (14.3%), Lebanon (13.1%) and New Zealand (16.4%).[34]

5.59 These figures do not differentiate maternal age, health or insurance status, which might also have an effect on Caesarean section rates. Nor do they provide information on the ethnic and health backgrounds of the fathers.

5.60 There appears to be only anecdotal evidence to support the claim that some practitioners see these circumstances (large size of baby when the mother is small) as warranting the performance of Caesarean sections. Indeed, the Committee received evidence of some births in which these circumstances prevailed and vaginal delivery was allowed to proceed despite significant distress to the mother and the baby.

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33 *Committee Hansard,* 6.9.99, p.172 (Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

34 Submission No. 170, p.5 (Australian Institute of Health and Welfare).

5.61 The Committee is therefore unable to ascertain the extent to which these factors have contributed to an increase in the Caesarean section rate, or indeed if they have made any such contribution. This is an area requiring further research and data against which the conflicting claims can be assessed.

(v) Indications for emergency Caesarean section

5.62 Emergency Caesarean sections are those in which the decision to operate is made after the onset of labour. It includes those cases of trial of scar and trial of breech delivery (discussed earlier) which cannot be sustained. The major medical reasons for emergency Caesarean sections are:

(a) foetal distress;

(b) failure to progress in labour; and

(c) placenta praevia.

5.63 Each of these is discussed below.

(a) Foetal distress

5.64 The Committee heard conflicting evidence on the appropriateness of Caesarean section as a response to foetal distress. Some witnesses claimed that continuous foetal monitoring of low risk infants, which is the norm in some hospitals, had adverse consequences for the mother and the baby. It restricted a woman's mobility during labour, confining her to a prone position on the bed, which was not the optimal position for labour or delivery. These witnesses also claimed that it exaggerated the extent of foetal distress, (through high false positive rates for the detection of foetal hypoxia or acidosis) resulting in the performance of Caesarean sections when in fact the baby's condition did not warrant it.

5.65 Obviously, there are circumstances in which foetal distress is such as to warrant prompt resort to Caesarean section. But it is impossible for the Committee to judge whether it is used in circumstances where it is not medically necessary. Again, fear of litigation in the event of an adverse outcome may influence practitioners' decisions here. Women's concern to avoid any risk of foetal damage is another major factor.

5.66 Certainly, foetal distress was said by doctors to be a major reason for the performance of Caesarean section. It was cited as the principal reason for it in 10.71% of cases in the 1997-98 casemix data set and as the secondary reason in 9.09% of cases.

(b) Failure to progress in labour

5.67 Evidence to the Committee suggested that failure to progress was the most common cause of emergency Caesarean section. Its incidence is not evident in

casemix data, which does not include this among the possible reasons for Caesarean interventions.

5.68 The reasons for failure to progress in labour were a matter of dispute in evidence to the Committee. Some evidence suggested that failure to progress was directly linked to induction of labour.

> The high epidural rate in some hospitals is undoubtedly related to the high rates of induction and labour augmentation (more painful labour). The use of epidural analgesia also results in an increased use of interventions such as forceps and/or caesarean section (due to failure to progress in labour). The use of medical interventions in labour often leads to other interventions becoming necessary, thus increasing maternity care costs.[35]

5.69 Other evidence suggested that it was a more general reaction to the medicalisation of the birth process.

> Where there is an emphasis on time limits, on ongoing monitoring, on the time constraints of the medical staff, such as shift changes and obstetrician's rosters, and on bright lights and technology, women become stressed, hormone levels alter, and the birthing process slows down or stops, leading to an intervention domino effect and more caesarean sections.[36]

5.70 The number of emergency Caesarean sections performed as a result of the mother's failure to progress in labour is impossible to determine. This is another area requiring research on which to assess the appropriateness of current practice. However, evidence to the Committee suggests that it is widely perceived as a significant contributor to Australia's high Caesarean section rate.

> The main [reason for the increase in the Caesarean section rate] – and it has been going on since the mid-1970s – has been the so called failure to progress in labour situations with the first baby. The cervix does not reach full dilation within a certain time and the patients and the doctors are concerned about the foetal wellbeing.[37]

(c) Placenta praevia

5.71 This is a condition in which the placenta covers the cervix, partially or completely blocking it. It causes sudden and severe bleeding in the mother, possibly resulting in her death. In these circumstances therefore Caesarean section is always indicated.

5.72 Caesarean section necessitated by placenta praevia accounts for a very small proportion of the total number of Caesarean sections performed. It was cited as the

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35 Submission No. 154, p.4 (Professor Marie Chamberlain and Ms Jannine van der Klei).

36 Submission No.184, p.2 (Birth Support, Bendigo).

37 *Committee Hansard*, 6.9.99, p.175 (National Association of Specialist Obstetricians and Gynaecologists).

principal reason for 1.54% of the Caesarean sections performed in 1997-98. It was never cited as a secondary reason.

5.73 In addition to the medical reasons for Caesarean section discussed above, a range of other medical conditions are also indicators for Caesarean intervention. These include sideways lie of the foetus, cord prolapse and eclampsia. They occur in a relatively small number of cases and so have not been included in this discussion.

5.74 Medical indications for elective and emergency Caesarean section have not changed significantly in many years, except for the flow on effect of Caesarean sections in women who have had an earlier birth by this method. The increasing Caesarean rate appears to reflect a readiness for earlier Caesarean intervention rather than any change in the medical indications for its use.

(vi) Patient demand

5.75 Patient demand is said to be a significant factor in Australia's escalating Caesarean rate. This is certainly a widely held perception in the community, although advice to the Committee suggested that patient request for Caesarean section was a determining factor in only about 5% of (mainly elective) Caesarean sections in cases where there was no medical justification for such a procedure.

5.76 The perception is fostered by the media, with its television serials portraying birth as a life threatening event from which woman and child can be saved only by emergency surgery following a high speed dash to hospital.

5.77 The print media too tends to portray Caesarean sections as the preferred alternative to vaginal birth – less mess and more convenient. The following excerpts have been selected at random from recent articles.

> …'it was good having a caesarean because it was over and done with, and there was no pain'.[38]

* * *

> 'I went in at 8 am and came out at 8.30, signed, sealed and delivered… It came down to my age, and the pain and the convenience. I had to fit in with my husband's holidays.'[39]

5.78 Some witnesses pointed to the increase in the Caesarean section rate as reflecting society's preoccupation with technological solutions to problems.

> …we have increasingly a technological perspective in our culture as a whole and this is reflected in the birth process. In all aspects of our life, we think technology is good and more technology is better and we take this into the

38 *Removing the uncertainty*. Adelaide Advertiser, 6.9.99.

39 *Caesareans – Just what the Mother-to-be Ordered.* Australian, 28.8.99, p.3.

> birth area where we think technology is good and most technology – caesarean section – must be better.[40]

5.79 Women were reported by witnesses as requesting Caesarean section for reasons of convenience. This was said to be especially the case for 'career' women, but was not restricted to that group.

> I do not like to put people in pigeon holes, but a lot of the more career oriented women are very in control people and do not like to not be in control. I really do believe that that is a driving force. I have no evidence for that; that is just an anecdotal thing, but I do see that quite often amongst the women that I look after.[41]

5.80 Women may request Caesarean section before the onset of labour because they want to avoid the pain of vaginal childbirth. They may also request it during labour, if they consider the pain is excessive.

5.81 The Committee heard some suggestion that partners are more likely than the woman giving birth to favour Caesarean section for pain avoidance or pain relief, but again, the 'evidence' was anecdotal. Some recent studies lend weight to this view however. Questionnaires completed by 278 women who gave birth by Caesarean section at the Women's and Children's Hospital in Adelaide in 1996 indicated that in a majority of cases (61%) partners' reaction during labour was one of the factors influencing the decision to undergo an emergency Caesarean section.[42]

5.82 An important reason for a woman's decision to choose a Caesarean section is concern to avoid some of the claimed long term ill effects of vaginal delivery, chiefly the risk of faecal or urinary incontinence resulting from damage to the pelvic floor or anal sphincter muscles during vaginal labour. Although these risks are not widely discussed they are well documented. The conditions are embarrassing and debilitating and may themselves require surgery in time.

> Women who deliver by C/S suffer less from urinary incontinence compared with those delivering vaginally. Of women without stress incontinence before or during pregnancy, none delivering by C/S had urinary incontinence in the puerperium compared with 13% of those delivering vaginally.
>
> Four per cent of women with no clinically obvious sphincter rupture begin experiencing faecal incontinence after childbirth. The incidence of faecal incontinence increases with the number of vaginal deliveries. Women who

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40 *Committee Hansard,* 15.9.99, p.526 (Dr Sarah Buckley).

41 *Committee Hansard,* 7.9.99, p.269 (Sister Edith Reddin).

42 See Turnbull Deborah A et al. *Women's role and satisfaction in the decision to have a caesarean section. Medical Journal of Australia* 1999; 170, pp.580-583.

> deliver by C/S have significantly less frequent faecal incontinence years later than women delivering vaginally.[43]
>
> * * *
>
> Childbirth was found to be associated with a variety of muscular and neuromuscular injuries of the pelvic floor that are linked to the development of anal incontinence, urinary incontinence, and pelvic organ prolapse. Risk factors for pelvic floor injury include forceps delivery, episiotomy, prolonged second-stage of labour, and increased fetal size.[44]

5.83 One submission to the Committee suggested that the adverse consequences of vaginal delivery, especially operative vaginal delivery, were not appreciated by midwives because they were often not apparent in the immediate post natal period. This influenced midwives' views of the comparative benefits of vaginal as opposed to Caesarean delivery.

> It is my belief that the general public are only beginning to realise how common and debilitating these conditions [urinary incontinence and genital prolapse] can be. **Most midwives are largely ignorant about prolapse and incontinence and their relation to childbirth because they do not deal with these problems in their professional lives.**
>
> This colours their view of the childbirth process and leads them to see a "natural delivery" with as little intervention (eg caesarean section) as possible as being the ideal. The terms of reference of your enquiry even legitimise this view and have the stated aim of minimising intervention.[45]

5.84 Other possible long term effects of vaginal delivery less frequently cited as reasons for choosing Caesarean section include dyspareunia (pain during intercourse) and perineal pain.

> Three months after vaginal delivery, 20% of women have dyspareunia and 12% seek medical advice because of perineal problems which may persist for years. Morbidity after operative vaginal delivery is greater and longer lasting than that after C/S. Perineal pain is a particular problem and leads to a higher incidence of sexual difficulties in this group.[46]

5.85 Women are concerned above all about the safety of the baby. Many state that their decision to opt for a Caesarean section is prompted by the belief that a Caesarean birth is safer for the baby than a vaginal birth.

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43 Cotzias C. Fisk N. *Patient demand for a Caesarean section.* Advances in Obstetrics and Gynaecology. Issue 15, pp.11-12.

44 Handa V. L. et al. *Protecting the pelvic floor; obstetric management to prevent incontinence and pelvic floor prolapse.* Obstetrics and Gynaecology 1996, September: 88 (3), pp.470-478.

45 Submission No. 188, p.1 (Dr Glen Barker, Vic).

46 Ibid, p.12.

> On balance, when we interviewed the women, both in a quantitative and qualitative sense, they very much talked about or thought about caesarean section as being less risky for the baby. They very much couched their reason in terms of safety to the baby.[47]

5.86 Some, privately insured women, it is suggested, see Caesarean section as a service they have purchased with their insurance.

> The perception I get is that when women are paying good money to have a doctor look after them, they want the doctor to look after them. If they want a certain thing – for instance, a caesarean – they feel that they are paying him or her and he or she ought to do it. I think they put as much pressure on the doctors perhaps as the doctors put on them, in some cases.[48]

5.87 Those in the community and the professions who are concerned about the numbers of women requesting (or demanding, as some witnesses claimed) Caesarean section without any medical indication see education as the key to reducing demand. They argue that women are ill informed about the relative advantages and disadvantages of Caesarean versus vaginal birth and that if they were fully aware of the consequences of each approach then fewer of them would chose Caesarean section. Some of the popular misconceptions which, in this view, need to be addressed are:

Caesarean birth is painless

5.88 Women need to be advised that Caesarean sections are not painless. They are major operations and post operative pain is a major factor to be considered. In addition, some women who opt for Caesarean sections to escape the pain of childbirth may not be aware of the techniques available to manage the pain of vaginal delivery.

Caesarean birth has no long term ill effects

5.89 Caesarean section limits mobility for up to six weeks, at a time when a woman has great demands placed upon her.

5.90 There is also increasing evidence that women giving birth by Caesarean section are more likely to suffer long term psycho social problems than are women giving birth naturally. They are more likely to have difficulty in breastfeeding, for example, and are more prone to post natal depression.

> As health professionals, we are becoming increasingly aware of the damage done to women, and therefore to their babies, through the misuse of intervention in birth. The latest evidence highlights the link between

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47 *Committee Hansard,* 7.9.99, p.265 (Dr Deborah Turnbull, University of Adelaide). Referring to study by Turnbull, Deborah A. *Women's role and satisfaction in the decision to have a Caesarean section.* Medical Journal of Australia 1999, 170: pp.580-583.

48 *Committee Hansard,* 7.9.99, p.269 (Sister Edith Reddin).

> obstetric intervention and post-traumatic stress disorder (PTSD) in childbearing women.[49]

5.91 Caesarean sections also entail an enhanced though small risk of subsequent ectopic pregnancy, placenta praevia, placenta accreta and emergency hysterectomy.

> Although peripartum emergency hysterectomy is an uncommon complication…it is 18 times more likely in women with a history of C/S compared with those who had a vaginal delivery. Previous C/S is also a risk factor for major obstetric haemorrhage in a subsequent pregnancy.[50]

Caesarean birth is safer for the baby

5.92 Babies delivered by Caesarean section have a higher risk of respiratory distress in the period immediately after birth, although for babies of normal gestational age, mortality and long term morbidity outcomes are similar whether they are delivered vaginally or by Caesarean section.

Caesarean section has a lower risk of maternal mortality

5.93 Maternal mortality rates are two to four times higher for Caesarean section.

Caesarean section is the only option where a previous Caesarean section has been performed, or where the baby is in a breech position

5.94 As discussed, breech presentation and previous Caesarean section do not preclude the possibility of vaginal birth. In both cases the majority of women can deliver vaginally without any risk to themselves or their babies.

5.95 Supporters of natural childbirth also point out that women who choose Caesarean section deprive themselves of one of life's great experiences. They claim that although vaginal birth may be hard work and is sometimes painful it is also empowering and uplifting (especially where there is minimal intervention), so that women who have experienced it begin their maternal role from a position of strength, viz a viz those who have not.

> Birth is very much a psychological process which is easily fractured if mishandled. Our society's expectations have in many cases shifted from where women empowered, educated and supported the birthing woman to a model where a professionally trained doctor is deemed to have the

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49 Submission No. 57, p.2 (Brisbane Independent Midwives). The research referred to is by D Creedy, and was published as *Birthing and the development of trauma symptoms: incidence and contributing factors.* Griffith University, Brisbane 1999.

50 Cotzias C. Fisk N. *Patient demand for a Caesarean section.* Advances in Obstetrics and Gynaecology. Issue 15. p13. Article refers to a number of studies on this issue including Greene R et al. *Long-term implications of caesarean section.* American Journal of Obstetrical Gynaecology 1997, 176, pp.254-256 and Coulter- Smith S et al. *Previous caesarean section: a risk factor for major obstetric haemorrhage,* Journal of Obstetrics and Gynaecology, 1996, 16, pp. 349-352.

> knowledge and the control over the birthing process. This has disempowered women, rendering them vulnerable, lacking in confidence and willing to 'hand over their bodies' to the professionals.[51]

5.96 There appears to be a link between women's education levels and the likelihood of their giving birth by Caesarean section. The available evidence suggests that those with the very best information – female obstetricians – are among the most likely to opt for Caesarean section.

> …when obstetricians were asked which mode of delivery they preferred for their own uncomplicated pregnancy at term, 31% chose elective C/S. The reasons cited were fear of pelvic damage, fetal safety and electively timed delivery.[52]

5.97 Other factors are obviously at work here. At a very general level, it might be assumed that poorly educated women are less likely to have private insurance and less likely to be attended by a specialist obstetrician, both factors associated with higher rates of intervention. More importantly, less educated women may be less likely to assert their 'right' to Caesarean section in the face of medical advice to the contrary and obstetricians may be less likely to accede to their requests.

5.98 A Victorian study suggested that obstetricians may see litigation as more likely to be instigated by better educated women than by others, and that this might influence their approach to intervention.[53]

> It is possible that confident, articulate, well pregnancy-educated women and their husbands may arouse greater anxieties about malpractice litigation in their treating physicians than those who are less articulate or well-educated. Obstetricians may then be less willing to risk a natural outcome of delivery in this group.[54]

5.99 However, some of the other limited evidence available on this issue suggests that there is no difference in terms of class or education between the women who opt for Caesarean section and those who do not.

> Our study [the Turnbull questionnaire] showed that women who seem to have a preference for caesarean section are no different from those who do not. I know that a lot of individual clinicians talk about articulate middle-class women having stronger preferences, wanting to plan the event and, therefore, demanding it more. Our research with a consecutive group of

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51 Submission No. 184, pp. 1-2 (Birth Support Bendigo).

52 Cotzias C. Fisk N. *Patient demand for a Caesarean section*. Advances in Obstetrics and Gynaecology, Issue 15, p.10.

53 This was a Melbourne study conducted by Dr Jane Fisher in 1993. It analysed questionnaires sent to 242 nulliparous pregnant women in the late stages of pregnancy and again six weeks after birth.

54 Fisher J et al. *Private health insurance and a healthy personality: new risk factors for obstetric intervention?* Journal of Psychosomatic Obstetrics and Gynaecology, 16, 1995, p.6.

> women, sampled in a systematic manner, does not indicate that that is so. The women who have preferences for section are no more likely to be educated women, they are no more likely to be older women, they are no more likely to be English speaking women.[55]

5.100 This witness hypothesised that the general view that it is middle class women who 'demand' Caesarean section has arisen because this is the group whom specialist obstetricians are most likely to treat, and on which, therefore, they base their assumptions about the type of women requesting elective Caesarean sections.

> It is an issue of selection bias. They [specialist obstetricians] are seeing a select group of women so they have no points of comparison.[56]

5.101 The dynamics of the relationship between doctor and patient must certainly be an important consideration in the final decision reached on whether or not to perform a Caesarean section. But this is an area about which very little is known. Deborah Turnbull's study reported that 61% of patients felt they had been included in the decision to have a Caesarean. Half 'strongly agreed' that they were satisfied with the decision to have a Caesarean and 40% 'agreed'.[57] However, 20 % reported they needed more information on other options and only 28% felt they had been given good information on the issues. In this study more than 25% of patients indicated that they 'had insisted on' or were 'keen to have' a Caesarean delivery. Similar percentages have been reported in recent studies in Scotland and Western Australia.[58]

5.102 It is impossible to ascertain the proportion of Caesarean sections performed at the patient's request where there is no medical reason. This is a particularly difficult area to examine given that few doctors are likely to admit to performing operations for which there is no sound medical justification. (Indeed, this is one of the few areas of medical practice where such an approach is even contemplated.)

5.103 Most evidence to the Committee suggested that the popular view of large numbers of women demanding Caesarean sections was grossly exaggerated.

> The majority of women come in [to an obstetrician] saying, "I want a natural birth without any intervention if possible". The group wanting caesarean sections is very small, but they are women who have thought

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55 *Committee Hansard*, 7.9.99, p.265 (Dr D Turnbull, University of Adelaide).

56 *Committee Hansard*, 7.9.99, pp. 266-7 (Dr D Turnbull, University of Adelaide).

57 Turnbull Deborah A. et al. *Women's role and satisfaction in the decision to have a caesarean section.* Medical Journal of Australia 1999; 170: pp.580-583.

58 See Wilkinson C, et al. *Is a rising caesarean section rate inevitable?* British Journal of Obstetrics and Gynaecology 1998, vol. 105, pp.45-52 and Quinlivan J et al. *Patient Preference the Leading Indication for Elective Caesarean Section in Public Patients – Results of a 2-year prospective audit in a teaching hospital.* Australian and New Zealand Journal of Obstetrics and Gynaecology, 1999, vol. 392, pp. 207-214.

> about what they want. They have thought about their choices, and this is what they want.[59]
>
> * * *
>
> The usual rationale provided by the clinicians who provide this care is that women are demanding these procedures. To my knowledge, there is very little evidence to support this assertion…[60]

5.104 Most doctors providing evidence to the Committee on this issue tended to the view that patient request/demand might account for 5% of Caesarean sections performed.[61] Those who discussed it said that where a healthy woman requested Caesarean section they would try to dissuade her by explaining the disadvantages of Caesarean section, as well as its advantages, in comparison to vaginal delivery. However, where a woman persisted in her request, despite full awareness of the consequences, most said that they would accede to the request.

> …the patient's input to any clinical management decision cannot and must not be overlooked. It must be as well informed as possible, but in the end it becomes a clinical decision. There are a number of reasons…why denying a patient a caesarean section may in fact be causing her, then and subsequently, an enormous amount of grief in various ways. But we would not simply give a blanket yes to a caesarean section request.[62]
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> * * *
>
> …I would say a minority would request a caesarean…It is usually not big, but it is very real. Some of them will choose a caesarean for that reason [difficult previous birth]. I must say, when they do, I would go along with that. In a particular situation like that, I would not be too insistent on trying to change their minds. In other situations, I would.[63]

5.105 There appears to have been a change in medical practice in this respect over the last ten years. In 1987, for example, the British Medical Journal advised readers in an editorial that 'a woman's request for caesarean section in an uncomplicated pregnancy should be refused'.[64] Yet recently, when 300 obstetricians at a conference in Adelaide were asked if they would perform a Caesarean section on a patient who demanded it, all said that they would do so.[65]

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59 *Committee Hansard*, 6.9.99, p.174 (National Association of Specialist Obstetricians and Gynaecologists).

60 *Committee Hansard,* 6.9.99, p.85 (Dr Jane Fisher, University of Melbourne).

61 *Committee Hansard*, 7.9.99, p.200 (Professor M Keirse, Flinders Medical Centre).

62 *Committee Hansard,* 27.8.99, p.68 (Women's Hospitals Australia).

63 *Committee Hansard*, 7.9.99, p.195 (Professor M Keirse, Flinders Medical Centre).

64 Hall M H. *When a woman asks for a caesarean section.* British Medical Journal 1987; 294: pp.201-202.

65 *Committee Hansard*, 6.9.99, p.170 (National Association of Specialist Obstetricians and Gynaecologists).

5.106 So what has changed in this 12 year period? Two major factors appear to account for this difference. The first is changing attitudes on the part of clinicians and some consumers to the balance of benefit versus harm between Caesarean sections and vaginal deliveries.

> …on the basis of the available evidence the concept of a prophylactic caesarean section being outrageous has been shattered by the fact that almost a third of female obstetricians would choose it for themselves. Prophylactic caesarean section can no longer be considered clinically unjustifiable, and it now forms part of accepted medical practice.[66]

5.107 While most commentators do not go so far as to agree that elective Caesarean section for non medical reasons 'forms part of accepted medical practice' there appears to be more general agreement that the balance is shifting in that direction.

> The trend for increasing use of caesarean section, coupled with a greater emphasis on patients' autonomy in medical decision making, has clearly progressed too far for a return to paternalistic directions to women on how they should give birth.[67]

(vii) Litigation

5.108 The second major factor is the threat of litigation in the event of a less than optimal outcome following refusal to perform a Caesarean.

5.109 Many doctors advised the Committee that litigation was very rare when a Caesarean had been performed, even when there was an adverse outcome. The patients' and lawyers' perception was that if a Caesarean had been performed then everything possible had been done. If a Caesarean had not been performed then this was interpreted as negligence on the part of the doctor, even in cases where there was absolutely no medical evidence to suggest that a Caesarean was either necessary or might have changed the outcome.

> The Obstetrician like the patient is striving for the perfect result but in the current climate he is seen to be giving of his best only when he performs a Caesarean. Then, though the result be unfavourable, blame is rarely apportioned by either the patient or a Court of Law.[68]

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66 Paterson-Brown S. *Should doctors perform an elective caesarean section on request?* British Medical Journal, vol. 317, 15 August 1998, p.463.

67 Olubusola Amu et al. *Maternal choice alone should not determine method of delivery.* British Medical Journal, vol. 317, 15 August 1998, pp. 462-463.

68 Additional Information 7.9.99 (Mercy Hospital for Women, Melbourne).

> …in the major court cases on obstetrics and litigation nobody has been sued for doing a caesarean section. Many people have been sued for failing – in the eyes of the plaintiff and her defence – to do a caesarean.[69]

5.110 Some witnesses suggested that the threat of litigation is more perception than reality. This view is supported by the findings of the Review of Professional Indemnity Arrangements, discussed in chapter 10, which concluded that:

> The statement that an obstetrician might cease delivering babies because of fear of being sued for a damaged baby shows a degree of fear out of all proportion to the real risk of such legal action occurring. While there are no comprehensive data available for the public and private sectors, it seems unlikely that the total number of claims made of this kind each year is more than 20, and the total number of claims paid out between five and ten. This gives a rate of "brain-damaged" baby claims of between 1 in 13 000 to 1 in 18 000 births, and a successful claims rate of between 1 in 26 000 and 1 in 52 000. If fear of being caught up in litigation were the motivating factor for practice change, then claims data would support a move out of gynaecological practice, rather than obstetrics.[70]

5.111 Nevertheless, there is no doubt that the fear of litigation exerts a powerful influence on obstetrical practice. Many doctors practice defensive medicine to avoid the threat of litigation. It is the conjunction of the threat of litigation and patients' unrealistic expectations of a perfect baby and a pain free birth every time by Caesarean section that explain doctors' propensity to perform a surgical operation for which there is no medical justification, in contradiction to medical best practice and ethics.

5.112 Both of these factors have been discussed by Dr Brian Roberman of King Edward Memorial Hospital, Perth who sees obstetricians as victims of their own success. Medical advances have made childbirth so safe that anything less than a perfect outcome is deemed a failure on the part of clinicians, and a cause for litigation.

> The penalty of success is increased expectations.
>
> […Dr Roberman] said it was ironic that it had never been safer for a mother to have a baby, yet it had never been more risky for an obstetrician to deliver one.[71]

5.113 The impact of litigation on medical practice is discussed in greater detail in chapter 10.

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69 *Committee Hansard*, 6.9.99, p.170 (National Association of Specialist Obstetricians and Gynaecologists).

70 Commonwealth Department of Human Services and Health. *Compensation and Professional Indemnity in Health Care. A Final Report,* Canberra 1995, p.281. The same Report noted (p.10) that '80% of the cases numerically made against obstetricians and gynaecologists related to their gynaecological practice'.

71 The West Australian. *Doctors pay a price for medical progress,* 27 January 1994, p.11.

(viii) Doctor convenience

5.114 Some evidence to the Committee suggested that some doctors may perform Caesarean sections for their own convenience. (This charge was made also in connection with other interventions, notably induction, and will be discussed in the next chapter.) This was said to be particularly the case for obstetricians tending women in more than one hospital. Since they obviously could not supervise births in more than one place at the same time, they tended to perform Caesarean sections which were quickly completed, thus allowing them to move to their next case.

> I think part of the problem is that private practitioners have their rooms and deliver women at various hospitals. If they were made to stay in one and the same spot they would be able to look after them more properly and they would not have to just end it quickly so that they could rush back to their rooms. If I had anything to say I would make it illegal to practice in two positions, but I must say I am not too popular when I say that to my colleagues.[72]

5.115 This was said to happen to a lesser extent where obstetricians were responsible for a number of births proceeding at the same time in the same hospital. Certainly there is evidence to suggest that the length of labour of privately insured women is significantly shorter than that of women without it, presumably because these labours have a greater likelihood of ending in Caesarean section.

5.116 A number of witnesses pointed out that obstetricians' training emphasises the unusual and potentially serious aspects of childbirth. This is appropriate if obstetricians are attending high risk births. It is not appropriate for the majority of normal births. When obstetricians do attend such births it is suggested that their training has not equipped them to stay in the background and let nature take its course, intervening only when things go wrong. They are trained to act and do so, it was suggested to the Committee, even when there is no medical justification for doing so and when labour could have proceeded without adverse consequences for the mother and baby.

> There is this great tension that the profession is highly trained surgically. It is suggested that they get more gratification from action than expectancy… the profession is highly trained surgically and, therefore, they have a strong urge to act. Their perception of danger is probably heightened. Their perception of risk is probably heightened. Their sense of achievement professionally comes from acting and intervening in this circumstance.[73]

5.117 If true, this is a further reason for encouraging midwives to attend normal births, with specialists concentrating on complex births but available to assist where normal births develop complications.

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72 *Committee Hansard,* 7.9.99, p.194 (Professor M Keirse, Flinders Medical Centre).

73 *Committee Hansard*, 6.9.99 p.92 (Dr Jane Fisher, University of Melbourne).

(ix) Financial incentives

5.118 There are no direct financial incentives in current funding arrangements which might encourage individual practitioners to perform Caesarean sections rather than vaginal deliveries. It is unlikely that casemix funding would have this effect at the hospital level. At the national level certainly, unnecessary Caesarean sections are a drain upon taxpayers, with the average Caesarean section costing about twice as much as the average vaginal delivery.[74]

5.119 These issues are discussed in greater detail in chapter 9 of this Report.

What is the optimal rate for Caesarean section?

5.120 No witnesses before the Committee were prepared to state an optimal rate for Caesarean section. Most agreed that current rates were too high (at least for elective interventions) and supported a reduction on the grounds that:

- some are now performed without any medical justification;
- many are now performed without adequate medical justification;
- there is generally higher maternal morbidity and mortality associated with Caesarean sections; and
- Caesarean sections are more costly.

5.121 This is not a universal view however. Overseas commentators in particular are questioning the preoccupation with rising Caesarean rates. The [British] Lancet, for example, recently stated that 'the uptake of caesarean sections in informed women is more appropriate than any target to reduce the Caesarean section rate'.[75]

> Obstetricians have assumed for too long that the indications for C/S are absolute. However, by considering the cumulative risk of abnormalities arising during the labour process, and given the poor predictive value of current fetal monitoring tests, and our ability to predict adverse fetal outcome, the risk-benefit ratio of C/S is altering.[76]
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> The [British] reports *Health Committee Maternity Services* and *Changing Childbirth* suggested that women should have a pivotal role in their obstetric care yet some are now being criticised for the choices they are making. These choices should not be discredited simply because they are not the

74 The West Australian Health Department, for example, advised that in a West Australian tertiary hospital an uncomplicated vaginal delivery costs $1776 and an uncomplicated Caesarean section costs $2640. The cost of each is significantly lower in non teaching hospitals. Additional information 21.10.99.

75 *What is the right number of caesarean sections?* Lancet editorial 1997; 348, p. 815.

76 Cotzias C. Fisk N. *Patient demand for Caesarean section*. Advances in Obstetrics and Gynaecology, Issue 15, p.13.

> ones that were expected. We should respect a woman's view and choice if it is fully informed, if she expresses a logical reason for wanting a caesarean section, and if she can demonstrate an understanding of the implications of the procedure. We should not be dictating to women what they should think, nor should we be judgmental of their values, if they happen to differ from our own.[77]

5.122 In the United States, concerns about the high Caesarean rate prompted the promulgation, in 1995, of a national goal to reduce the rate to 15% (it was then 25%) by the year 2000. This approach has been widely criticised both within the United States and overseas as being unachievable and arbitrary.

5.123 The figure of 15% was adopted following the World Health Organisation's definition of that figure as constituting a reasonable rate for Caesarean section.[78]

The Committee's conclusions

5.124 The Committee is concerned by Australia's high Caesarean section rate. As noted, Australia has one of the highest rates in the developed world. The Committee is also concerned by the significant variation in rates between States, between hospitals and between women with public insurance and those without it.

5.125 Evidence to the Committee during the course of this Inquiry provides some explanation for this high rate and for the wide variations in practice described but does not fully account for it.

5.126 The variations relate almost entirely to elective rather than to emergency Caesarean section. The Committee is not persuaded that patient demand is a major contributor to the high rates of elective Caesarean section, despite the widespread publicity given to this view. Nor does it believe that patient request is an adequate reason for performing a major surgical procedure.

5.127 In condemning the current high rate of elective Caesarean section the Committee acknowledges that examples of excellent obstetrical practice were brought to its attention during the course of the Inquiry. It was advised, for example, of many instances in which a single obstetrician had reduced the Caesarean rate at the institution at which they worked.

5.128 To ensure that best practice is more widely adopted the Committee believes that guidelines should be developed by the relevant professional bodies. A number of recent State and national reports have come to the same conclusions and made recommendations to this effect. None has been implemented. The Committee believes therefore that it is entirely appropriate for the Commonwealth Government, through

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77 Paterson-Brown S. *Should doctors perform an elective caesarean section on request?* British Medical Journal vol. 317, 15 August 1998, p.463.

78 World Health Organisation. *Appropriate Technology for Birth.* 1985. Sometimes referred to as the Fortelesa Declaration.

the National Health and Medical Research Council (NHMRC), to take the lead in addressing this issue.

5.129 The Committee believes that the NHMRC should work with the relevant professional bodies to develop best practice guidelines. It believes that a body such as the proposed Maternity Services Committee should monitor the implementation of the guidelines and the extent to which individual hospitals conform to a proposed target for Caesarean section. The Committee considers such a target should be set at 15%, as recommended by the World Health Organisation.

5.130 The Committee believes that a reduction in Caesarean rates will also be assisted through dissemination of recent research findings on Caesarean section, through encouragement of existing best practice and through peer review and persuasion. Greater consumer awareness and education will assist. The Committee considers that enhanced consumer awareness of the advantages and disadvantages of various forms of intervention, including Caesarean section, and of the hospitals at which they are most frequently performed will be achieved through implementation of other recommendations in this Report.

Recommendation

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.

Recommendation

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.

Recommendation

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 6

OTHER INTERVENTIONS IN CHILDBIRTH

6.1 Despite widespread publicity and concern about the increasing number of Caesarean sections being performed in Australia, more than three-quarters of all Australian babies are born by vaginal delivery. However, only a small proportion of these are totally 'natural' births, in the sense that they are free from any form of intervention. In Dr Fisher's Melbourne study (referred to earlier) for example, only nine of the 272 women who participated had no intervention of any kind, although some of the interventions were quite modest. Figures from Victoria for 1988 and 1989 showed that 61% of women went into labour spontaneously but two thirds of these had either an episiotomy or a tear repaired by stitches. Only 11% had a spontaneous labour and a spontaneous delivery without an epidural or a tear requiring stitches. Almost three quarters (71%) had some form of pain relief.[1]

6.2 Each of the commonly performed interventions in vaginal delivery is discussed in this chapter.

Induction

6.3 Induction is the process of initiating labour by artificial means. It is usually carried out by rupturing the membranes (amniotomy) then waiting for labour to begin. If it does not do so after some hours (the period varying according to the custom in individual hospitals rather than any agreement on the optimum period to wait) then a drip is given containing syntonin or prostaglandin, both synthetic forms of natural hormones.

6.4 In 1996, 22.2% of women had their labour induced. The figure has increased slightly, but not dramatically over the last 30 years. In 1991, for example, the national average was 19.5%.[2] The current rate is more than double the World Health Organisation goal of 10%.

6.5 There is significant variation in induction rates between States. Western Australia had consistently higher rates than any other State in each of the last five years for which figures are available, varying from 24.9% in 1991 to 27.9% in 1996. Tasmania had the lowest induction rate in 1996, when it was 16.6%.

6.6 It has not been possible to ascertain differences nationally according to the insurance status of the mother but, given that data on all other forms of intervention

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1 Health Department of Victoria. *Having a baby in Victoria. Final Report of the Ministerial Review of Birthing Services in Victoria,* Melbourne 1990, p.91.

2 These and other figures in the following paragraphs are from Submission No. 170, p.2 (Australian Institute of Health and Welfare) and Submission No. 97, p.19 (Department of Health and Aged Care).

consistently indicate higher rates for privately insured women, this is also likely to be the case for induction. It is certainly suggested in statistics provided to the Committee from individual hospitals. The Mater Misericordiae Mothers' Hospitals in Brisbane, for example, advised the Committee that in the year ending 30 June 1999 the induction rate was 24% for public patients and 31% for those with private insurance.[3]

6.7 There are significant variations between hospitals in the number of inductions performed. The induction rate is lower in birthing centres and smaller hospitals than in large tertiary hospitals. This can be at least partly explained by the larger number of high risk women in the latter institutions, but it is not possible to determine whether this factor alone accounts for the variation. The Committee was advised by Women's Hospitals Australia, for example, that the average induction rate in each of its hospitals in 1998-99 was 27.22%, with a range from 20.6% to 36.12%, a difference from the national average which it said could 'probably be largely explained' by the tertiary nature of its member hospitals.[4]

6.8 Information on induction rates in New South Wales hospitals however suggests that type of hospital is not the only factor influencing the rate of induction.

> The induction rate for NSW in 1997 was 21.8% with rates varying from a low of 9.3% in one of the largest, highest risk referral hospitals (King George V) to over 30% in some private hospitals.[5]

6.9 Induction of labour may be indicated in a number of circumstances, the most common being extension of pregnancy significantly beyond the due date, which can increase the possibility of foetal death. Prolonged pregnancy was the reason cited by practitioners in the 1997-98 casemix data as the principal reason for induction of labour in 22.4% of all inductions. It was cited as a secondary reason in 9.26% of cases. Other factors influencing a decision to induct may include hypertension in the very late stage of pregnancy or failure of labour to begin after natural rupture of the membranes (either prematurely or at term). Induction may also be performed in cases in which mothers are awaiting the birth of their babies far from home.

6.10 Evidence to the Committee however suggests that induction may often take place for convenience, either of the clinicians or of the woman and her family, rather than for medical reasons.

> One of the reasons that our other witness was not here today…is that it is Friday. Friday is induction day…doctors try to keep it within hours so that they can have a rest of life.[6]

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3 In an attachment to Submission No. 78, p.13 (Mater Misericordiae Mothers' Hospitals, Brisbane).

4 See Submission No. 69, p.16 (Women's Hospitals Australia and Australian Healthcare Association).

5 Submission No. 38, p.7 (NSW Midwives Association).

6 *Committee Hansard,* 27.8.99, p.40 (Women's Electoral Lobby).

> …in our hospital, nearly half of the inductions are for non-medical reasons. Women want induction because they are fed up or because of family reasons eg. Husband works away from home 2 weeks out of 4). Is this best practice for that family or not?[7]

6.11 A number of problems are associated with induction of labour. The first is the possibility of an error in calculating the due date so that an induction could be performed before the woman's body is ready for birth. In these circumstances where the membranes have been ruptured but labour does not begin there is a risk of infection to the baby and to the mother. This may necessitate a Caesarean section which could have been avoided had labour been allowed to proceed naturally.

6.12 The birth is often more painful when it is triggered through the administration of synthetic hormones because the contractions develop more rapidly and are stronger than when birth develops naturally. To counteract this pain the woman may require an epidural anaesthetic. This in turn may slow labour and a woman's ability to push during its later stage, leading to the use of forceps or vacuum extraction (discussed later). In this sense induction is often said to lead to a 'cascade of intervention' which in many cases might have been avoided were the birth allowed to begin naturally.[8]

6.13 A number of submissions referred to the 'cascade of intervention' and the need to educate women about the possible flow on effect from one intervention to the next.

6.14 When oxytocin is administered it suppresses the production of the naturally occurring hormone, both in the mother and in the baby. This might have long term adverse consequences on the bonding of mother and infant, according to one witness, although such a link has not been positively established.

> …the surge of [naturally produced] oxytocin that the mother experiences is a critical part of her "bonding" to her baby, and the baby is also, in these critical moments, laying the foundation of his/her capacity to love via the 'setting' of oxytocin levels and patterns of release. When this hormonal balance is not as nature intended, (ie disrupted by the oxytocin that crosses the placenta, activating the baby's negative feedback system and reducing its own oxytocin production) there is the risk that the baby's capacity to love will be impaired.[9]

Augmentation of labour

6.15 Augmentation is a process in which oxytocin or prostaglandin is administered to a woman whose labour has commenced naturally but is proceeding slowly.

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7 Submission No. 5, p.2 (Dr B.R. Pridmore, Queen Elizabeth Hospital, Adelaide).

8 See Submission No. 154, p.6 (Professsor M Chamberlain & Ms Janine van der Klei, University of Sydney).

9 Submission No. 110, p.11 (Dr Sarah Buckley, Qld).

6.16 According to the Australian Institute of Health and Welfare in 1996, 67% of births began spontaneously in Australia and of these 21.5% were augmented during labour.[10] Rates of augmentation varied widely between States, from 12.6% in Victoria to 29.9% in Queensland. Rates also varied significantly between hospitals, at least in New South Wales, the only State for which this information is publicly available. In 1997, for example, augmentation took place in 13.3% of spontaneous births at Westmead Hospital and in 7.5% of births at Parkes Hospital. Rates were highest at Tweed Heads Hospital, at 34.9%.[11]

6.17 The Committee has been unable to obtain a more detailed analysis of these figures to show variations between public and private health status. It is likely that augmentation rates are higher for privately insured women, since their labours tend to be shorter than those of public patients. Some of these labours are shortened by resort to Caesarean section. The proportion shortened by augmentation has proved impossible to determine.

6.18 Both augmentation and induction have been encouraged by the 'active management of labour' approach to birth pioneered in Dublin in the 1970s. The intention there was, through the use of induction (especially amniotomy) and augmentation (especially the administration of high doses of oxytocin when the progress of labour slowed to a dilation of the cervix of less than 1 cm an hour) to speed up the labour and reduce the need for forceps and ventouse delivery and for Caesarean section.

> …the Dublin obstetricians were so confident in their regimen that they gave women an undertaking that labour would be terminated by caesarean section if it lasted longer than 12h.[12]

6.19 The active management of labour approach has been widely adopted, including in Australia, but only certain aspects of the approach are generally used. These include amniotomy and augmentation but not the special labour preparation classes, psychological support in labour and regular supervision of the delivery area by senior staff which were all intrinsic to the original Dublin model. Consequently, many of the objectives, especially lower Caesarean rates, have not been achieved.

6.20 Assessments by the Cochrane Collaboration in Oxford suggested:

> …that psychological support in labour lowered the caesarean section rate in those settings where partners were not usually present, but did not suggest

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10 Australian Institute of Health and Welfare. *Australia's mothers and babies 1996*, p.68.

11 New South Wales Health Department. *New South Wales Mothers and Babies 1997,* Sydney 1998, pp.85-86. The document lists all hospitals with more than 200 deliveries annually.

12 Thornton Jim G. *Active management of labour,* Current Opinion in Obstetrics and Gynaecology, vol. 9, no. 6, December 1997, p.366.

> that routine amniotomy, or oxytocin either alone or combined with amniotomy, reduced caesarean delivery.[13]

6.21 One submission commented on the active management approach in Australia:

> One main success of active management (and the original reason for its development) has been to improve the throughput, and therefore 'efficiency' of the labour ward.
>
> It is interesting to note that many studies show midwifery can lead to equally low CS rates, but also with low rates of amniotomy and augmentation. This has not been taken up with the same enthusiasm as Active Management.[14]

Epidural anaesthesia

6.22 Epidural anaesthesia is becoming the preferred choice for pain relief during labour in Australia. It is used in both Caesarean sections and during vaginal births. Normally it is injected through the lower back into the epidural space around the spinal cord. It numbs the nerves in the uterus and birth canal when used during vaginal delivery. When used as an alternative to general anaesthetic during Caesarean section it has the advantage of allowing a woman to see her baby being born and of holding the baby immediately after birth.

6.23 The use of epidural anaesthetic varies from State to State, but has been increasing everywhere.

> In 1990, 17% of women used epidural anaesthesia for pain relief during vaginal delivery. In 1997-8, 19.7% of women used epidural for pain relief during vaginal delivery…there are significantly different rates of epidural use between states - 33% in South Australia versus 15-16% in Tasmania and Victoria…[15]

6.24 Epidural anaesthesia must be administered by an anaesthetist. For this reason it is not generally available outside major centres. Women who consider they may benefit from an epidural block therefore tend to arrange for confinement in large tertiary hospitals. In these circumstances one would expect variations in the rates of epidural use according to the size of the hospital. In fact however there are wide variations even between hospitals of similar size, at least in respect to use during vaginal delivery. Rates for Caesarean section are more uniform.

> Epidural anaesthesia was recorded for 90.4% of women delivered by caesarean section [in Western Australia] and there is no doubt that this is the preferred method for that procedure. However during 1997/98, the usage

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13 Ibid, p.367.

14 Submission No. 110, p.12 (Dr Sarah Buckley, Qld).

15 Submission No. 97, p.19 (Department of Health and Aged Care).

> rates among women who delivered vaginally vary between 8.8% and 44.1%.[16]
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> Analgesia in labour is used widely in Australian hospitals. For example, in major public hospitals in NSW the epidural rate was between 34 and 43% and between 58 and 66% in some private hospitals in 1997.[17]

6.25 As with other interventions, the use of epidural block is more common among privately insured women than others, at least in respect to vaginal deliveries.

> Women with private accommodation status are also about twice as likely to receive an epidural block for pain relief during vaginal delivery than public patients. States with the highest rates have high rates for both public and private patients.[18]
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> The use of epidural anaesthesia/analgesia for women admitted as public and private patients delivered by caesarean section [in Western Australia] was more equitable at 87.7% for public patients and 94.9% for private patients. However the use of epidural analgesia during labour and vaginal delivery among women admitted as public patients was 26.2% compared with 50.3% for private patients.[19]
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> Epidural anaesthetics for pain relief in labour are given to more women in private hospitals [in NSW] (44%) than to women in public hospitals (21%). While epidural is a highly effective form of pain control, it may still carry a risk of more operative deliveries. It is possible that despite the increasing use of narcotic epidurals and the practice of allowing the dose to wear off for the 2nd stage of labour, the higher rates of epidural in the private sector may be associated with the higher rates of other childbirth interventions noted.[20]

6.26 Epidural is safe and effective but has significant drawbacks which, it seems, are not always well understood by women requesting epidural assistance during vaginal delivery. Epidural anaesthesia slows down the birth process because it numbs the nerves which control the pelvic muscles and legs (as well as the uterus and birth canal). A woman may therefore be given an oxytocin drip to speed up the labour. She

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16 Submission No. 179, p.2 (Health Department of Western Australia).

17 Submission No. 51, p.6 (Midwifery Practice and Research Centre, NSW).

18 Submission No. 97, p.20 (Department of Health and Aged Care).

19 Submission No. 179, p.3 (Health Department of Western Australia).

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

cannot push during the second stage of labour (because of the effect of the epidural) and thus it may become necessary to use forceps or vacuum extraction to remove the baby, or to perform a Caesarean section. This is a further example of the 'cascade of intervention' referred to earlier. It is estimated that an epidural used during vaginal birth reduces the chance of a normal delivery to less than 50% and doubles a woman's chance of Caesarean section for dystocia.[21]

6.27 Some of these adverse effects have been limited through continuous administration of low doses of epidural anaesthetic rather than, as previously, providing intermittent large doses. In the former case, women's movements are less restricted and so they are better are able to contribute to the birth, overcoming the slowing down in labour associated with the latter approach.

6.28 There are serious side effects in a small number of epidural cases such as permanent nerve damage, cardiovascular and heart and breathing difficulties (1 in 20,000 cases). Since epidural anaesthetic is absorbed by the baby when it is in utero there are concerns about its effects on the infant, but few studies have been conducted to determine the extent of such effects, or indeed whether there is a measurable impact.

6.29 A recent review of available research by the Cochrane Collaboration has provided some indication of the costs and benefits of epidural anaesthesia for the mother, but not for the baby.

> With regard to the use of epidural anaesthesia the Cochrane review (27/9/1997) showed that epidural anaesthesia was more effective than non-epidural methods in providing pain relief, and was associated with motor blockade. Adverse effects suggested by the rather small trials reviewed include longer first and second stages of labour, increased oxytocin use, instrumental delivery and caesarean section. The study concluded that epidural analgesia is an effective method of pain relief during labour. Further research is needed to define the adverse effects more accurately particularly the long term adverse effects and to evaluate different regional analgesia techniques.[22]

6.30 The Cochrane findings have been disputed by American researchers who concluded, after reviews of seven randomised clinical trials and five observational studies conducted in the United States that 'Epidural analgesia… may increase the risk of oxytocin augmentation but not that of caesarean delivery'.[23]

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21 See Buckley, Dr Sarah. *Epidurals – real risks for mother and baby,* Australia's Parents Aug/Sept 1998, entitled *All about epidurals.*

22 Submission No. 17, p.6 (Royal Australian College of Obstetricians and Gynaecologists).

23 Zhang Jun et al. *Epidural analgesia in association with duration of labour and mode of delivery. A quantitative review.* American Journal of Obstetrics and Gynaecology, vol.18 (4) April 1999, p.970.

6.31 Given these conflicting views it seems imperative that more research is conducted into the long term effects of epidural anaesthesia, particularly in view of the continuing expansion in its use in Australia.

6.32 Other commonly used analgesics for vaginal delivery include nitrous oxide and narcotics, chiefly pethidine. Nitrous oxide has been considered effective and safe because of its short half life. However, there is some evidence that it can lead to a reduction in the oxygen level of the baby. Pethidine is less effective as a pain killer, has a range of side effects on the mother (such as nausea and vomiting) and may result in breathing difficulties for the baby. Some overseas research postulates a link between nitrous oxide or pethidine use during birth and later drug dependency in children of these births.[24] Other research suggests a link between in utero exposure to oxytocin and an increased likelihood of autism in the exposed offspring.[25]

Forceps delivery

6.33 Forceps is one of two forms of operative vaginal delivery. The other is by suction cup or vacuum extraction (described in the next section). The forceps, a pair of curved blades, is applied to the baby's head as it emerges during vaginal birth, usually to hasten delivery but occasionally to slow it down, for example when delivering the after coming head in a breech delivery. Forceps are normally used to hasten birth where there is foetal or maternal distress during the second stage of labour or where there is failure of the labour to progress during the second stage.

6.34 The use of forceps has declined in Australia as the use of Caesarean section (and to a lesser extent vacuum extraction) has risen. In 1985, 14.9% of vaginal deliveries involved the use of forceps. By 1996 the figure had dropped to 7.4%.

6.35 Comparisons by State or by the insurance status of the mother are difficult to obtain. However, data supplied for Victoria by the Victorian Branch of the Australian College of Midwives indicate that forceps deliveries accounted for approximately 8% of births in public hospitals in Victoria in 1998. The figure for privately insured women was approximately 12%.[26] In New South Wales, forceps delivery accounted for 13.4% of deliveries in private hospitals in 1996 and for 5.8% of deliveries in public hospitals.[27]

6.36 An episiotomy is normally required before a forceps delivery is performed. A forceps delivery requires skill on the part of the doctor, may be traumatic for the mother and frequently results in tearing of the perineum. More rarely, forceps delivery

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24 Jacobsen B. et al *Opiate addiction in adult offspring through possible imprinting after obstetrical treatment*. British Medical Journal, 10 Nov 1990, vol.301, pp.1067-70.

25 Haire, Doris. *Medications used in Labour and their effects on Mother and Newborn.* Paper presented at UNICEF Birth without Boundaries conference, Chiang Mai, Thailand, 1 March 1997.

26 Submission No. 14, Appendix 2 (Australian College of Midwives Inc, Vic).

27 Shorten Allison and Shorten Brett. *Episiotomy in NSW hospitals 1993-1996: Towards understanding variations between public and private hospitals.* Australian Health Review, Vol.22, No. 11, p.25.

may damage the vagina or bladder. It can cause haematoma in the foetal scalp or, if performed without the necessary skill, intracranial haemorrhage.

Vacuum extraction

6.37 Vacuum extraction is generally less used by Australian doctors than forceps. Indications for use are similar. Extractors are applied where there is failure of the labour to progress during its second stage or where the mother is tired. Extractors are of metal or plastic. They are cup shaped and applied to the emerging foetal skull to which they adhere through negative pressure, normally supplied by a vacuum pump.

6.38 In 1996 only 4% of births in Australia involved the use of vacuum extraction. Again, vacuum extraction is more often used in private than in public hospitals. In New South Wales in 1996, for example, 8.8% of births in private hospitals involved vacuum extraction. The figure for public hospitals was 4%.[28]

6.39 Vacuum extraction often requires an episiotomy to be performed on the mother. It requires less maternal analgesia and causes less maternal trauma than forceps delivery but scalp trauma is increased in the baby.[29] If performed without the necessary skill damage can occur to the cervix and to the vaginal wall.

6.40 The use of vacuum extraction is more widespread in Europe and the United States than in Australia. In the United States its use has increased significantly in some hospitals, perhaps because of the pressure to reduce the rate of Caesarean delivery. While generally safe, increased use of vacuum extraction has resulted in an increased incidence of neonatal injury in the hospitals concerned. As a result, a protocol has been developed specifying the selection of women for this procedure, the supervision to be provided by physicians and technical aspects of the use of the extractor.[30]

6.41 Both forceps and vacuum extraction have significantly greater adverse long term effects than do spontaneous vaginal births.

> Compared with spontaneous births, women having forceps or Venthouse extraction had increased odds of perineal pain, sexual problems and urinary incontinence. These differences remained after adjusting for infant birth-weight, length of labour and degree of perineal trauma.[31]

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28 Ibid, p.25.

29 See Chamberlain Geoffrey and Steer Philip. *Operative delivery.* British Medical Journal, vol. 318, May 1990, pp.1260-1264.

30 See Sachs B.P. et al. *The Risk of Lowering the Caesarean-Delivery Rate,* New England Journal of Medicine, 7 Jan 1999, vol. 340 pp.54-57.

31 Submission No. 97, p.23 (Department of Health and Aged Care). Refers to a study by Brown S. and Lumley J. *Maternal health after childbirth: result of an Australian based survey.* British Journal of Obstetrics and Gynaecology, February 1998, 105 (2), pp.156-161.

Episiotomy

6.42 An episiotomy is an incision of the perineum in order to enlarge the vaginal opening, lessen the curvature of the birth canal and facilitate the birth of the baby. It is necessary because the perineal skin does not stretch as well as the vagina and is subject to tearing during delivery. An episiotomy is also performed in cases where perineal tearing can be anticipated.

6.43 In some countries episiotomies are routinely performed during vaginal deliveries. This is not the position in Australia.

> About 22% of Australian women have an episiotomy associated with delivery. This includes forceps and vacuum extraction deliveries. A woman is least likely to receive an episiotomy if she delivers in Queensland or the Northern Territory and most likely in South Australia. Repair of laceration was recorded in 10% of vaginal deliveries with an episiotomy but in 44% of vaginal deliveries without an episiotomy.[32]

6.44 As with other forms of intervention, rates of episiotomy are generally much higher for women with private insurance than for those without it.

> Episiotomy rates also vary markedly by accommodation status. A woman who elects private accommodation status on admission is almost twice as likely to receive an episiotomy than a woman with public accommodation status. The data for repair of perineal lacerations and, in the long term, for incontinence or uterine prolapse is not available by insurance status at delivery.[33]
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> Analysis of vaginal births from the above database [NSW Midwives Data Collection] does, indeed, confirm that episiotomy rates were substantially higher in private than in public hospitals throughout this period…In fact, episiotomy rates were around 10 to 13 percentage points higher in private hospitals. Given that episiotomy rates in public hospitals were of the order of 20%, this translates to a substantially higher probability (50-60% higher) of experiencing episiotomy when delivering vaginally in a NSW private hospital. Moreover, whilst [the figures] suggest a clear downward trend in the use of episiotomy in the public sector, perhaps in response to dissemination of current scientific evidence, consumer demand, or both, no such trend is evident in the private sector.[34]

6.45 The picture is not uniform however. In Western Australia episiotomy rates in public hospitals are much higher than in some private ones.

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32 Ibid, p.19.

33 Ibid, p.20.

34 Shorten Allison and Shorten Brett. *Episiotomy in NSW Hospitals 1993-1996: Towards understanding variations between public and private hospitals*. Australian Health Review, vol. 22, no.1 1999, p.22.

> Episiotomy is not routine in the private health sector (eg 27% of women having deliveries at St John of God Health Care had an episiotomy in 1997-98)…The West Australian figures indicate that 42% of vaginal deliveries have an episiotomy.[35]

6.46 There appear to be wide variations between hospitals. Women's Hospitals Australia advised the Committee that the average rate in its hospitals was 13% with a range between 4% and 27.7%.[36] In New South Wales rates varied from one health service area to another.

> The episiotomy rate for NSW in 1997 was 19.3%. Rates varied in area health services from 3.2% in the Far West to 29.1% in Northern Sydney, to as high as 40% for some individual private hospitals. Women giving birth in private hospitals in NSW have a 50-65% higher chance of receiving an episiotomy than those in public hospitals.[37]

6.47 Episiotomy has significant and long term effects on the mother. It is painful, can cause serious blood loss and dyspareunia. It may result in sphincter damage, although planned episiotomies are generally performed to reduce the damage associated with a large perineal tear which might occur if no episiotomy were performed.

6.48 Evidence considered by the Cochrane Collaboration in 1998 suggests that a conservative approach to episiotomy should be adopted.

> The Cochrane Review (Carroli, Belizan & Stamp, 1989) comparing routine versus restrictive use of episiotomy states that restrictive use reduces rates of posterior perineal trauma, reduces the need to suture and has reduced associated healing complications by the seventh day postnatal. There was no evidence of increased pain, dyspareunia, urinary incontinence or severe vaginal or perineal trauma. Whilst anterior trauma was increased the evidence clearly supports a restrictive policy.[38]

Interventions in childbirth – conclusions

6.49 Some of the interventions performed during childbirth are minimal, but evidence to the Committee suggests that close to 90% of all births in Australia include some form of intervention. The Committee was advised that once an intervention occurs it is likely to be followed by others as a consequence of the 'cascade of intervention' referred to earlier.

6.50 The culture of intervention in childbirth is now so pervasive that, it was suggested to the Committee, women requesting an intervention free birth were likely

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35 Submission No. 89, p.7 (Catholic Health Australia).

36 See Submission No. 69, p.16 (Women's Hospitals Australia and Australian Healthcare Association).

37 Submission No. 38, p.7 (NSW Midwives Association).

38 Ibid, p.7.

to receive a much less sympathetic hearing than those who requested some form of intervention.

6.51 Patient demand/request, which is said to be a factor in Caesarean section, was rarely mentioned in connection with other interventions except with respect to epidural anaesthesia and, to a lesser extent, to induction.

6.52 High rates of intervention are associated with private health insurance and the size and style of the hospital in which birth takes place. Although the high rate of intervention among privately insured women can be partly explained by the older age of women in this group it does not fully explain the differences, given that such women are generally healthier and better prepared for the birth. Similarly, the concentration of women at high risk of developing complications in large tertiary hospitals can partly account for the higher rates of intervention in those institutions but it does not fully explain it.

6.53 The most significant determinant of intervention in childbirth is the type of care provided during birth and the background of the principal carer. For every form of intervention, rates are lowest where midwives are the principal carers, higher where general practitioners are the principal carers and highest where specialist obstetricians have this role. Again, the differences can be partly explained by the nature of the client group. Specialists attend women at highest risk and midwives those at least risk. Even allowing for these differences however, there is a clear association between type of carer and number of interventions.

6.54 Irrespective of the background of the principal carer, continuity of carer during the antenatal period and throughout the birth appears to be a significant contributor to low rates of intervention.

6.55 Some interventions are life saving, either for the mother or for the baby or for both. Others greatly reduce trauma, suffering and long term adverse consequences to mother and child. However, many appear to be almost routinely undertaken without any scientific evidence of their benefits as against their costs, in terms of perinatal and maternal morbidity. Factors other than objective clinical guidelines appear too often to influence the decision to intervene.

6.56 In these circumstances the Committee considers it imperative that evidence based research be undertaken on the costs and benefits of commonly performed interventions and on other routine practices in antenatal care and childbirth. Such research could then form the basis of best practice guidelines.

6.57 These issues are discussed in the following chapter.

CHAPTER 7

BEST PRACTICE GUIDELINES FOR ANTENATAL CARE AND FOR CARE DURING BIRTH

The current position

7.1 Antenatal care and care during birth are both of a generally high standard for most women in Australia but individual aspects of that care vary considerably in their availability, quality, cost and appropriateness. One of the major determinants of the type and appropriateness of services offered to individual women is the professional background of the person from whom they receive them.

7.2 It is claimed that each of the professional groups has a different emphasis in the services offered. General practitioners and obstetricians generally, as one would expect, have a more medical approach to care than do midwives, who emphasise pregnancy and birth as natural functions requiring minimal intervention in healthy women. The differences in approach can be partly explained by their training. It is also influenced by the fact that medical professionals include within their clientele a higher proportion of at risk women.

7.3 While the emphasis differs **between** professional groups there appear also to be some variations **within** each of these groups. It is difficult to build up an accurate national picture because of the lack of adequate, nationally consistent data on many of the practices associated with antenatal care and care provided during birth. However, the available data from the Australian Institute of Health and Welfare, the Midwives Data Collection, the Health Insurance Commission and the private health funds suggests that practices are determined by individual institutions, by individual practitioners and by the health of individual patients rather than by the State in which they take place.

7.4 Health insurance status has a significant impact on the type and level of care provided during pregnancy and birth. All forms of intervention are higher among women with private health insurance (a position which cannot be justified by the older age of women in this group since they are also generally healthier and better prepared than women without insurance). The differences between insured and uninsured women may also be partly explained by the greater proportion of insured women receiving their care from specialist obstetricians rather than general practitioners or midwives.

7.5 There are major differences in types and levels of care provided to women in rural areas as compared to those elsewhere. Choices are limited in rural areas (although standards of care are not necessarily compromised, as discussed). Women there have fewer interventions, both because specialists are in short supply and because women at risk (for whom an interventionist approach is more appropriate) are transported to urban centres for the birth of their babies.

7.6 In some cases, practice is determined by custom rather than based on evidence, an approach not confined to obstetrics.

> Unfortunately, the introduction of tests into obstetric practice has too often owed more to a process of 'myth and fashion' than to a carefully planned and scientific evaluation of the benefits compared to the costs or hazards.[1]

* * *

> While there have been some studies that have addressed these issues, we generally lack adequate evidence about the effect of what I would say are large uncontrolled experiments in health care.[2]

* * *

> The Royal Women's Hospital like many health care institutions has found that whilst there is substantial evidence available regarding aspects of antenatal care some of the difficulties around developing specific and accepted clinical guidelines in this area have been:
>
> - Practice based on history
> - Antenatal care has been largely determined by tradition and training
> - Antenatal care is provided by three different health care professionals – midwives, GPs and Obstetricians, each group having different views on some aspects of the provision of antenatal care.[3]

* * *

> Because there is no universally recognised standard of care, never mind best standard of care, then best practice may be a function of who delivers the care. The consumer has little chance of being able to judge the value, both medically and financially, of interventions suggested by the various possible care givers.[4]

7.7 Several witnesses commented on the significant variations in practice now evident in Australia. These differences cannot be entirely explained by differences in the characteristics of the women involved.

> While there are fixed [antenatal] tests that are considered mandatory for all pregnant women, there are still a number for which there is no clear-cut

1 National Health and Medical Research Council. *Options for effective care in childbirth*, 1996, p.8.

2 *Committee Hansard*, 27.8.99 (Australian Institute of Health and Welfare).

3 Submission No. 46, p.2 (Royal Women's Hospital, Vic).

4 Submission No.104, p.5 (Central Sydney Area Health Service).

> evidence as to what might be regarded as "best practice." In fact, best practice may vary in different parts of the country.[5]

7.8 The Committee concluded on the basis of information obtained during its Inquiry that the standard of care provided to women during pregnancy and birth is generally high. This is particularly the case with respect to maternal and perinatal mortality. However, it considers that the significant variations in practice evident between professional groups, between institutions and within these groups when treating women with similar needs cannot always be explained by reference either to clinical best practice or to evidence based demonstrations of optimal outcomes. To assist in overcoming some of the problems identified in current approaches to practice the Committee supports the development of best practice guidelines for care during pregnancy and birth.

The need for best practice guidelines

7.9 The purpose of best practice guidelines is to improve the quality of health care, to reduce the use of unnecessary, ineffective services or harmful interventions and to ensure that care is cost effective.

7.10 There is widespread interest in their development and implementation, both within Australia and overseas. This interest extends beyond care in pregnancy and childbirth to include all areas of medicine. The reasons for this interest have been succinctly stated by the National Health and Medical Research Council (NHMRC):

> This worldwide interest has been prompted by concern about unjustifiable variations in clinical practice for the same condition, the increasing availability of new treatments and technologies, uncertainty about the effectiveness of many interventions in improving people's health, and a desire to make the best use of available health resources.[6]

7.11 Evidence to the Committee suggested that there was general, but not universal, agreement on the need for best practice guidelines:

> Best practice guidelines are desirable because there is widespread concern about unjustifiable variations in clinical practice for the same condition.[7]

* * *

> I think best practice guidelines are helpful for all clinicians.[8]

* * *

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

6 National Health and Medical Research Council. *A guide to the development, implementation and evaluation of clinical best practice guidelines,* Canberra 1999, p.9.

7 Submission No. 109, p.19 (NSW Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research).

8 *Committee Hansard*, 6.9.99, p.158 (Royal Women's Hospital, Vic).

> Best practice guidelines are desirable and could help ensure national standards are met.[9]
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> * * *
>
> The Department of Human Services supports the efforts to increase the promulgation of evidence based practice, and the development of best practice guidelines facilitates this process, with complementary information provided to women. While guidelines on antenatal screening are particularly overdue, national guidelines could usefully be developed across the birthing episode.[10]

7.12 Those who questioned this need did so for a range of reasons. One was the narrow focus of existing work on best practice guidelines, and their failure to acknowledge the emotional aspects of pregnancy and childbirth.

> …Birthplace understands that interventions during childbirth can best be minimised through a thorough reassessment of the nature of ante natal services. Interventions, we believe, *will not* be minimised through "best practice screening standards" *unless* this term is broadened out to include, and respond to, elements beyond the physical condition of the pregnant woman…Best practice screening standards during pregnancy *must* include detecting any emotional, social, psychological and cultural issues which might inhibit a woman's ability to give birth, *if* intervention rates are to decline.[11]

7.13 Another was the perceived danger that they might override clinical judgement.

> When a doctor is confronted by an unprecedented situation, he must be able to work out an appropriate course of action from first principles. The idea that standard management handbooks and so-called "Best Practice" Policies can substitute for clinical judgement is ignorant, naive, and probably partisan.[12]

7.14 A further reason was that guidelines might be 'captured' by a particular group, to the detriment of other groups and individuals.

> Guidelines in public policy have a history of starting out with good intentions. They quickly become controlled by particular professional groups who manipulate them for their own purposes. Their stated purposes are usually couched in terms of beneficial outcomes, community responsiveness, safety, minimum professional standards etc; but history

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9 Submission No. 51, p.12 (Midwifery Practice and Research Centre, NSW).

10 Submission No. 163, p.6 (Department of Human Services, Vic).

11 Submission No. 171, pp.1-2 (Birthplace Support Group Inc).

12 Submission No. 18, p.2 (Dr Ron Chang and others, Qld).

> usually shows that they act to restrict anyone who does not belong to their group or is controlled by their group.[13]

7.15 Those who favoured the development of best practice guidelines stressed the critical importance of ensuring that they were evidence based.

> Best practice guidelines need to be evidence based and developed by practising clinicians informed by national and international research.[14]

* * *

> Many screening practices are not evidence-based, rather have developed historically or from clinician's personal opinions. Guidelines for best practice may well improve this situation and ensure standardisation in many aspects of antenatal care.[15]

7.16 The National Health and Medical Research Council has defined six levels of evidence which are, in order of value:

- evidence obtained from a systematic review of all relevant randomised controlled trials;
- evidence obtained from at least one properly designed randomised controlled trial;
- evidence obtained from well designed pseudo randomised controlled trials, such as alternate allocation;
- evidence obtained from cohort studies, case controlled studies or interrupted time series with a control group;
- evidence obtained from comparative studies with historical control and two or more single arm studies; and
- evidence obtained from a case series, either post test or pre test and post test.[16]

7.17 The evidence based approach represents a departure from the traditional approach to the development of best practice guidelines which was based on consensus among experts. This consensus approach is increasingly discredited.

> Traditionally, guidelines have been based on consensus among experts. But this method has its limitations. Expert opinion does not always reflect the state of current medical knowledge. And, even when guidelines are supported by literature surveys, if the medical literature has been analysed in

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13 Submission No. 147, p.4 (Mr and Mrs J. Wade, Qld).

14 Submission No. 70, p.5 (Royal Australian College of General Practitioners).

15 Submission No. 51, p.4 (Midwifery Practice and Research Centre, NSW).

16 Taken from NHMRC. *A guide to the development, implementation and evaluation of clinical practice guidelines,* Canberra 1999, p.56.

> an unsystematic way biased conclusions can result. In the past this has led to unnecessary delays in the recommendation of effective interventions and delays in the withdrawal of ineffective or harmful treatments.[17]

7.18 Recognition of the potential of best practice guidelines, and their importance, have long been features of obstetrical medicine, as the Committee was reminded during the Inquiry.

> …obstetrics has led the field in looking for best practice. Obstetrics was the first group of professionals who contributed to the Cochrane Collaboration for evidence based medicine. Obstetrics was first and neonates was second…Best practice is something with which the obstetrical profession and the midwifery profession have been struggling longer than almost any other branch in medicine.[18]

7.19 One of the major factors inhibiting the development of best practice guidelines to date has been the lack of adequate, evidence based research and data on many aspects of care during pregnancy and childbirth. This is particularly the case for evidence based on randomised controlled trials, described repeatedly in the evidence as the most reliable form of research on which to base any standards. Such research would therefore be an essential prerequisite for the development of meaningful and useful guidelines.

7.20 Successive governments, both Commonwealth and State, have failed to implement the recommendations of a range of previous reports advocating the establishment of best practice guidelines and the commissioning of research on which to base them. Evidence to the Committee suggested that work had not proceeded through lack of funding.

7.21 This point was made by Women's Hospitals Australia in relation to antenatal screening guidelines, its work on which has been halted by lack of funding.

> The development and implementation of evidence based standards is significant for a number of reasons:
>
> - For the patient, the standards will inevitably mean that an appropriate level of testing is undertaken, and she is subjected only to screening tests that are of proven benefit. In addition, an appropriate level of screening will ascertain any problems with the pregnancy that may need intervention for delivery. Concomitantly, screening may also rule out any need for further intervention.
> - For health service providers, best practice will prevail ensuring efficient and effective use of resources.

17 Ibid, p.10.

18 *Committee Hansard*, 6.6.99, p.162 (Royal Women's Hospital, Vic).

- Funding authorities, ultimately the Commonwealth, will benefit and significant savings will be achieved if the standards are adopted as the norm.[19]

7.22 They were supported by witnesses from the NHMRC's Health Advisory Committee.

> [Women's Hospitals Australia] tried to introduce some regulation on the provision of antenatal surveillance and testing. They tried to do that by seeking our assistance to develop with them guidelines about what should be done in the way of screening and testing of women during pregnancy.
>
> …whilst the Health Advisory Committee recommended unanimously that that should be done, it was not possible to find the funds within the department to do it.[20]

7.23 Most witnesses considered that guidelines should be nationally focussed but not prescriptive, to allow practitioners to respond appropriately to the different circumstances in which they operated, and especially to differences in their client groups.

> Best practice guidelines assist in ensuring that certain standards are met and practised throughout Australia in relation to childbirth. However care must be taken to recognise that Australia is a very diverse country and organisations and communities can vary dramatically.[21]
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> * * *
>
> I think there also has to be some mechanism built in that women require a variety of services and some women will need more than what is designated as best practice, and there needs to be some flexibility.[22]

7.24 Not everybody shared this view. Some evidence to the Committee suggested that because clinicians' circumstances were so varied, it would be impossible to develop guidelines which would be appropriate for all of them. They therefore considered that guidelines should be developed at the institutional level.

> …I think it [best practice guidelines] should be hospital by hospital. There is so much variation. What is right in a small peripheral hospital would not be right in a tertiary referral hospital.[23]

7.25 The more general view was that guidelines should be national in scope, a view shared by the Committee.

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19 Submission No. 69, p.12 (Women's Hospitals Australia and Australian Healthcare Association).

20 *Committee Hansard*, 14.9.99, p.412 (Health Advisory Committee of NHMRC).

21 Submission No. 48, p.10 (Australian College of Midwives Inc, Goldfields Sub-Branch).

22 *Committee Hansard,* 6.6.99, p.158 (Royal Women's Hospital, Vic).

23 *Committee Hansard,* 6.6.99, p.171 (Royal Australian and New Zealand College of Obstetricians and Gynaecologists).

The development of best practice guidelines

7.26 There was a strong view in evidence to the Committee that best practice guidelines should be developed primarily by the professionals who will be required to use them. This view is supported by the Committee.

> …I think that it has to be a clinically driven process. It has to be a process in which the stakeholders feel as though they not only have input but some degree of ownership of whatever is the final output.[24]

* * *

> All of the research on behavioural change says that you need to develop the guidelines or ways of doing things with the people who have to implement it.[25]

7.27 Consumer input was also considered important. Not surprisingly, this view was stressed in evidence from consumer groups but it was no by no means confined to them. Many professional groups commented upon the importance of consumer input.

> Best practice guidelines are only desirable and useful if the process clearly invites consumers' final comment of the model developed. A common experience of AIMS members is that we are involved in the process to provide authenticity, but the final model doesn't reflect our concerns.[26]

* * *

> All too often, professionals get together and draw up codes that they think are very relevant but they are not consumer focused. So it requires consultation – and representative consultation – of the people who know what it is all about…[27]

7.28 The importance of consumer input has been recognised in the 1992 NHMRC Act, which obliges the Council to undertake public consultations whenever it is proposing to issue guidelines on any matter falling within its charter.

7.29 Some witnesses suggested that as most consumers lacked the in depth medical knowledge upon which best practice guidelines must necessarily be based their input should be focussed on consumer needs rather than on professional practice.

> If we look at the New Zealand model where consumers have been very strongly part of the movement, the consumer is not involved in looking at

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24 *Committee Hansard,* 27.8.99, p.59 (Women's Hospitals Australia).

25 *Committee Hansard*, 14.9.99, p.421 (Health Advisory Committee of NHMRC).

26 Submission No. 56, p.5 (Association for Improvement in Maternity Services, Qld).

27 *Committee Hansard*, 6.9.99, p.127 (Health Services Commissioner, Victoria).

> the best professional practice; the consumer is there to advise the practice model about what they see as the strongest needs of the consumer.[28]

7.30 Others stressed that input should not be limited to clinicians and consumers but should extend to all key stakeholders.

> There is a great need for the development of current evidence based guidelines for the conduct of all maternity care in Australia. I believe these objectives would best be arrived at by the consensus of groups encompassing equal numbers of consumers, health professionals, local government representatives and other key stakeholders. Such a consensus would allow for socially and culturally sensitive care. It would also be economically efficient because it would address alternative models and reduce costly interventions. All of this would be based on ongoing appropriate research and evaluation.[29]

7.31 The NHMRC also supported an inclusive approach.

> The process of guideline development should be multidisciplinary and should include consumers. If guidelines are to be relevant, those who are expected to use them or to benefit from their use should play a part in their conception and development. Involving a range of generalists and specialist clinicians, allied health professionals, experts in methodology, and consumers will improve the quality and continuity of care and will make it more likely that the guidelines will be adopted.[30]

7.32 The Committee supports the majority view presented in the evidence that best practice guidelines should be national in scope, evidence based and developed by professionals, with significant consumer input. The Committee considers that the Commonwealth should provide a leadership and coordination role in the development of the guidelines, given their national application. The National Health and Medical Research Council (NHMRC) is the most appropriate body to fulfil this function.

7.33 The NHMRC has undertaken extensive work on the development and implementation of general clinical practice guidelines, the results of which were endorsed and published this year, updating an earlier version published in 1995.[31] The NHMRC has demonstrated an awareness both of the potential and of the limitations of best practice guidelines and of the difficulties associated with their implementation and evaluation. It has, through its Health Advisory Committee, instituted a process

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28 *Committee Hansard*, 14.9.99, p.384 (Australian Midwifery Action Project, NSW).

29 *Committee Hansard*, 14.9.99, p.386 (Professor M Chamberlain, University of Sydney).

30 National Health and Medical Research Council. *A guide to the development, implementation and evaluation of clinical practice guidelines,* Canberra, 1999, p.2.

31 See *A guide to the development, implementation and evaluation of clinical practice guidelines,* referred to above. Other NHMRC publications on related topics include, for example, the *Report of the Health Care Committee Expert Panel on Perinatal Morbidity,* 1995, which discussed best practice in prevention and management of perinatal morbidities and *Care around Preterm Birth – Clinical Practice Guidelines.*

whereby guideline development can be scrutinised. This involves public consultations. Its guidelines are evidence based and subject to numerous peer reviews, as well as public involvement.

7.34 The NHMRC has also undertaken some preliminary work on the development of best practice guidelines in antenatal care. These were published in 1988 but have not been generally adopted and have since been withdrawn by the NHMRC for modification and updating in the light of more recent research findings. They have been used in Victoria where their recommendations on antenatal testing and investigation have been adopted, in modified form, by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. The Victorian adaptation of the guidelines has been distributed to all practising obstetricians and midwives in Victoria.

7.35 Work is currently being undertaken in a number of institutions and organisations throughout the country on the development of best practice guidelines in antenatal care. Examples brought to the Committee's attention include the collaborative effort between the Southern Health Care Network, the Mercy Maternity Hospital and the Royal Women's Hospital in Victoria to develop evidence based consensus guidelines on antenatal care as it applies to the particular demographic populations served by their organisations. It was also advised of work by Women's Hospitals Australia (now suspended through lack of funding by the Commonwealth Department of Health and Aged Care) to develop guidelines for antenatal care and screening aimed at rationalising services and reducing unnecessary costs. The Committee commends these efforts to develop guidelines which could form the basis for wider dissemination of best practice.

7.36 Some individual hospitals are developing their own guidelines, in the absence of more broadly focussed best practice. The Women's and Children's Hospital in Adelaide, for example, has developed protocols for 41 of the conditions associated with pregnancy, labour and childbirth.[32] They were, however, developed on the basis of clinical practice rather than evidence based medicine and did not include significant consumer input. Westmead Children's Hospital has included as part of its policy the use of the best evidence available on the treatment of children.

7.37 The NHMRC, in its work on the development of best practice guidelines, acknowledged that they should not be implemented in isolation from other approaches to improving care.

> Recent research has shown that clinical practice guidelines can be effective in bringing about change and improving health outcomes. But they are just one element of good medical decision making, which also takes account of

32 Women's and Children's Hospital, Adelaide. *Perinatal Protocols and Guidelines for Management,* 1996.

> patients' preferences and values, clinicians' values and experience, and the availability of resources.[33]

The implementation of best practice guidelines

7.38 Difficulties in implementation of best practice guidelines and on compliance with their requirements were generally recognised in evidence to the Committee as potentially serious impediments to the widespread dissemination of best practice.

> I am sure you are aware that current clinical practice lags well behind available evidence for best practice
>
> …We are concerned because a wonderful [NHMRC] document for clinicians and consumers entitled *Care Around Preterm Birth* contained a wealth of clinical information, but there was no formal mechanism in place to disseminate those documents…It seems a shame that there was no mechanism in place to disseminate or to evaluate whether the information contained in those booklets was adopted in clinical practice or helped to inform consumers.[34]
>
> * * *
>
> …the NHMRC is putting in enormous work and public funds to develop some terrific guidelines but the Commonwealth Department of Health and Aged Care seems to sit and wait for that to filter down through the profession. We wonder whether there could be some proactive mechanism at Commonwealth level whereby that information is picked up by the Commonwealth department of health and distributed down through the state departments of health so that the pregnant women actually get their hands on it.[35]

7.39 Few concrete proposals were forthcoming on successful strategies for encouraging implementation and compliance, although witnesses acknowledged the importance of funding incentives to encourage the adoption of agreed best practice guidelines.

> In Australia there is still no well-resourced and well-developed national effort to disseminate and implement best practice guidelines. One way to achieve this would be to explicitly link best practice in pregnancy and childbirth to the operation of the Medicare Benefits Schedule (MBS). For example, last year the Commonwealth established the Medicare Services Advisory Committee (MSAC) to advise on which new and existing medical services should attract funding under the MBS. This is an important initiative, but unfortunately none of the procedures awaiting evaluation are

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33 National Health and Medical Research Council. *A guide to the development, implementation and evaluation of clinical practice guidelines,* Canberra 1990, p.1.

34 *Committee Hansard*, 14.9.99, p.459 (NSW Pregnancy and Newborn Services Network).

35 *Committee Hansard,* 14.9.99, p.473 (NSW Pregnancy and Newborn Services Network).

> related to obstetrics. To redress this situation, the Commonwealth could support a partnership between MSAC and the Australasian Cochrane Centre. This would potentially be a very effective policy lever to shift the focus of providers towards the provision of more effective evidence-based medicine.[36]
>
> * * *
>
> …there is no point in having best practice guidelines unless there are incentives for their implementation and real consequences for contraventions.[37]

7.40 The Committee acknowledges the outstanding work of the Cochrane Collaboration, to which its attention has been repeatedly drawn during the course of this Inquiry, and supports Australia's continued participation in its work.

7.41 The limited information available in the literature suggests that Australian obstetricians are well informed about systematic reviews of randomised trials and that they modify their practices accordingly.[38] They are generally much more likely to know about the results of trials and much more likely to use this information than are their United Kingdom counterparts.[39]

7.42 The NHMRC commented that little was known about the relative effectiveness of audit and feedback, as opposed to the views of major opinion leaders, in changing behaviours so as to reflect evidence based practice.[40] Some evidence to the Committee certainly suggested that the views and practices of well respected clinicians could have a significant impact on health outcomes for women within their institutions. (See for example the drop in Caesarean rates at the Queen Elizabeth Hospital in Adelaide from 21.1% in 1989 to 16.6% in 1996 and at the two Geraldton hospitals, described earlier, from 16.5% in 1994-95 to 7.3% in 1998-99.)

7.43 However, the NHMRC tended to the view that in most institutions the power of a single, respected opinion leader to change attitudes and practices was declining.

> The type of person you are describing is usually a full-time person who is dedicated to work in that hospital and is usually involved in teaching and research as well – whether they call them a staff specialist, or an academic

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36 Submission No. 109, pp.19-20 (NSW Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research.).

37 Submission No. 56, p.5 (Association for Improvement in Maternity Services, Qld).

38 Jordens, Christopher F. C. et al. *Use of systematic reviews of randomised trials by Australian neonatologists and obstetricians.* Medical Journal of Australia 1998, 168, pp.267-270.

39 Paterson-Brown S. *Are Clinicians Interested in Up to Date Reviews of Effective Care?* The British Medical Journal, vol. 307, 4 December 1993, p.1464 and Olufemi A et al. *Physicians' attitude toward evidence based obstetric practice: a questionnaire survey.* British Medical Journal, January 31 1998, vol. 316, p.365.

40 See *Committee Hansard* 14.9.99, p.414.

> and things. I think that for a long time Australian obstetrics has not been driven by that group of people but has been dominated by the visiting medical officer people, who are fee-for-service private practitioners, and causes a lot of the variation.[41]

7.44 By implication, any hope of successfully implementing best practice guidelines would require a systemic approach in addition to reliance upon the foresight and cooperation of individuals.

7.45 A number of witnesses suggested that, if adherence to best practice guidelines were a recognised legal defence, this would be a powerful incentive to their adoption.

> If the Senate Committee or any other body could arrive at "best practice" standards which if adhered to guaranteed a watertight legal defence against allegations of negligence, obstetricians would adopt them overnight.[42]

7.46 The NHMRC does not rule out the use of best practice guidelines as a defence in case of litigation.

> It is certainly possible that guidelines could be produced as evidence of what constitutes reasonable conduct by a medical practitioner. The National Health and Medical Research Council's Health Advisory Committee considers that practitioners who use guidelines will be afforded a measure of protection.[43]

7.47 Other witnesses pointed to existing guidelines which, though probably not having the status to be used as a legal defence, nevertheless assisted clinicians reluctant to undertake procedures for which they could see no clinical justification.

> We have developed, in conjunction with the Royal Women's Hospital, a shared care protocol. In that is detailed the advice about ultrasound, that ultrasound in early pregnancy is only indicated if there is, for instance, significant vaginal bleeding or abdominal pain, so it is done on an indication. In that we state if a routine scan is done then it is best done at 18 to 20 weeks. That protocol has been distributed to all general practitioners. It has now been adopted by Queensland Health as the model for the whole of Queensland…
>
> …They [general practitioners] have welcomed this protocol because they say, "Well, it says here it really is not indicated," and that will make it easier for them to order these tests responsibly.[44]

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

42 Submission No. 34, p.3 (Division of Women's Health and Newborn Care – Westmead Hospital).

43 National Health and Medical Research Council. *A guide to the development, implementation and evaluation of clinical practice guidelines,* Canberra 1999, p.6.

44 *Committee Hansard,* 15.9.99, p.533 (Mater Misericordiae Mothers' Hospital, Qld).

7.48 However, in the general literature opinion is divided on whether best practice guidelines could assist clinicians in litigation cases or be used against them.

> It is perhaps not surprising that there is a lack of clarity about how CPGs [clinical practice guidelines] may be used in a legal arena. In particular, there is confusion about whether doctors will be more, or less, vulnerable to a successful lawsuit if they follow guidelines or depart from guidelines for sound clinical reasons. Will the guidelines be a shield, enabling doctors to show that they were not negligent because they followed the CPGs? Or will they be a sword, enabling a plaintiff's lawyers to establish negligence in court when they show that the doctor's treatment of the patient departed from the CPG's? How will the courts deal with the fact that proper clinical management of individual patients cannot always be achieved by strict adherence to guidelines?[45]

7.49 Because of concerns by some clinicians about the adoption of the NHMRC's early breast cancer guidelines the National Breast Cancer Council commissioned a paper in 1997 on the medico-legal implications of best practice guidelines. It concluded:

> Clinical practice guidelines neither hinder nor encourage litigation directly – they are simply likely to be considered another form of expert evidence; or evidence of practice in a court case.
>
> …guidelines can aid the legal process by presenting a clear summary of available evidence, rather than leaving the courts with the responsibility of distilling this information from expert testimony.[46]

7.50 The Committee concluded, on the basis of the evidence received, that there was widespread, but not universal, recognition of the need for the development of best practice guidelines on care during pregnancy and birth. The Committee further concluded that such guidelines would need to be national in scope, developed by medical and midwifery professionals through the auspices of the NHMRC, have significant consumer input and be grounded in evidence based research.

7.51 The Committee acknowledges the significant past and present work undertaken on the development of best practice guidelines. It considers that the immediate focus of new work should be on the development of best practice guidelines for the use of ultrasound. This is an area in which there is a great deal of concern among practitioners, consumers and government about current practice and where recent and continuing research increasingly indicates that current practices cannot be justified in terms of outcomes or cost effectiveness.

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45 Pelly Janet et al. *Clinical practice guidelines before the law: sword or shield?* Medical Journal of Australia 1998, 169, pp.330-333.

46 Tito F, Newby L. *Medico-legal implications of clinical practice guidelines.* Sydney, National Health and Medical Research Council National Breast Cancer Centre, 1998.

7.52 In the last budget the Government announced a very large increase in health research funding (an additional $614 million over six years). The NHMRC will have a major role in directing these funds to areas of national health priority. Given the lack of evidence based research in all areas of maternal and infant health, and the importance of maternal and infant health to subsequent health status, the Committee considers that a portion of this funding could justifiably be directed to the commissioning of evidence based research and to the development of guidelines based upon it.

Recommendation

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.

7.53 A major impediment to the implementation of best practice guidelines for the care of women during pregnancy and childbirth is the current fragmented approach to maternal and perinatal care. There are gaps and overlaps in the care provided by each of the major types of providers (midwives, general practitioners and obstetricians). There are further gaps, but fewer overlaps, between the organisations providing care (community based services, hospital based services and services provided by private clinicians). There are gaps and overlaps between antenatal, intrapartum and post natal care. There are gaps and overlaps between services provided by State governments and those provided by the Commonwealth. Current funding arrangements exacerbate these divisions.

7.54 This fragmentation has significant adverse consequences for the care of women during pregnancy and childbirth (and indeed for health outcomes more generally). It contrasts with the seamless care arrangements said to operate in New Zealand and Holland.

7.55 In recognition of the difficulty of implementing national best practice guidelines in this environment the NHMRC suggested to the Committee that the NHMRC's role should be limited to guideline development, while their implementation should be the responsibility of a national maternity care committee.

> …I think the NHMRC's role is technical. It is technical in its policy advice but the implementation belongs to the world of health departments, policy makers, funders, politicians and clinicians who are employed in services or subject to professional goals.
>
> We need a maternity care committee at a national level that is beyond and incorporates state positions and professional positions but that advises the health ministers to that they can make decisions and put in place the sorts of standards that will ensure all Australian women get an opportunity for good care. They are the people who could take the NHMRC guidelines and say

> "These must guide the standard of care in your hospitals that are providing maternity care".[47]

7.56 The NHMRC envisaged the role of such a committee as extending beyond the implementation of best practice guidelines to encompass information dissemination and education and, most importantly, to consideration of means by which funding incentives could be tied to best practice.

7.57 The existing Joint Committee on Maternity Services could form the basis of such a committee, although its membership would need to be expanded to include all professional groups involved in health care provided during pregnancy, childbirth and post natally, as well as consumers. At present its membership is confined to representatives from the Royal Australian College of Obstetricians and Gynaecologists and the Australian College of Midwives Inc and it is largely inactive. An expanded role for the Joint Committee was recommended by the NHMRC in its report *Options for effective care in childbirth.*

7.58 The Committee considers a national maternity committee of the type proposed may have the potential to tackle the systemic problems undermining health outcomes for mothers and babies. It believes such an approach deserves more detailed consideration.

Recommendation

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.

7.59 The Committee recognises that while best practice guidelines for care during pregnancy and birth can make an important contribution to improved health outcomes for mothers and babies, they are not the only means of doing so. Also important are the dissemination and encouragement of existing best practice, peer review and increased consumer awareness and education.

7.60 These objectives would be assisted if each State Government published a list of all its hospitals at which births took place, with statistics on each of the interventions performed there for public and private patients. Only New South Wales currently does so. Such a report could include explanations and clarifications pointing out, for example, why major tertiary institutions could be expected to have higher intervention rates than other hospitals.

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47 *Committee Hansard*, 14.9.99, p.417 (Health Advisory Committee of NHMRC).

7.61 Such information would assist consumers to make informed choices, and possibly exert a measure of peer pressure. This appears to be happening in some New South Wales hospitals. According to information supplied to the Committee, the Caesarean rate at Sutherland Hospital, for example, dropped from 27% to 10% over an 18 month period 'as a result of a public outcry, following press reports of the high caesarean rate'.[48]

7.62 The Committee was advised that the former Victorian Government was considering such an approach to conform with the requirements of competition policy, one of which is the need to overcome the existing information asymmetry between the consumers and the providers of services.[49] The Committee is disappointed to note that the former Victorian Government was persuaded to the adoption of such an approach through the demands of competition policy rather than by any concern for improvements to medical practice.

Recommendation

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.

48 In Submission No. 14, pp.10-19 (Australian College of Midwives, Vic).

49 By the Health Services Commissioner, Victoria. See *Committee Hansard*, 6.9.99, pp.129-130.

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.
>
> 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.
>
> 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]
>
> * * *
>
> 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]
>
> * * *
>
> 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]

* * *

> 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.
>
> 15% of clients discharged home on these programs require more visits than the program pays for.
>
> 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

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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

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.

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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]

* * *

> 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]

* * *

> 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

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.
>
> 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]

* * *

> 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.

CHAPTER 9

FUNDING ISSUES

9.1 The chapter begins with a consideration of general funding issues which have been repeatedly brought to the Committee's attention as having an adverse impact upon the quality and appropriateness of antenatal, intrapartum and post natal care.

Fragmentation and cost shifting

9.2 Fragmentation and cost shifting are features of health provision generally in Australia and maternity and neonatal care are no different.

9.3 Antenatal care for public patients may be funded by the Commonwealth, if it is provided by a general practitioner or specialist outside hospital, or by the State, if it is provided through a hospital antenatal clinic or community service. Care during birth is funded by State governments where the birth takes place in a public hospital labour ward or birth centre and the woman is attended by salaried nurses and/or salaried registrars or obstetricians.

9.4 If the birth takes place in a country hospital and the woman is attended by a nurse and general practitioner/obstetrician the costs for public patients are also met by the State as the general practitioner/obstetrician normally has Visiting Medical Officer status, that is, they are employed by the hospital. In fact the position is more complex than this since about half of all hospital funding is provided directly to the States by the Commonwealth through the Medicare Agreements and the remainder is provided indirectly through financial assistance grants.

9.5 Post natal care for public patients in the period immediately following birth is normally funded by the States, from their hospital budgets, regardless of whether it is provided in hospital or in the community. However, as noted earlier in the Report, with the increase in early discharge some of the costs of this care are now being met by the Commonwealth, where it is provided by general practitioners, or jointly by the Commonwealth and States where it is provided by programs such as Home and Community Care. Most post natal care is provided by infant welfare sisters (whose titles vary from State to State) and are State funded.

9.6 The antenatal care of women with private insurance may be paid for by their health fund in cases in which it is provided in a private hospital antenatal clinic, with the woman paying the difference in costs between the fee charged and the Medicare rebate. Some women with private insurance choose to receive their antenatal care at public hospitals as public patients and in this case the costs are met by State governments through their hospital budgets.

9.7 The costs of care for women with private health insurance who give birth in public hospitals as private patients or in private hospitals are normally met by the

health funds, with women paying for the gap between clinicians' charges, the Medicare rebate and health fund rebates. The same situation generally applies to post natal care although for women with private health insurance such care is normally provided only in hospital.

9.8 Some private health insurance funds will cover some, but not necessarily all, of the costs of employing an independent midwife for women who choose to give birth at home or, more rarely, for women who give birth in hospital in the care of an independent midwife accredited to that hospital. This option is severely restricted as very few hospitals extend accreditation to independent midwives. Most women, who employ independent midwives, for either a home birth or a hospital birth, must meet the full costs themselves.

9.9 A major problem with the current fragmentation of funding arrangements is that it contributes directly to fragmentation in service provision. This is an issue for health care generally in Australia, and is not confined to obstetrical care. Instead of encouraging a seamless episode of care extending from the beginning of pregnancy, through birth and into the post natal period 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.

> As a result of this fragmentation consumers typically have to "navigate" their own way through the various approaches and services offered. This often results in duplication and lack of continuity in information sharing and generally a sub-optimal service delivery system.[1]

9.10 The fragmentation of service provision is exacerbated by attempts at cost shifting between jurisdictions. Again, quality of care is adversely affected.

> It is part of the difficulties with having state and federal relations; it becomes really complicated as to who pays for what health care. The woman is the one that gets stuck in the middle. She gets pushed from one side to the other, getting more and more fragmented care and not knowing when to put out her Medicare card and when to give her other card. If we are talking about woman centred care, at the moment it is the kind of system and practitioner–centred care that is chaotic.[2]

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> In "protecting" or optimising their particular role in the start-to-end process, service providers make resource allocation decisions that are necessarily driven by internal imperatives rather than by the best interests of the consumer (for example, budget cuts on hospitals drive shorter lengths of stay). Thus while elements of the start-to-end system may be "optimised",

1 Submission No. 108, p.1 (Professor P Marshall, Flinders Medical Centre).

2 *Committee Hansard*, 14.9.99, p.440 (Midwifery Practice and Research Centre, NSW).

> the overall system is often compromised and functions in a sub-optimal way.[3]
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> * * *
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> Public hospitals are increasingly looking for ways to reduce costs, particularly in the provision of antenatal care. This organisation of services, however, potentially impinges on women receiving high quality, cost effective care that meets their needs. Currently, in many public hospital antenatal clinics women are "bulk billed" for their care if they have been referred by an obstetrician. This occurs in general clinics as well as specialised 'day only' clinics for high risk women. This system means costs are shifted from the state to the federal system. However, it also means women must see an obstetrician, essentially, increasing costs for no proven benefit.[4]

9.11 A separate but related issue is the impact on service provision of cost cutting by State governments, especially to antenatal and post natal care services and especially in Victoria. These issues are discussed earlier in the Report.

The impact of casemix funding

9.12 Casemix funding is a means of measuring and tracking hospital expenditure on the treatment of groups of related conditions called diagnostic related groups (DRG). In essence it is funding based on the mix of cases which the hospital treats. It is possible to compare the costs of treating patients with similar conditions in one hospital with the costs of doing so in another hospital. These costs form the basis of resource allocations to hospitals in subsequent years. Casemix funding was introduced initially in Victoria in 1993 and has been progressively extended since then to most other States. It includes 18 related conditions affecting the mother in DRGs related to pregnancy, childbirth and the puerperium (that is, the first six weeks after birth). A further DRG relates to newborns.

9.13 Evidence to the Committee suggested that the casemix system has the potential to impact adversely on the quality of care provided to women during pregnancy and birth. The DRGs assume a degree of homogeneity among patients that does not always exist, despite the fact that DRGs make allowances for serious divergences from the norm. Also, because the DRGs focus on medical and obstetrical needs they do not take adequate account of psychosocial issues which, in the case of a relatively small group of women, require quite intensive support. In effect therefore, hospitals which provide this support are not adequately compensated for doing so, which is a disincentive to its provision.

9.14 A further consequence of the DRG approach, as currently administered, is that funding is provided according to the diagnosis at discharge rather than at admission. A

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3 Submission No. 108, p.1 (Professor P Marshall, Flinders Medical Centre).

4 Submission No. 51, p.2 (Midwifery Practice and Research Centre, NSW).

woman who is admitted to hospital 10 weeks before giving birth because, for example, she requires monitoring and care for preeclampsia, and who subsequently gives birth to a healthy baby attracts funding only for the birth. The same funds would be provided in the case of a woman admitted during labour who gives birth to a healthy baby, despite the fact that the hospital's costs in the former case are obviously far greater.

9.15 The same inequities are evident with respect to post natal funding and also to the treatment of newborn babies.

> The way in which hospitals in most states, and certainly in South Australia, are funded is on Casemix and casemix is a very broad based lumping of patients. If you are in a postnatal ward being admitted for breastfeeding, you are linked to other patients who are conventional patients having had a baby. It is the same case payment for being readmitted for four hours of breastfeeding versus five days of postnatal care, which means that the Casemix income for those real patients is then diluted. The people who are admitting these patients are blissfully unaware of what they are doing.
>
> …Another good example is the admission of the newborn…The admission rate for neonates in hospitals varies from about 18 per cent to 75 per cent. The criteria for admission vary enormously across the country, and the variation is largely Casemix driven. The real need for newborns to be admitted to a special care or intensive care nursery is probably somewhere between 15 and 20 per cent.[5]

9.16 Casemix payments are adjusted over time and will thus partly overcome these anomalies. In the case of women readmitted for four hours of breastfeeding care and funded for five days of post natal care, for example, funding adjustments over the longer term will result in a payment to the hospital which represents a mean of the costs of caring for women staying five days and those staying four hours. Thus in the future the hospital will be financially penalised if it admits a greater proportion of women for five day stays (until a subsequent funding adjustment catches up with the reality of the hospital's current practice).

9.17 In the cases referred to above, many witnesses suggested, funding arrangements are illogical. They provide opportunities for manipulation of the funding system by doctors (rather than by governments). They do not encourage either the most effective use of scarce resources or the most appropriate care. The deficiencies in current arrangements were succinctly summarised in a submission from Flinders Medical Centre.

> Contrast, for example, the incentive provided by a fee-for-service (GP's medicare rebate) with an episodic fee (Hospital case mix or DRG

5 *Committee Hansard*, 7.9.99, pp.186-187 (Professor P Marshall, Flinders Medical Centre).

> reimbursement); one rewards over-servicing, the other rewards cost shifting, but neither reward or encourage cooperation.[6]

9.18 Casemix funding has a number of deficiencies but it is generally an improvement on the previous funding system, which involved the allocation of funds to a public hospital according to what the hospital spent the year before.

9.19 The Committee considers that casemix funding needs to be evaluated to minimise the practices referred to above, which have developed in an effort to deal with funding shortages and the time lags involved in funding adjustments through casemix.

9.20 Current funding arrangements contain perverse incentives, as noted above. They may, for example, encourage hospitals to admit newborn babies when there is no medical requirement to do so, or discharge women after birth without adequate support. It is alleged by some that current funding arrangements encourage the use of Caesarean section and that this explains the increase in the use of the procedure in Australia.

9.21 The Committee has found no evidence to support this view. While it is true that casemix funding allocates more money to hospitals for Caesarean section than for vaginal births, it is also the case that hospitals incur higher costs in the former case. The funding differentials are not so great as to enable them to profit from the performance of a large number of Caesarean sections in preference to vaginal deliveries.

9.22 Births by Caesarean section have increased slowly but steadily for thirty years. The rate has not been radically affected by the introduction of casemix funding. Indeed, the rate is highest for privately insured women, as noted, but there has been far less comprehensive use of casemix funding by private hospitals.

9.23 Nor did the deletion of a separate Medicare Benefits Schedule (MBS) item for Caesarean births in 1988 have any measurable impact on the increase in the rate of Caesarean section. (The most recent change to the MBS, for complex births, will be discussed later in this chapter.)

> There have been changes over recent years in the Medicare Benefits Schedule, which for a time included caesarean section as one item. We do not have any evidence that I know of that says that the changed practices are due to changes in the Medicare Benefits Schedule funding arrangements.[7]

9.24 There also appears to be no direct financial incentive for Caesarean section in the arrangements of private health funds.

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6 Submission No. 108, p.1 (Professor P Marshall, Flinders Medical Centre).

7 *Committee Hansard*, 7.9.99, p.250 (Department of Human Services, Vic).

> To the best of my knowledge, there are no actual financial incentives for one procedure as against another. It is not a case of differential benefits being paid by the health fund for a caesarean or for natural childbirth, although if it is an episodic payment there may be a higher payment for a caesarean because of the longer expected length of stay.[8]

9.25 The Committee formed the view, on the basis of evidence presented during its Inquiry, that there is a link between funding arrangements and the Caesarean section rate but that it is not a direct link. In the current situation, where an obstetrician is paid the same for a delivery, regardless of whether it is a vaginal birth or by Caesarean section, it is in the obstetrician's financial interest to opt for the Caesarean and get it over with quickly rather than waiting for hours through a natural birth to obtain the same financial reward.

> Rather than acting as a deterrent, it seems that a global fee might actually work as an inducement to intervene, on the grounds that a caesarean section is often a much quicker option for a busy obstetrician than dealing with the uncertainties involved in the expectant management of natural labour and birth. If the monetary reward is the same regardless of the type of delivery then caesarean section could be seen as a preferred option, potentially involving less work than the alternative.[9]

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> …in the Medicare confinement fee there is absolutely no reward for the effort involved in managing a difficult confinement through to a normal vaginal delivery and for using one's clinical skills. In the same way, there is no reward for effort for delivering a baby as a breech.[10]

9.26 While financial considerations do not necessarily affect clinical decisions on the performance of Caesarean sections, current arrangements are unsatisfactory, both for the women concerned and for obstetricians. The Committee suggests that a positive financial incentive should be considered for vaginal births where such an approach would not jeopardise the health of the mother or baby. This would reward obstetricians for their skills and help to reduce the deskilling now causing concern in the profession. It is possible that the new rebate might have this effect because it rewards, for example, trial of vaginal breech delivery and trial of scar following a previous Caesarean section. However, some witnesses suggested that it was more likely to encourage intervention than to reduce it, as discussed later in this chapter.

9.27 Some funding initiatives have encouraged a less interventionist approach to birth, notably the Alternative Birthing Services Program. This was initially funded by the Commonwealth and has now been subsumed into a broader public health program

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8 *Committee Hansard*, 27.8.99, p.81 (Australian Health Insurance Association Ltd).

9 King, James E. *Obstetric intervention and the economic imperative*, British Journal of Obstetrics and Gynaecology, April 1993, Vol. 100, p.303.

10 Committee Hansard, 6.9.99, p.171 (National Association of Specialist Obstetricians and Gynaecologists).

with seven other health programs. These are funded through the Public Health Outcome Funding Agreements which the Commonwealth signed with each State government for the period 1997-1999. As with other broadbanded funding arrangements, it is extremely difficult to track what happens to individual program funds once they are subsumed into broader programs. In the Committee's view it cannot be concluded that funds formerly earmarked for alternative birthing initiatives are continuing to be spent on such initiatives. This is a further example of the potential for cost shifting inherent in current funding arrangements.

9.28 An issue related to the funding of obstetricians is the pressure on them to perform Caesarean sections in circumstances where they are caring concurrently for women in a number of different hospitals.

> The other thing that has been suggested is that one of the financial incentives is the physician convenience – that you can do five deliveries in a day fairly readily if they are all lined up to go into the theatre. But if you are actually hanging around in five labour wards for five long labours that is much more difficult to do. So part of the financial incentive comes in time management of a busy practice.[11]

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> If a private provider has admitting rights at four different maternity hospitals and who has a theatre list, rooms, patients booked and three or four women in labour on different sides of the city at once, that is an enormous pressure to be under. If you have to actually deliver to collect the fee, then the very structure of a practice can influence patterns of behaviour in subtle ways. I am not suggesting that people go out of their way to surgically deliver every pregnancy, but one has to take account of the pressures that people are working under and which direction those pressures are pushing them in.[12]

9.29 To avoid the extension of these pressures to midwives a number of witnesses opposed the granting of an MBS item number to midwives.

> I personally feel that fee-for-service remuneration is not a good model for practice of any description. I cannot see that that should not apply to midwives as well.
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> … But I would fear – and there is evidence to back this up, particularly from New Zealand – that, if this were given a fee-for-service remuneration – a Medicare thing – we would see the same kinds of problems with midwifery fee-for-service. It would not be exactly the same because midwives do not wield knives, but they will be just as open to commercial pressures for testing, laboratories, induction at the weekends and so on. I cannot see any

11 *Committee Hansard*, 6.9.99, pp.98-99 (Dr Jane Fisher, University of Melbourne).

12 *Committee Hansard*, 14.9.99, p.461 (NSW Pregnancy and Newborn Services Network).

> reason why that would be a better model for midwifery than it is for current obstetrics, of which I have been a critic.[13]

The inverse care law

9.30 A disproportionate amount of funding for antenatal, birth and post natal care is channelled to the 80% of women at no risk, especially those with private health insurance, rather than on those with high needs. This is sometimes referred to as the inverse care law. Many healthy women receive specialist obstetrical care when there is no medical indication for it and where midwifery care would be equally appropriate and less expensive. At the same time, many women at high risk receive inadequate general health care.

> In no other "condition" are well people expected to visit medical specialists for primary health care. Yet this is the main option for women with private health insurance, and for many rural women regardless of health insurance status, for care during pregnancy. Rates of medical intervention have been shown to be greater than average in the privately insured group of women, who receive care from a specialist obstetrician. This phenomenon, described as the "inverse care law" is obviously a huge waste of resources, and much of the cost is borne by the tax payer.[14]

9.31 The Committee was advised that childbirth is a major reason for women to take out private health care. They do this, it is said, to ensure continuity of carer (a specialist obstetrician) through pregnancy and birth. Evidence to the Committee during the course of the Inquiry reinforced the importance to women of continuity of carer. When this option is more generally available in the public sector (as discussed in chapter 2) it is possible that fewer women will take out private insurance.

Funding inequities between antenatal, intrapartum and post natal care

9.32 At present the bulk of funding for care during pregnancy, birth and in the immediate post natal period is directed to antenatal care. This accounted for a total of $68.6 million in the year to June 1999, while funding for labour, delivery and post natal care totalled $27.6 million.[15] The largest and fastest growing component of antenatal care is routine ultrasound scanning, the cost of which totalled $35.8 million. The remaining $30 million spent on antenatal care was to cover the costs of antenatal visits. There were over 1.4 million such visits in the year ended June 1999.

9.33 Given that over a third of total funding for antenatal, birth and post natal care is spent on a procedure for which there is no proven medical benefit in the majority of

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13 *Committee Hansard*, 15.9.99, p.513 (Professor James King, Qld Council on Obstetrical & Paediatric Morbidity and Mortality).

14 Submission No. 14, p.5 (Australian College of Midwives Inc, Vic Branch).

15 All figures in this section are from Health Insurance Commission Medicare Benefits Schedule Item statistics generated 5 October 1999 (excluding services provided by hospital doctors to public patients in public hospitals).

cases and about which there are growing concerns, there is a strong case for reviewing the costs of this procedure.

9.34 Recommendations on antenatal and post natal funding appear in the chapters discussing these aspects of maternal and infant care.

Conclusion

9.35 Existing funding arrangements for antenatal, intrapartum and post natal care are seriously flawed. They encourage fragmentation in service provision, cost shifting and overservicing and direct a disproportionate amount of funding to those who least require it. They encourage a level of intervention for the majority of women for whom this is not necessary and indeed for whom it may be inappropriate.

9.36 This issue is part of the broader problem facing Australia's public hospitals. This Report is obviously not the place to make recommendations about overall changes to funding. However, evidence to the Committee during this Inquiry points overwhelmingly to the fact that current funding arrangements and the fragmentation of services consequent upon them have adverse effects on the quality of care.

9.37 The Committee concludes that major improvments in the quality of maternal and neonatal care will not be achieved until the funding issue is resolved.

The impact of the new Medicare rebate

9.38 On 1 November 1998 a new Medicare Benefits Schedule (MBS) item was introduced for complex births. It increased the Medicare fee to $950 for complex births ($964 since 1 November 1999). This compares with a fee of $404 (now $410) for a standard delivery (either vaginally or by Caesarean section) and $472 for a Caesarean section in cases in which the patient's care has been transferred to a doctor who has not previously provided care. (There is only a small number of such cases.) The rationale for its introduction was to eliminate the high gap payments faced by privately insured women whose confinements were deemed to be complex, while ensuring that obstetricians received adequate remuneration for difficult obstetrical cases. It was estimated that about 20% of births would fall into the complex category.[16]

9.39 The Committee has received conflicting advice on whether or not the rebate has reduced gap payments and by how much. Some witnesses believed that it has had no effect on the size of gap payments.

> The Medicare rebate for complex births was intended to reduce gap payments. AHIA [Australian Health Insurance Association Ltd] supports the increase in the rebate. However, it did not of itself reduce medical gap payments. Indeed, the experience at the time in relation to the health fund

16 See Senate Community Affairs Legislation Committee, *Committee Hansard,* estimates 31.5.99, p.102.

> which was providing a gap benefit for childbirth was that some doctors increased their fees.[17]
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> Following the introduction of the complicated confinement item (Item No 16522) in November 1998, Health Insurance Commission data to date suggests that gap payments do not appear to have fallen. The AMA contends that it is still too early to be clear as to the level that gap payments will eventually settle at. A longer period will be required before more definitive conclusions can be drawn as to the level of gaps for this item.
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> Nevertheless, in view of the above identified pressures on the incomes of obstetricians, the AMA would also argue that the fact that gap payments have not increased is a positive outcome for consumers.[18]

9.40 Others considered that gap payments had been reduced as a result of the new rebate.

> Certainly the impact of the new Medicare rebate provided for complex births has assisted in the reduction of average gap payments.[19]
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>
> NASOG [National Association of Specialist Obstetricians and Gynaecologists] has data suggesting there has been a significant drop in gaps in Australia after the introduction of this Item number.[20]

9.41 The Commonwealth Department of Health and Age Care estimated that gap payments had fallen slightly, from $300 for the standard confinement item (MBS no. 16519) to $218 for the new complex item (MBS no. 16522).[21] In other words, most of the additional $478 now paid by Medicare for complex births is retained by the obstetricians and not passed on to the insured women in the form of reduced gap payments. The Department advised that 56% of claims under the new complex item were for services where women were charged above the schedule fee (compared with 72% for the standard confinement item).[22]

Views on the new Medicare rebate

9.42 Some witnesses welcomed the new rebate.

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17 Submission No. 146, p.3 (Australian Health Insurance Association Ltd).

18 Submission No. 175, p.7 (Australian Medical Association Ltd).

19 Submission No. 89, p.12 (Catholic Health Australia).

20 Submission No. 100, p.1 (National Association of Specialist Obstetricians and Gynaecologists).

21 See Senate Community Affairs Legislation Committee, *Committee Hansard*, estimates, 31.5.99, pp.102-103.

22 Additional information to Senate Community Affairs Legislation Committee estimates, 31.5.99.

> This initiative has had a significant impact on rural GPs and has enabled many to consider staying in obstetrics that might have otherwise pulled out. It was welcomed by all rural GPs and is recognition of the difficulty with high risk Obstetrics. The government is to be applauded for this. It has certainly reduced the gap payment.[23]

9.43 Others opposed it, mainly because they feared it would encourage overservicing.

> The new rebate was supposed to be spread through obstetricians' practices to reduce "gaps" for women. In reality it seems that most obstetricians view it as being paid appropriately for difficult cases. The concern is whether the additional fee acts as an inducement to intervene.[24]

* * *

> I think it is a considerable concern that the financial incentive that used to exist for intervention that was removed has now been replaced and that there will be a further incentive – if any further incentive is needed.[25]

9.44 Others felt that the rebate should be more closely linked to health outcomes for mothers and babies.

> …the sizeable increase in the rebate for "complex births" introduced a financial incentive for more births to be categorised in this way, particularly since the recipient of the benefit was the person making the judgement as to whether the criteria was met. This concern was alleviated in some way by the list of criteria included in the Medicare item, but a review of the impact on outcomes is necessary for assurance that the changes have not unduly influenced health care decisions.[26]

* * *

> The impact of the new Medicare rebate for complex births should be closely monitored by the Health Insurance Commission (HIC) to determine its effect on patterns of provider services and to detect any associated changes in perinatal morbidity. For example, the inclusion of "fetal distress" in the definition of a complex birth is problematic. Given the existing diagnostic uncertainties surrounding this condition, the definition has the potential to increase the already high levels of interventions such as routine fetal heart rate monitoring in normal pregnancy.[27]

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23 Submission No. 70, p.7 (Royal Australian College of General Practitioners).

24 Submission No. 51, p.13 (Midwifery Practice and Research Centre, NSW).

25 *Committee Hansard,* 6.9.99, p.98 (Dr Jane Fisher, University of Melbourne).

26 Submission No. 153, pp.15-16 (Maternity Alliance, NSW).

27 Submission No. 109, p.21 (NSW Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research).

9.45 Given the divergence of opinion on the potential of the new Medicare rebate for complex births to act as an incentive for overservicing, the Committee considers the rebate should be monitored to ensure that it does not result in an increase in Caesarean sections and other interventions where these are not indicated on medical grounds.

Recommendation

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.

Qualified and unqualified neonates

9.46 The issue of funding arrangements for qualified and unqualified neonates is quite separate from the issue of the Medicare rebate for complex births and predates it by many years.

9.47 When Medibank was first introduced in 1975 Commonwealth and State governments agreed to provide a bed subsidy for all hospital patients. It was decided that healthy new babies housed with their mothers should not 'qualify' for the bed subsidy because there was no clinical need for them to be in hospital, except to be near their mothers, who did have such a need. Accordingly, they were not classified as patients. They were defined as patients only if they were less than nine days old (originally seven days old) and required treatment which could only be provided in an intensive care or special care unit (in other words, separate from their mothers). However, the second and subsequent children of a multiple birth were defined as patients.

9.48 Under the current Australian Healthcare Agreement no bed subsidy is paid for hospital patients so the original reason for the exclusion of new babies from the definition of 'patient' no longer exists. However, modifications to the Act from 1 July 1996 did not address this fundamental legislative flaw.

9.49 It can have serious funding implications. For example, a woman who is privately insured but whose baby is unqualified can make no claim upon her health fund or Medicare for care and treatment provided to the baby.

> "Unqualified" neonates that require Specialist treatment while still by the mother's bedside do not attract a gap rebate if privately insured, which is a significant vexation to insured families, and indeed is a discrimination against the baby.[28]

9.50 There are wide discrepancies between States in the number of neonates gaining qualified status. This varies from 10% to 70%.[29] Where unqualified neonates

28 Supplementary information, 7.9.99 (Royal Women's Hospital, Vic).

29 Submission No. 78, p.37 (Mater Misericordiae Mothers' Hospital, Brisbane).

are admitted the costs of their care are attributed either to the mother's admission and/or across all qualified neonate admissions. This can have the effect of artificially inflating the costs of other obstetric DRGs and of disadvantaging hospitals caring for unqualified neonates, which is why so many hospitals reclassify them as qualified.

9.51 The differentiation between qualified and unqualified neonates can also have an adverse impact on the care of the newborn. It provides a financial incentive to classify babies as qualified and to treat them separately from their mothers in situations where such a separation is not medically necessary and in fact is inimical to their development because it deprives them of the benefits of early bonding and maternal support.

> Even worse, to attract the bed payment for an inpatient stay, babies are sometimes moved from their mother's bedside into the nursery for treatment there, when the baby could have been equally well treated without separation from the mother, if this anomaly were not in place. This is encouraging bad medical practice.[30]
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> * * *
>
> The term Qualified and Unqualified Neonates is counter productive to good neonatal care; it encourages the admission of mild to moderately sick neonates to special Care Nurseries, when many of them could be better (and more economically) cared for at their mother's bedsides. It also makes clinical costing difficult because of the failure to recognise "unqualified" neonates as individual patients.[31]

9.52 In both medical and financial terms it is important that all neonates be recognised as qualified. At the very least, definition as qualified should be based on diagnosis and type and intensity of care required rather than on physical location.

Recommendation

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.

30 Supplementary information, 7.9.99 (Royal Women's Hospital, Vic).

31 Submission No. 46, p.10 (Royal Women's Hospital, Vic).

CHAPTER 10

LITIGATION AND OBSTETRIC PRACTICE AND PROVISION

Introduction

10.1 The Inquiry's terms of reference did not directly raise the issue of litigation and its effect on obstetric practice in Australia. Nonetheless, many practitioners and other witnesses raised concerns about the impact of litigation on birthing service practice and provision. Due to the frequency with which the issue was raised and its marked impact on practice and provision of services the Committee has included this discussion of litigation issues in its Report. Aspects of litigation are also discussed in chapters 2, 5 and 7 of the Report.

10.2 The alleged effects of litigation include:

- both obstetrician/gynaecologist specialists and GPs leaving obstetric practice because of the level of medical indemnity premiums;
- obstetrician/gynaecologist specialists and general practitioners leaving obstetrics because of **fear** of litigation;
- an aggravation of an already existing shortage of rural birthing service providers; and
- the practice of so-called 'defensive medicine', particularly in relation to the performance of Caesarean section but also in relation to other procedures such as ultrasound screening.

10.3 All these issues were discussed in some depth in the Final Report of the Professional Indemnity Review (PIR) in 1995, which concluded a four and a half year review of compensation and professional indemnity arrangements for health care professionals in Australia.[1] Many of the conclusions of the PIR were supported 18 months later by the conclusions of the Victorian Law Reform Committee.[2] Both these reviews arose partly out of the same concerns as those expressed to this Committee. For example, the Victorian Committee's Chairman's Forward stated that the inquiry:

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1 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care - A Final Report*. (PIR Final Report) AGPS Canberra November 1995 (Australian Government Publishing Service) AGPS Canberra : chapter 10. Copies of this chapter and the rest of the report are available at the following location on the Department of Health and Aged Care's web-site: http://www.health.gov.au/pubs/hrom/theainsu2.htm.

2 Parliament of Victoria Law Reform Committee. *Legal liability of health service providers*. Final Report. (VLRC Report) May 1997 Victorian Government Printer Melbourne.

> arose out of Government concern that the increasing cost of professional indemnity insurance could affect access to medical services, particularly in provincial and rural Victoria.[3]

Publicly available data on litigation

10.4 Unfortunately, the Committee faced many of the same barriers as the PIR did in trying to assess the validity of most of these assertions. There is still no publicly available national data on the frequency, cost (including payouts and legal fees) and causes of medical negligence litigation in Australia. As an urgent starting point to a truly informed debate on these important issues, the Committee supports recommendation 9 of the PIR which proposed:

> the establishment of a national minimum data set for health care negligence cases, which includes sufficient details to allow the data to be used to examine trends in particular specialties and diagnostic areas, and to detect areas likely to be able to benefit from the intervention of active prevention strategies. The contributors to the data base should be all MDOs, any insurers providing health care professional indemnity cover either to individual practitioners or facilities, and all State governments and private sector self-insurers.[4]

10.5 Without such information no sensible decisions can be made about the increase in litigation, sometimes referred to as a 'litigation affliction,' said to be adversely affecting birthing services in Australia may well be inappropriate. There are also no other readily accessible public sources of data on medical litigation. The courts generally do not keep separate statistics for medical litigation, though the period since the conclusion of the PIR has seen the establishment of a separate 'medical list' in the County Court of Victoria in January 1998. While the list also includes litigation against related professionals, such as chiropractors, dentists and veterinarians, it provides some limited information.[5] The head of the list reported at a Workshop of the Royal Australasian College of Surgeons in October last year that:

> At the commencement of the list there were 300 matters on it and some 10 months later there were just under 430. Five to ten cases were being resolved per month.[6]

10.6 While the data is relatively limited, being from one court in one state only, it provides some support for the assertion that overall an increasing number of cases are being brought against doctors, though the number of cases remains relatively low.

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3 See VLRC Report at note 2 : p.xvii.

4 See PIR Final Report - note 1: para 2.93, p.31.

5 Tito F. "Royal Australasian College of Surgeons Workshop on Medical Litigation - Alternative Processes - Friday 30 October 1998: Summary of Proceedings" in *The* Quarterly Journal of the Royal Australasian College of Medical Administrators March 1999 vol 32(1): p.6.

6 Ibid, p 5.

Data on litigation from Medical Defence Organisations

10.7 Although there have been some limited inroads by private insurers in low risk areas of the medical profession, medical defence organisations (MDOs) still provide the vast majority of professional indemnity cover for medical practitioners in Australia. Their operations are described briefly below.

10.8 Despite requests from the Committee, MDOs were unwilling to provide data on the frequency, cost and causes of litigation against both specialist obstetrician/gynaecologists and general practitioners providing obstetric services.

10.9 Even their own members have been unsuccessful in gaining access to this information. Following a recent 'call' on their members by some MDOs, a meeting was held between the AMA and the MDOs in Melbourne on 27 November 1999. At this meeting options to gather nationally aggregated, deidentified data were once again raised with the MDOs, with the options of collection by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare being raised. The AMA is still pursuing this national option.

10.10 The urgency of the issue has surfaced recently with at least two of the MDOs, MIPS and MDAV, making 'calls' on their members to address chronic underfunding of their 'incurred but not reported' (IBNR) liabilities. For obstetricians/gynaecologists in MIPS, this call means their contribution this year will be $54,000 (double their annual contribution of $27,000 for 1999/2000) though the MDOs are allowing members experiencing difficulty in meeting the call to contribute over a 4 year period to lessen its immediate impact. There is a requirement for a practitioner to pay at least 20% of the call this year. This would make the amount payable this year to MIPS for a specialist obstetrician/gynaecologist up to $32,400, which is still below the NSW United Medical Protection (UMP) contribution of $41,400.

10.11 Even at these levels, specialist obstetricians/gynaecologists are rightly concerned that contribution levels may continue to rise. For example, UMP were reported as claiming that their $41,400 contribution still involves significant cross subsidisation with other parts of the medical profession. Without this cross-subsidisation, UMP has claimed that these contributions would be over $60,000. Without better data, publicly available and available to their members, the accuracy or otherwise of these estimates is impossible to judge.

Obstetrician/gynaecologist concerns about data

10.12 Obstetricians/gynaecologists have themselves expressed scepticism about the accuracy of subscription estimates, which are made without reference to publicly available data. They base their concerns upon their recent experiences in NSW. NSW specialist obstetrician/gynaecologists campaigned late last year to get the liability for negligence actions relating to public patient births covered by the NSW Government's professional indemnity arrangements, rather their own private MDO coverage. They

claim that they had been led to believe that this would result in a decrease in contributions.[7]

10.13 However, following the obstetricians/gynaecologists successful campaign, the principal MDO in NSW (UMP) further increased its subscription rate for specialist obstetricians. This resulted in significant anger in the specialty group. The UMP claimed that if the specialists' campaign had not been successful, fully funded contributions would have exceeded $90,000. Without publicly available data and open member scrutiny, doctors argue that the validity or otherwise of any of these assertions cannot be tested and their financial positions are subject to the untested whims of the relevant MDOs. They also argue that without this information they cannot properly direct their risk management efforts.

10.14 This is consistent with concerns raised in the PIR's Final Report, which showed that, in terms of the frequency of litigation, the number of cases involving specialist obstetricians/gynaecologists', gynaecological business far exceeded the number of cases involving their obstetric business, in particular, the number of cases involving so called 'brain-damaged babies'.

> Because of the large cost effects of this very small number of claims, public discussion on these issues has wrongly linked the frequency of suit to brain-damaged baby litigation. In fact, 80% of the cases numerically made against obstetricians and gynaecologists relate to their gynaecological practice.[8] Almost one quarter of these claims related to complications following hysterectomy, while the next two most frequent groups of claims relates to failed sterilisations (18%) and laparoscopic complications (15%). The next two biggest groups – each around 10% – related to missed or delayed diagnoses and problems associated with intra-uterine contraceptive devices. The remainder consisted of a mixed bag of complications of various operative procedures, accidental sterilisations, failed terminations, burns, drug errors and retained swabs/instruments.
>
> Of the remaining 20% of cases, relating to their obstetric practice, slightly less than half related to damage to the mother in the birthing process, and just over half related to damage to the baby.[9]

10.15 The reverse is true in relation to the costs of litigation, with the very small number of successful 'brain damaged baby' cases contributing disproportionately to

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7 Statements made by Dr Phillip Cocks of the National Association of Specialist Obstetricians and Gynaecologists at the joint RACOG/NASOG conference entitled 'In the Trenches' held in Sydney on 24-25 April 1999.

8. The PIR reported that 'This data on claims made between 1980 and 1993 was kindly provided by the Medical Protection Society - other MDOs were unable or unwilling to provide this information, though none have provided any contrary information to this. The view has been conveyed by several that this is broadly similar to their experiences'. It is understood that the perception is that the pattern remains similar in more recent years.

9 PIR Final Report - see note 1: paras 10.52-10.53, p.275.

the costs of MDO premiums, and driving the costs of premiums for those specialists who practice obstetrics significantly above those who do not in most MDOs. In terms of prevention of the frequency of litigation, this kind of information is invaluable, but it is not currently available.

10.16 The Committee understands that the AMA is currently attempting to obtain access to such data on a national, anonymous, aggregated basis across all areas of medical practice to enable much better targetting of preventive risk management effort. The Committee believes that the current secrecy surrounding the operations of the MDOs is unacceptable and that the MDOs should be open to public accountability and scrutiny.

Recommendation

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 MDO Industry

10.17 There has been some consolidation in the medical defence industry since the mid 1990s. At the time of the PIR there were 10 MDOs operating in Australia. This is now down to 6:

- United Medical Protection (UMP), which competes nationally and has almost all MDO business in NSW and Queensland;
- the Medical Indemnity Protection Society (MIPS) which operates in Victoria;
- the Medical Defence Association of Victoria (MDAV) which operates in Victoria;
- the Medical Defence Association of South Australia (MDASA) which operates in South Australia;
- the Medical Defence Association of Western Australia (MDAWA) which operates in Western Australia; and
- the Medical Protection Society of Tasmania (MPST) which operates in Tasmania.

10.18 The two large British based MDOs – the MDU and the Medical Protection Society (MPS) – have essentially withdrawn from the market. There have been some minor incursions into the territory of the MDOs by private insurers, but most of the market is still operating under the traditional MDO discretionary mutual arrangement.

10.19 The distinguishing feature of the operations of MDOs is that the 'cover' of their members is not considered to be an insurance contract. As such, their discretionary operations are not regulated by the Insurance and Superannuation

Commission and are not licensed under the *Insurance Act 1973*. In its purest form, members of MDOs pay subscriptions and the MDOs exercise their discretion to pay out on any claim made against a member. The concept of discretionary cover was explained in the PIR's Final Report in the following manner:

> *Discretionary cover* describes the indemnity cover provided by medical defence organisations (MDOs) and a small number of other health care professional discretionary mutuals operating in Australia at the moment. No contract exists whereby a member is guaranteed payment of their professional indemnity liabilities, though there appears to be only a few examples where MDOs have exercised their discretion not to cover an individual doctor or group of doctors.[10] Recent statements from one MDO have indicated that they may exercise their discretion adversely against certain kinds of cases such as negligence cases involving sexual impropriety.[11] The nature of this indemnity means the organisations offering it are not insurance companies, and so they operate outside of the regulatory framework covering insurance.[12]

10.20 Some MDOs now offer a combined arrangement, where there is a 'claims-made' insurance policy with a discretionary 'claims-incurred' supplement. Where these arrangements exist, MDOs often provide the 'claims made' insurance component of their business under a solely owned subsidiary company which holds an insurance licence (a so-called 'captive insurer'). This component of their business is required to meet the prudential requirements of the Insurance and Superannuation Commission, but the core discretionary component of their businesses remains without external regulation.

Some operational principles for MDOs

10.21 To understand these arrangements and the most recent 'crisis' in the industry, it is helpful to understand the difference between 'claims made' and 'claims incurred' cover, and to understand the concept of 'incurred but not reported' (IBNR) claims and 'run-off cover'.

> *Claims incurred cover* provides indemnity for any claim which arises from an incident which occurred while the health care professional is either a member (in the case of an MDO) or has paid their insurance premium (in the case of an insurer). This variety of cover is sometimes called *occurrence-based* cover, and is the type of cover which applies to the majority of personal injury insurance in Australia – that is, employer's

10. Some examples where MDOs have exercised their discretion against a doctor or class of doctors has been the retrospective exercise of the discretion after Dr Harry Bailey's death by suicide in relation to claims arising from his activities at Chelmsford by the NSW Medical Defence Union, and the refusal by the Medical Protection Society to pay claims incurred but not reported at the date of cessation of membership for past members who transferred to the Medical Defence Association of Victoria or the Medical Defence Association of Western Australia.

11. Public statements by Dr Megan Keaney, United Medical Defence.

12 PIR Final Report - see note 1, para 9.5, pp.225-226.

liability and third-party motor vehicle personal injury insurance. It is also the product offered by MDOs in Australia.

IBNR or Incurred But Not Reported liability arises with claims incurred cover. It refers to those claims where an incident has already occurred (that is the liability has been incurred), but the claim has not yet been reported to the risk carrier. Estimates of these are made using historical claims reporting data.

Claims made cover provides cover for previously unreported claims made in the year a premium was paid or membership held. This form of cover is generally provided for economic loss insurance, such as professional indemnity for financial professionals. It is also the kind of cover generally offered by insurers and insurance brokers for health professionals.

Run-off cover arises with claims made products. When a health professional, who has claims made professional indemnity cover, stops practising, they need to buy cover for any new claims which come forward from the period they were in practice. This is called run-off cover.[13]

10.22 MDOs in Australia have traditionally provided 'claims incurred' cover for doctors. This form of cover is the most beneficial for both doctors and patients, as it covers them securely for all future liabilities which arise from any particular year of coverage. Gaps in coverage can more easily arise with claims made cover, which is why the PIR recommended that unlimited claims incurred cover provided the best option for consumers and doctors.[14]

10.23 The practical difficulty with 'claims incurred' cover is in estimating the appropriate reserves for the IBNR liability. In an unregulated market, such as exists in the MDO discretionary sector, there is also a great temptation to set premiums at a rate which does not adequately reserve for these contingencies. This is even more likely in a business like medical negligence cover, where the payment of damages often occurs a long time after the incident which gives rise to it. For example, at the time of the work of the PIR, almost 60% of cases were not finalised within seven years of the occurrence.[15] The theory is that in the time from when the claim becomes known and the time payment needs to be made, sufficient additional contributions can be collected to ensure that the MDO will be able to make the payments.

10.24 This 'catch up' played a big part in the rises in MDO premiums in the late 1980's and early 1990's. At that time, what data was available showed that rather than a recent massive increase in the number of claims immediately beforehand, there had

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13 PIR Final Report - see note 1 : paras 9.8-9.11, p.226.

14 PIR Final Report - see note 1: recommendation 137, para 9.90, p.239; and recommendation 136, para 9.80, p.237.

15 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care - An Interim Report.* (PIR Final Report) February 1994 AGPS Canberra: para 6.86, p.162.

been a gradual increase over the previous 15 years, which had, to a large extent, been unfunded. While claims rose, contribution rates had remained low. In 1989, this led to several MDOs needing to make calls on their members. 'Calls' are where the MDO seeks an additional amount from all members to ensure its continuing capacity to exercise its discretion positively and 'cover' its members. Most of their constitutions limit the size of calls to an additional year's subscription.

10.25 This has remained a significant issue throughout the 1990s, with actuarial studies funded by the PIR estimating that the MDO industry was underfunded to the extent of between $100 and $250 million.[16]

The recent 'crisis'

10.26 A number of MDOs have recently made calls on their members and there is speculation that all will be required to do so. This situation has arisen partly because of the continued shortfall in IBNR funding and partly for other reasons. In its Fact Sheet for members, the MIPS gave the following explanation for why they had decided to make the call at this time:

- In an increasingly consumerist society, it is inevitable that litigation rates (and costs) will continue to rise.
- Legislation has been foreshadowed, in Victoria, which would require each doctor, as a condition of registration, to provide proof that he or she is adequately indemnified for professional liabilities.
- The Australian medical defence organisations (MDOs) collectively are not fully-funded at the present time – i.e. their total reserves may be sufficient to fund their known (reported) and accepted liabilities but are not enough to in addition fund the currently *unknown* professional liabilities of their members, those liabilities which will arise from incidents which have occurred but have not yet been reported. This is despite the very significant increases in subscriptions over the last decade.
- The introduction of the GST will affect the MDOs' costs of meeting their members' liabilities.
- A new accounting standard has been proposed which would require the MDOs to declare both their known and currently unknown liabilities in their annual reports. (Currently only the known liabilities must be taken up into their balance sheets.)[17]

10.27 The Fact Sheet goes on to acknowledge that the MDO industry operating in Australia has been considerably underfunded for many years, specifically in relation to IBNR liability. It then refers to the PIR's estimates listed above and states that:

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16 PIR Final Report - see note 1: para 9.179, p.255. Also see more generally paras 9.178-9.187, p.255-256.

17 MIPS. Back Funding Contribution Fact Sheet, November 1999: p.1.

> There is no published evidence to suggest that this figure has fallen in recent years...Litigation rates and costs have increased significantly in recent years, and across the industry it has been difficult to keep up with the hyperinflation in reported claims, let alone to make adequate provision for the IBNR liabilities.[18]

10.28 The Fact Sheet provides a thorough outline of the financial and prudential reasons for the call and provides transparency about the financial operations of an MDO. While there has been much media speculation about a new 'crisis', the MIPS Fact Sheet makes the chronic industry-wide nature of the issue very clear. This emerging openness in the industry is to be supported and encouraged.

10.29 Improved funding of the IBNR liability also places organisations which adequately reserve for their IBNRs in a strong competitive position, if and when Governments decide they should be regulated, as recommended by the PIR. Bodies which do not reserve to meet these liabilities will be obliged to make calls on their members at that time, and will not have the advantage of the income-earning potential of the reserves in the meantime.

10.30 Other MDOs such as UMP argue that they are collecting additional subscriptions each year to improve their IBNR funding without having to make a call on their members. The President of UMP stated that their annual contribution rates now fully fund their occurrence-based cover each year and includes an additional amount of premium for the unfunded IBNRs into each year's premium, with the intention of 'insuranising' their business over time.

MDO subscription increases

10.31 It is impossible to tell from currently available data the relative contributions that different factors have made to increased MDO contributions, both across the medical profession and within specialty and practice groups. Some of the factors are a rising rate of claims, rising claims cost (well above inflation and principally driven by costs of future care), increased prudential reserving and a reduction in the internal cross-subsidisation of contribution rates between different groups of doctors. As was asserted by the PIR, while there is clearly widespread fear of litigation among medical practitioners, it is not based on any evidence. This was confirmed by the later work of the Victorian Law Reform Committee which concluded in 1997 that:

> The Committee has found that the perception of the medical profession concerning recent increases in the cost of professional indemnity insurance is not reflected in a significant increase in either the quantity of claims or their quantum. Rather, a number of high profile cases, particularly in New South Wales, has led to a widespread belief that there is a crisis in medical negligence litigation when, in fact, there is not. The Committee's view is that there is no real crisis in the level of premiums that is impacting on

18 MIPS. Back Funding Contribution Fact Sheet, November 1999 : p.2.

> service delivery, or is likely to impact in the near future. Present premium levels are not oppressive.[19]

10.32 Equally, it is difficult to be certain exactly what impacts any of these are having on practice changes, when all the other influences are looked at as well. For example, there were many fears expressed to the Victorian Law Reform Committee about the impact of litigation on rural practice. However, the Law Reform Committee concluded that:

> there is evidence of a widespread fear of litigation among doctors generally. However, there is no evidence of a significant increase in medical litigation. The shortage of doctors in some areas of practice has not been shown to be a consequence of any rise in the cost of obtaining professional indemnity insurance. Rather the Committee has received extensive evidence to the effect that the shortage of doctors in rural areas, for example, is due to other social and economic factors.[20]

10.33 What is absolutely clear is that there has been a rapid rise in professional indemnity contributions in some states over the past decade. For example, medical indemnity subscriptions for specialist obstetricians/gynaecologists in NSW have risen from $7,200 in 1990 to $41,400 in 1999. A selection of MDO contribution rates for specialist obstetrician/gynaecologist and for gynaecologist only practitioners appears in Table 1 below. As can be seen from Table 2, these increases have also affected GPs providing obstetric care, which is a particular issue for rural health care, where a larger proportion of private sector deliveries are provided by GPs and where GPs may be more likely to be providing public hospital birthing services as well.

10.34 The Committee is concerned at the enormous variety between the states and the variations between MDOs even within states, as illustrated by these tables. Some of the variations may be a consequence of differences in behaviour so far as litigation is concerned. NSW is claimed by doctors to be the most litigious state and UMP operates mainly in NSW. However, the litigation experiences are generally assumed to be similar between NSW and Victoria, because both have law firms and barristers who specialise in this area. However, there are significant differences in the costs between UMP and MIPS and MDAV, all of whom operate in Victoria. It also seems that it is unlikely that all the difference between these states relate to differences in levels of damages. While some of the differences between MDOs may relate to different claim profiles and different IBNR reserving policies as outlined earlier, it is difficult to know exactly why these differences arise. In all cases, there is insufficient publicly available data to make any definitive statements about the reasons for the differentials.

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19 VLRC Report - see note 2 : p.xviii

20 VLRC Report - see note 2 : para 9.68, p.230.

Table 1 : Selected MDO contribution rates for Obstetrician/Gynaecologist and Gynaecology Only Medical Practitioners

1994/5 to 1999/2000

MDO[a]	Contribution Category	1994/95 $	1995/96 $	1996/97 $	1997/98 $	1998/99 $	1999/2000 $
MIPS	O/G	9,900	14,000	15,000	20,000	22,000	27,000
	G only	4,500	6,600	10,000	13,500	15,000	18,000
MDAWA	O/G	25,000	25,000	27,750	29,140	30,050	32,000
	G only	11,500	11,500	12,800	13,450	13,870	15,750
UMP	O/G	17,900	19,500	25,000	30,000	36,000	41,400
	G only[b]	16,700	14,500	18,000	16,500	22,500	25,875
MDAV	O/G	7,500	11,000	15,000	20,000	22,000	25,000
	G only	3,400	6,500	10,000	13,500	14,850	17,500
MPST	O/G	4,300	5,500	6,600	7,500	9,400	11,050
	G only	4,300	3,600	4,550	5,200	6,700	7,800

a The MDOs are listed in paragraph 10.17.

Table 2 : Selected MDO contribution rates for General Practitioners practising obstetrics

1994/5 to 1999/2000

MDO	1994/95 $	1995/96 $	1996/97 $	1997/98 $	1998/99 $	1999/2000 $
MIPS	2,990	5,500	7,000	7,500	8,250	9,500
MDAWA	5,000	5,000	5,750	6,040	6,480	7,500
UMP	4,050	4,650	5,800	6,950	8,750	9,796
MDAV	2,700	5,500	7,000	7,500	8,250	9,000
MPST	2,000	2,550	2,750	2,500	3,500	4,150

Is there a 'litigation crisis' in obstetrics?

10.35 In the face of these rises, some doctors have continued to assert that there is a 'litigation crisis'. As was noted earlier, one of the real impediments to any proper analysis of this issue is the total absence of useful data on the incidence and costs of claims against medical practitioners, whether they are involved in birthing services provision or not. The uncertainty and speculation arising from this situation has changed very little from when the PIR Final Report said, with some frustration:

> Publicly available information is so scarce that counteracting what could be seen as a fear campaign among health care professionals is very difficult. When data is sought to back up the public statements, it is frequently delayed, if it can be found at all. In the case of MDOs, there have been alleged to be concerns about revealing information to competitors. The availability of data on such basic things as the number of claims made and the number of claims where a plaintiff is successful have fostered an environment of crisis, when the absolute numbers of claims appears to be still very low in Australia.[21]

10.36 The particular reasons for sharper rises in obstetric related contributions compared to other groups were outlined in the PIR's Report and it appears that they have changed little since then.

> The data which is available in relation to birthing service provider actions in the 1990s indicates a steady, very low level of claims. One MDO publicly confirmed this in 1993 – "the number of actions in which it is asserted that severe neurological handicap has arisen from an obstetrician's negligence appears to be both low and rising only slowly".[22]
>
> Rather than increased claims, the three main reasons for contribution increases have been:
>
> - the move away from a single flat rate contribution payable by all doctor members, whatever they practised and wherever they practised, which had applied to MDO business over the first 80 odd years of this century;
> - the need to address long term underfunding of liabilities, which was caused by indemnity subscriptions being held at an artificially low level for many years, particularly in the 1970s and 1980s, when the frequency of claims increased dramatically from a very low level; and
> - larger awards for future care costs for severely disabled people and the need to adequately reserve for these costs in future cases.
>
> The reasons for the disproportionate effect of subscription rises on birthing service providers are described above – obstetrics generates a very small

21 PIR Final Report - see note 1: para 2.63. p.26.

22. Nisselle P. Murray J. 'Obstetrics in crisis?' 1993 *Medical Journal of Australia*, vol 159, pp.219-221: 219.

> number of very expensive claims, and gynaecology generates a significant number of generally low value claims.[23]

10.37 Available data provides inadequate evidence from which to draw conclusions about the existence or otherwise of a litigation crisis. What is clear is that litigation and medical defence subscription rates are issues of continuing significant concern to doctors, and that the fear of litigation, whether it is based on reality or not, is affecting the practice decisions of at least some doctors. None of the recommendations of the PIR, which sought to ensure better information was available to assess these claims, have been acted on and so the Committee is in no better position than was the PIR to reach any definitive conclusions on these issues.

The way forward

10.38 The Senate Committee has been concerned to discover the extent of the secrecy surrounding the operations of the medical defence organisations. They are not publicly accountable. They do not have to provide information either to the public or even to their members on basic aspects of their operations such as the size of their reserves, the criteria governing the size of their premiums or the extent of the cross subsidisation which, they claim, affects premium levels. The obstetrician/ gynaecologist specialists claim that without such scrutiny 'their financial positions are subject to the untested whims of the relevant MDOs'. Such a situation is clearly unacceptable.

10.39 Better information on these issues requires greater investigation than has been possible during this Inquiry. In addition to greater understanding of the reasons for subscription rises, there is a need to consider a wide range of other issues in more detail, including:

- the impact of fear of litigation on the quality of care provided to birthing women eg through defensive medical practices;
- the impact of premium levels and types of cover on the availability of services from other practitioners, such as self-employed midwives;
- the impact of birth related litigation on State Government health departments' liabilities, given that the majority of births occur in that area;
- the evidence that is continuing to emerge that, in the vast majority of children affected by cerebral palsy, there is little or no link to sub-standard obstetric care, and the need for further evidence based research to look at whether there are specific characteristics of the condition in children where sub-standard obstetric care (either in pregnancy, labour or birth) was the likely cause of their disabilities;

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23 PIR Final Report - see note 1: paras 10.62-10.64, p.278.

- the use or otherwise of such evidence by lawyers and judges in determining whether a child is entitled to damages, including issues such as the use of expert evidence and clinical practice guidelines;
- the models which are operating in jurisdictions such as Virginia, Florida and some Scandinavian countries, where no-fault regimes are substituted for compensation based on negligence;
- the various different ways state governments have made changes to their indemnity arrangements to accommodate the fears of medical practitioners providing birthing services in the public system, particularly in rural areas[24];
- the emerging public recognition of the importance of adequate care for all children and adults with significant neurological impairments and the inadequacies of community- funded services for these people;
- the impact these service and assistance inadequacies have on the incentives for families to litigate and whether this is in fact occurring;
- the impact of litigation on both practitioners and the families of children born with significant disabilities, whether litigation is successful or not; and
- the impact of assisted reproduction technologies on the incidence of children born with cerebral palsy and the relationship between this and litigation (if any).

10.40 These issues need further investigation.

Recommendation

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.

24 For information on the Victorian Government's special arrangements, see VLRC Report, paras 9.63-9.68, pp.228-230.

MINORITY REPORT ON CHILDBIRTH PROCEDURES BY GOVERNMENT SENATORS

Government Senators opposed the establishment of this inquiry for a number of reasons.

As many witnesses remarked, this issue has had many inquiries undertaken by various governments and other bodies. All the inquiries seem to be repetitive and draw roughly the same conclusions.

Probably most importantly however, it was opposed on the basis that most, if not all, of the inquiry was outside the jurisdiction of the Federal Government and that the Federal Government should not be dictating to the States how they should be running services that fall within their responsibilities.

The other major factor in such a decision by Government Senators was that it was clear that the issues under scrutiny that did not involve the States were ones for the medical profession and patients – not for senators. By this we cite by example the expressed view on Caesarean sections.

While many are concerned about the number of surgical interventions we believe that such decisions are not for medically unqualified senators to make without the knowledge of a patient's particular circumstances. Those types of decisions (and many like them) should be clinical decisions made by doctors in consultation with their patients and based on clinical need.

We believe that for members of parliament to start dictating who should or should not have particular procedures, access to certain tests, the frequency of specific tests, or the like is not only unwise but undesirable.

There is much in the Report of the Opposition Senators that can be supported purely as general observations and reservations or concerns however, that does not mean that Senate Committees can somehow start and dictate to others what should or should not happen. The parliament does not seek to interfere with other medical or surgical procedures or tests that are deemed necessary by treating medical practitioners. Childbirth procedures where there are medical or surgical implications should be regarded no differently.

For example, there have been marked increases over the last one to two decades in cardio-thoracic tests, surgery and preventative treatments as procedures have been developed and refined. There has not been a suggestion that the parliament should somehow influence those clinical decisions or any other decisions where the numbers of procedures has grown markedly. Childbirth procedures should be no different.

When one looks at the recommendations they basically come down to a 'wish list'. Very few of them have anything to do with the Federal Government. Many that request the Federal Government to act are asking for the Federal Government to cut across areas of direct State responsibility. Two such examples are the suggestion that the Patient Assistance Travel Scheme be extended for friends or relatives of patients and 'that hospitals fund existing birthing centres and establish others'.

Others are requests that have no organisation or person/s to execute the request.

Others are asking for statistics on procedures and events that are already readily available. Such a recommendation states 'that adequate funding be provided to develop and support consistent, reliable and timely data collection on maternal and perinatal morbidity and mortality'. That information is already provided annually by the Australian Institute of Health and Welfare.

There are, of course, a number of recommendations that suggest government intervention in clinical decisions with which government senators cannot agree. The suggestion in the recommendation of Opposition senators that a target rate of 15% for Caesarean sections should be established is untenable because it ignores the question of what happens after that figure has been reached. Patients needing or wanting such a procedure cannot be asked to come back 'next year'?

Additionally, there are some recommendations for the government to take certain initiatives that have already been taken by the Coalition government such as those relating to the provision of services to Aboriginal and Torres Strait Islanders and visiting doctors to rural and remote areas. We are amazed that such significant policy initiatives have been overlooked by the Opposition Senators.

The Federal Government has already put $8.2 million into a Fly-In Fly-Out female GP service for women living in rural and remote Australia. This measure was announced in the 1999-2000 Budget. Female GP's will visit up to 160 locations nationally about four times a year, complimenting the outback clinics offered by the Royal Flying Doctor Service and other agencies. One, but not the only, reason is to give women an opportunity to discuss conditions such as contraception and gynaecological and obstetric care with a female doctor if they prefer.

Over time it is hoped the service will provide valuable research about the health needs of rural women, laying the basis for future improvements in treatment and care.

This service is among a raft of Federal Government health initiatives funded by a $200 million budget commitment to improve access to medical care in rural and regional Australia.

We express concern that so many personal opinions have been quoted in the Opposition Report as evidence with inadequate qualification that it is not necessarily accepted by the Committee as fact.

We do hope that the State Governments will focus upon and implement many of the initiatives that have been proposed over the years as a result of previous inquiries. Australians deserve and expect safe outcomes from all medical episodes.

Senator Sue Knowles, Deputy Chairman
(LP, Western Australia)

Senator Tsebin Tchen
(LP, Victoria)

APPENDIX 1

ORGANISATIONS AND INDIVIDUALS WHO PRESENTED WRITTEN PUBLIC SUBMISSIONS AND SUPPLEMENTARY INFORMATION TO THE COMMITTEE

1 Ms Kerry Peart, Coordinator Graduate Diploma of Midwifery, University of Ballarat (VIC)

2 Ms Rebecca Smith (SA)

3 Ms Elizabeth McCall, Byron District Hospital midwives (NSW)

4 Dr William Boyd (QLD)

5 Dr B R Pridmore, Director, Obstetrics and Gynaecology, Queen Elizabeth Hospital (SA)

6 Ms Kym Boyes, CNM Maternity Unit, Bunbury Regional Hospital (WA)

7 Ms Jenny Parratt (VIC)

Supplementary Information

- Papers: *Victorian Home Births 1995-1998* and *Partnership in Practice – An Evaluation,* Parratt J & Sprague A, received 22.9.99

8 Dr Andrew Child, Director, Obstetrics and Gynaecology, King George V Memorial Hospital, (NSW)

9 Ms Adrienne Palmer (VIC)

10 Ms S A Ridler (NSW)

11 Australian and New Zealand College of Anaesthetists (VIC)

12 Ms Kerri Newman (QLD)

13 Ms Jane Svensson, Health Education Coordinator, Royal Hospital for Women, (NSW)

14 Australian College of Midwives Incorporated – Victorian Branch (VIC)

15 Dr Kathleen Fahy and Dr Karen Lane (VIC)

Tabled at public hearing 15.9.99

- *Meta-analysis of the Safety of Home Birth,* Olsen O
- *Outcomes of 11,788 planned home births attended by certified nurse-midwives,* Anderson RE and Murphy PA
- *Perinatal death associated with planned home birth in Australia,* BMJ 27 Feb 99

16 Royal Women's Hospital Health Service District – Brisbane (QLD)

17 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (VIC)

Tabled at public hearing 6.9.99

- Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Annual Report 1996

Supplementary information

- Correspondence dated 5 October 1999
- Correspondence dated 15 November 1999

18 Dr Ron Chang; Dr Robert Likeman; Dr Steve Mokrzecki; Dr Toni Uptin; Dr Eric Green; Dr David Watson and Dr Phil Moon (QLD)

19 Dr Chris Wilkinson; Dr Deborah Turnbull and Sr Edith Reddin (SA)

20 Ms Robin Payne (VIC)

21 Midwifery Unit Managers, Westmead Hospital (NSW)

22 New England Area Health Service (NSW)

23 Ms Frances M Postma (VIC)

24 Ms Annie Popelier (TAS)

25 Ms Helen McDonald (TAS)

26 Dr Jane Fisher, Lecturer, University of Melbourne (VIC)

27 Ms Susan Ross (NSW)

28 Perinatal Society of Australia & New Zealand (SA)

Tabled at public hearing 7.9.99

- Cochrane News, August 1999 and four articles from The Cochrane Library, Issue 3 1999:
- *Patterns of routine antenatal care for low-risk pregnancy*, Villar J, Khan-Neelofur D
- *Caregiver support for women during childbirth*, Hodnett ED
- *Episiotomy for vaginal birth*, Carroli G, Belizan J, Stamp G
- *Active versus expectant management of the third stage of labour*, Prendiville WJ, Elbourne D, McDonald S

29 Royal College of Nursing Australia (ACT)

30 Homebirth Network of South Australia (SA)

31 Queensland Council on Obstetric and Paediatric Morbidity and Mortality (QLD)

32 Ms Justine Caines (ACT)

33 Port Augusta and Region Maternity Advisory Group (SA)

34 Division of Women's Health and Newborn Care – Westmead Hospital (NSW)

35 Dr Donald Clark (WA)

36 Ms Clarissa Cook (TAS)

37 Ms Pauline Green (NSW)

38 NSW Midwives Association (NSW)

39 Ms Catherine Graham-Smith and Ms Athalie Pugh (WA)

40 Ms Carolyn Hastie (NSW)

41 Dr Peter Malavisi (VIC)

42 Ms Fiona Meredith (TAS)

43 Ms Heather Hancock, Senior Lecturer (Midwifery), University of South Australia (SA)

44 Dr Jacqueline Scurlock (WA)

45 Prof Lesley Barclay, Ms Pat Brodie, Ms Sally Tracy - Australian Midwifery Action Project (NSW)

Tabled at public hearing 14.9.99

- Papers: Issues in Midwifery Workforce, Reorganising Australian Maternity Care; Reforming Midwifery – A Discussion Paper on the introduction of Bachelor of Midwifery Programs into Victoria; and an information brochure

46 The Royal Women's Hospital (VIC)

Supplementary Information

- Comment on qualified and unqualified neonates and Abstracts of Cochrane Reviews, dated 7.9.99

47 Ms Carole Gilmour (VIC)

48 Australian College of Midwives Inc – Goldfields Sub-Branch (WA)

49 Australian Society of Independent Midwives (NSW)

50 Community Based Midwifery Program (WA)

51 Midwifery Practice and Research Centre (NSW)

52 Selangor Private Hospital Maternity Centre (QLD)

53 Australian College of Midwives Inc – SA Branch (SA)

54 Community Health for Adolescents in Need (CHAIN) (NSW)

55 Dr Rosalie Boyce (QLD)

56 Association for Improvement in the Maternity Services (QLD)

Tabled at public hearing 15.9.99

- Copies of AIMS Journal and AIMS Australia with information brochure

57 Brisbane Independent Midwives (QLD)

58 Flinders University, Adelaide – School of Nursing, Midwifery (SA)

59 Mrs and Mr Claire and Bruce Reeler (QLD)

60 Port Pirie Regional Health Service (SA)

61 Midwives Act Lobby Group (SA)

62 Australian College of Midwives – WA Branch (WA)

63 Benevolent Society of New South Wales – Centre for Children (NSW)

64 Geraldton Health Service (WA)

65 Dr Joanna McCubbin (VIC)

66 Ms Monika Geisselbrecht (SA)

67 Orange Base Hospital – Maternity Unit (NSW)

68 The Australian Multiple Birth Association (NSW)

69 Women's Hospitals Australia and Australian Healthcare Association (ACT)

Tabled at public hearing 27.8.99

- *Perinatal Protocols and Guidelines for Management,* Women's and Children's Hospital Adelaide, 1996; various data and alterations to submission

70 The Royal Australian College of General Practitioners (VIC)

Tabled at public hearing 8.9.99

- *Why are General Practitioners ceasing obstetrics? A study of Victorian GPs,* data from Obstetrics Review, and overheads by Dr Kathy Innes

71 Ms Beth McIntosh (QLD)

72 Office of Health Review – Western Australia (WA)

73 Australian College of Midwives – Queensland Branch (QLD)

Tabled at public hearing 15.9.99

- *Equity & access to services & choices of place of birth & care provider for indigenous women living in remote communities of far north Queensland;* and a

brochure on implementing quality care

Supplementary Information

- Model for Funding of Midwifery Care
- Paper 'Can Midwifery Balance the Budget?'

74 Ms Nicola Galea (TAS)

75 The National Association of Childbirth Educators (NSW)

Supplementary Information

- Correspondence, dated 25 November 1999

76 National Health and Medical Research Council – Health Advisory Committee (ACT)

77 Nunkuwarrin Yunti of South Australia (SA)

Tabled at public hearing 7.9.99

- Data from SA Dept of Human Services

Supplementary Information

- Information on Community Midwifery Program, North Metro CHS, Adelaide, dated 24.9.99

78 Mater Misericordiae Mother's Hospital (QLD)

Tabled at public hearing 15.9.99

General information pamphlets; clinical activity statistics 1998-99; and the following documents:

- Antenatal Education Program, Mater Mothers' Private Hospital
- Client Education Programs, Mater Mothers' (Public) Hospital
- Women's Health Strategic Plan, Mater Hospitals Brisbane
- Protocol for Shared Antenatal Care, Dec 98
- Annual Clinical Report 1995, Dept of Neonatology

79 Women's Action Alliance (Australia) Inc (VIC)

80 Birth and Beyond (NSW)

81 Launceston Birth Centre and Australian College of Midwives Accredited Independently Practicing Midwives (TAS)

82 Far North Coast Midwives (NSW)

83 Ms Jennifer Watkins (SA)

84 Birth Matters (SA)

85 Mr Nigel Duncan (QLD)

86 Ms Lois Berry (NSW)

87 Ms Jennifer Quinlan (VIC)

88 Ms Virginia Kelly (VIC)

89 Catholic Health Australia (ACT)

90 Ms Catherine Harris (WA)

91 Team Midwifery Consumer Participation Group, John Hunter Hospital (NSW)

92 The Maternity Coalition Inc (VIC)

93 Central Coast Midwives Association (NSW)

94 Home Midwifery Association (QLD)

Tabled at public hearing 15.9.99

- Information on electronic fetal monitoring, homebirth, midwifery care versus obstetrical management, homebirth ongoing midwifery education program
- Report of the Working Party on Homebirths and Alternative Birth Centres, NHMRC, Nov 1987
- Extracts from *Compensation and Professional Indemnity in Health Care*, A Final Report, Nov 1995
- *Appropriate Birth Care in Industrialised Countries*, Wagner M
- *Pursuing the Birth Machine*, Wagner M

95 National Council of Single Mothers and their Children Inc (SA)

96 Ms Maureen Ryan (NSW)

97 Department of Health and Aged Care - Commonwealth (ACT)

Tabled at public hearing 27.8.99

- *Ultrasound: More Harm than Good*, by Marsden Wagner

Supplementary Information

- Response to questions from hearing 27 August, dated 23.9.99

98 Ms Julie Brennan (NSW)

99 South Australian Independent Midwives Association (SA)

100 National Association of Specialist Obstetricians and Gynaecologists (QLD)

Tabled at public hearing 6.9.99

- *Patient demand for Caesarean Section*, by Cotzias C and Fisk N

101 Associate Professor Karen Simmer, Flinders Medical Centre (SA)

102 Australian College of Midwives Inc (VIC)

103 Keep the Queen Elizabeth Hospital Delivering Community Action Group (SA)

104 Central Sydney Area Health Service (NSW)

105 Ms Anne Thacker (QLD)

106 Dr Dawn Rayner-Brosnan (TAS)

107 The International College of Spiritual Midwifery (VIC)

108 Flinders Medical Centre - Women's and Children's Health Division (SA)

Supplementary Information

- Clarification by Prof Mashall re: MBS and caesarean section dated 21.9.99

109 NSW Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research (NSW)

Tabled at public hearing 14.9.99

- *National Public Health Information Development Plan*, AIHW
- *Care around Preterm Birth: Clinical Practice Guidelines* (Dec 1996) and *A Guide for Parents* (Feb 1997), NHMRC
- Extracts from *Effective Care in Pregnancy and Childbirth*, eds Chalmers I, Enkin M, Keirse MJNC

Supplementary information

- Recommendations from previous reviews of maternity services

- Supplementary articles concerning medical and health economics; guidelines, evidence-based practice, quality and audit; place of birth; medical practice and indemnity issues and UK childbirth inquiries
- *Families First,* NSW Government

110 Dr Sarah Buckley (QLD)

Tabled at public hearing 15.9.99

Additional papers:

- *Perinatal origin of adult self-destructive behaviour,* Jacobson B
- *Labour – Your hormones are your helpers,* Buckley S
- Wattle Park House Home Birth Statistics 1981-1999
- *The Place of Birth: Managing Change in Midwifery Practice,* Guilliland K
- *Birth trauma and birth injury as contributing factors to subsequent criminal behaviour and violence,* Haire D

111 Royal District Nursing Service (VIC)

Tabled at public hearing 6.9.99

- Home Healthcare

112 Women's Electoral Lobby South Australia (SA)

113 Mrs Julie Cronin (WA)

114 Mrs Jean Boer (NSW)

115 Ms Sharon Mulheron (QLD)

116 Mrs Rashelle Szoke (QLD)

117 Ms Susan Burnette (NSW)

118 Ms Claire Brassard (QLD)

119 Ms Kez BenAvi (QLD)

120 Ms Penny Burrows (NSW)

121 Ms Angela De Palma (QLD)

122 Ms Elissa Freeman (QLD)

123 Ms Lisa Joseph (NSW)

124 Ms Joanne Davies (WA)

125 Ms Jane Pearce (NSW)

126 Ms Helen Semler (TAS)

127 Ms Mary Reilly (VIC)

128 Ms Sharlene Fritz (QLD)

129 Ms Frances Blines (QLD)

130 Ms Francesca Lejeune (QLD)

131 Mr Daniel Prokop (QLD)

132 Ms Dierdre Bowman (QLD)

133 Ms Isabelle K O'Toole (TAS)

134 Ms Jane McCammon (NSW)

135 Mr Arthur & Mrs Santina Sannen (NSW)

136 Sr Alison Bush (NSW)

137 Mrs Michelle Green (SA)
138 Mrs Suzette Curtis (TAS)
139 Ms Julia Williams (QLD)
140 Mr Ian Gittus (QLD)
141 Ms Maria Mark (NSW)
142 Ms Nicole Foder-Jones (NSW)
143 Mr and Mrs Rob and Robyn Lamb (NSW)
144 Anu (QLD)
145 Centre for the Study of Mothers' and Children's Health – La Trobe University (VIC)
146 Australian Health Insurance Association (ACT)
Tabled at public hearing 27.8.99
- Member Support program, Maternity Options Package

Supplementary information
- Number of obstetricians in SA and Victoria dated 8 October 1999

147 Mr and Mrs John and Karen Wade (QLD)
148 Regional and General Paediatric Society (VIC)
149 Ms Michele King (TAS)
150 Royal North Shore Hospital – Hospital Based Midwives (NSW)
151 Kalgoorlie Regional Hospital (WA)
152 Homebirth International Australia (NSW)
153 Maternity Alliance (NSW)
- Supplementary submission dated 8 September 1999

154 Professor Marie Chamberlain and Ms Jannine van der Klei, The University of Sydney (NSW)
Supplementary information
- Responses to questions from public hearing dated 14 October 1999

155 King Edward Memorial Hospital for Women (WA)
Tabled at public hearing 8.9.99
- Clinical Practice Guidelines

156 Aboriginal and Torres Strait Islander Commission (ACT)
157 Homebirth Australia Inc (NSW)
158 Royal Australasian College of Physicians, Division of Paediatrics (NSW)
159 Ms Marina Begolo (QLD)
160 Women's Health Queensland Wide Inc (QLD)
161 Coalition for Woman-Centred Birth (NSW)
162 Australian Society of Anaesthetists (NSW)
Supplementary information
- Material addressing epidural analgsia; research into obstetric anaesthesia and fees for obstetric anaesthesia services dated 14 October 1999

163 Department of Human Services – Victoria (VIC)
164 Women's Electoral Lobby Australia (ACT)

165 Team Midwives John Hunter Hospital (NSW)

166 Queensland Health (QLD)

Tabled at public hearing 15.9.99

- Queensland Health corporate presentation, 15 September 1999
- Mothers & Babies: An evidence based synthesis of Queensland Health endorsed documents to guide the development of public sector services for mothers and neonates, August 1998
- *Maternal Health Services in Aboriginal Communities: A clinical needs assessment of five communities and A framework for service enhancement,* February 1998

Supplementary information

- *Maternity Services Review*, Phase One 1998-1999
- *Maternity Services: Future Diection 1999-2000*, Phases Two and Three
- Reponse to questions on notice from public hearing dated 15 September 1999

167 Mrs Sharon Harwood (QLD)

168 Victorian Health Services Commissioner (VIC)

169 Mildura Base Hospital (VIC)

170 Australian Institute of Health and Welfare - National Perinatal Statistics Unit (NSW)

Supplementary information

- *Women's role and satisfaction in the decision to have a caesarean section*, Turnbull D et al, MJA 1999 received 2.9.99

171 Birthplace Support Group (WA)

Tabled at public hearing 8.9.99

- Papers: Birth in the Warburton Region; Traditional Aboriginal Birthing Issues; and Doula Research Application

172 Health Rights Commission (QLD)

173 Australian College of Midwives Inc – Northern Territory Branch (NT)

174 Danila Dilba Medical Service (NT)

175 Australian Medical Association (ACT)

176 Nursing Mothers' Association of Australia (VIC)

177 NSW Health Department (NSW)

Supplementary information

- Alternative Birthing Services Program

178 Dr Kevin Barham (VIC)

179 Health Department of Western Australia (WA)

Tabled at public hearing 8.9.99

- Your Birthing Choice; and WA Hospital data

Supplementary information

- Responses to question on notice from public hearing dated 8 September 1999

180 Ms Katrina Maranik (NSW)

181 Health Care Complaints Commission (NSW)

182 Northern Territory Health Services (NT)

183 Mr and Mrs John and Louise Moulang (NSW)

184 Birth Support Bendigo (VIC)
185 Ms Regina Gleeson (VIC)
186 Port Hedland Regional Hospital – Maternal Services (WA)
187 Ms Coral Eden (VIC)
188 Dr Glen Barker (VIC)
189 Australasian Association of Paediatric Surgeons (VIC)
190 Ms Sarah Prosser (ACT)

Additional Information

Mercy Hospital for Women Vic – Obstetric audit statistics and copy of a paper *Vaginal Breech Delivery: A Lost Art;* Targett CS	Dated 7.9.99
Senator Trish Crossin – Supplementary information and a copy of *The NT Review of Birthing Services Implementation Status Report – October 1992*	Dated 22.9.99

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS

Friday, 27 August 1999 at 9.05 am, Senate Committee Room 2S1, Parliament House, Canberra

Department of Health and Aged Care
Mr Charles Maskell-Knight, A/g First Assistant Secretary, Health Access and Financing Division
Dr Margaret Dean, Medical Officer
Ms Marion Dunlop, Assistant Secretary, Health Strategies and Research Branch
Dr Bill Nichol, Assistant Director, Diagnosis Related Groups Development Section, Acute and Coordinated Care Branch, Health Services Division
Mr Robert Wells, First Assistant Secretary, Office of National Health and Medical Research Council
Australian Institute of Health and Welfare
Associate Professor Paul Lancaster, Director, National Perinatal Statistics Unit

Women's Electoral Lobby Australia Inc
Ms Helen Leonard, National Executive Officer
Ms Ingrid McKenzie, Convenor, Childbirth and Breastfeeding Working Group
Dr Barbara Vernon, Member, Childbirth and Breastfeeding Working Group

Catholic Health Australia
Mr Francis Sullivan, Executive Director

Women's Hospitals Australia and Australian Healthcare Association
Dr Stan Goldstein, President, Women's Hospitals Australia
Professor Jeremy Oats, Executive Member, Women's Hospitals Australia
Dr Ross Sweet, Member, Women's Hospitals Australia
Ms Jenni Jarvis, Member, Women's Hospitals Australia
Ms Anne Cahill, National Director, Women's Hospitals Australia

Australian Health Insurance Association Ltd
Mr Russell Schneider, Chief Executive Officer

Monday, 6 September 1999 at 10.10 am, 1st Floor Committee and Conference Room, Royal Women's Hospital, Carlton, Vic

Dr Jane Fisher
Lecturer, Key Centre for Women's Health in Society, University of Melbourne

Australian College of Midwives Inc - Victorian Branch
Ms Julie Collette (Hon President)
Ms Joyce Johnston, Professional Officer

Royal District Nursing Service
Ms Pat McPherson, Policy Officer
Ms Rosemary Brookes, Postnatal District Nurse

Victorian Health Services Commissioner
Ms Beth Wilson, Commissioner
Ms Lynn Griffin, Investigator

The Maternity Coalition
Ms Rhea Dempsey, Executive Committee Member
Dr Kerreen Reiger, Committee Member
Ms Anne Sprague, Midwife Member
Ms Laura Delaney, Editor, *Birth Matters*

The Royal Women's Hospital
Dr Neil Roy, Divisional Director, Neonatal Services
Ms Ro Hogan, Divisional Director, Maternity Services
Dr Chris Bayly, Divisional Director, Community Health Services
Dr Len Matthews, Consultant Obstetrician
Ms Lisa Dunlop, Unit Manager, Perinatal Medicine
Ms Janet Joss, Manager, Well Women's Services

Royal Australian and New Zealand College of Obstetricians & Gynaecologists
Dr Janet Duke, Honorary Secretary

National Association of Specialist Obstreticians and Gynaecologists
Dr Jillian Woinarski, Treasurer
Dr Samual Campbell, Vice-President

Tuesday, 7 September 1999 at 9.05 am, Reception Room, Ground Floor the Samuel Way Building, Women's and Children's Hospital, North Adelaide, SA

Flinders Medical Centre
Associate Professor Peter Marshall, Director, Women's and Children at Flinders
Professor Marc Keirse, Head of Department

Perinatal Society of Australia and New Zealand
Professor Jeffrey Robinson

Nunkuwarrin Yunti
Mrs Ethel Abdullah, Health Worker, Adelaide Central Community Health Service
Ms Lynette Andersen, Aboriginal Health Worker, Karpa Ngarrattendi, Flinders Medical Centre
Ms Katherine Morgan, Manager, Karpa Ngarrattendi Aboriginal Health Unit, Flinders Medical Centre
Ms Susan Cameron, Team Leader, Nunkuwarrin Yunti
Ms Felicity Bhatnagar, Community Health Nurse, Adelaide Central Community Health Service

Birth Matters
Ms Vanessa Shribman
Ms Jennifer Watkins
Ms Megan Resch
Ms Jenny Taylor

The Keep Queen Elizabeth Hospital Delivering Community Action Group
Ms Lisa Buttery, Committee Member
Ms Carol Hanna, Committee Member
Ms Michelle Moore, Committee Member
Ms Lan Nguyen, Community Member Representing NESB Communities
Mr Trevor White, Community Volunteer

SA Department of Human Services
Ms Kay Anastassiadis, Prinicipal Policy Officer
Mrs Judith Brown, Executive Officer, Obstretric Review
Dr Annabelle Chan, Senior Consultant, Pregnancy Outcome Unit
Dr Michael Jelly, Chief Medical Officer, Statewide Services

South Australian Independent Midwives Association
Ms Julie Pratt, Member

Midwives Act Lobby Group
Ms Anne Littlejohn, Member
Ms Sally Littlejohn, Member

Dr Deborah Turnbull & Sr Edith Reddin
University of Adelaide and Women's and Children's Hospital

Dr Julia Vnuk (Private capacity)

Dr Brian Pridmore
Director, Obstetrics & Gynaecology, Queen Elizabeth Hospital

Wednesday, 8 September 1999 at 9.15 am, Clinical Staff Lounge, 2nd Floor, King Edward Memorial Hospital for Women, Subiaco, WA

Dr Hilda Turnbull MLA
former Chairman, WA Legislative Assembly Select Committee on Intervention in Childbirth

King Edward Memorial Hospital for Women
Ms Robyn Collins, Midwifery Director, Obstetric Clinical Care Unit
Professor John Newnham, Professor of Maternal Foetal Medicine
Dr Brian Roberman, Medical Director

Community Based Midwifery Program
Ms Andrea Taman, Vice-Chairperson
Dr Ralph Hickling, Chair, Management Steering Committee
Mrs Enid Facer, Midwife Representative
Ms Tracy Reibel, Project Administrator

Royal Australian College of General Practitioners
Dr Kathy Innes, Joint Consultative Committee, Obstretrics/Gynaecology

Professor C.A. Michael
National Director, Health Services Development, St John of God Health Care

Birthplace Support Group
Ms Linda Rawlings, Committee member

Health Department of Western Australia
Dr Dorothy Jones, Medical Director, Clinical Care Casemix and Purchasing Unit
Ms Bernadette Hodgins, Senior Purchasing Manager, General Health Purchasing
Ms Vivien Gee, Coordinator, Maternal and Child Health, Health Information Centre

Australian College of Midwives – WA Branch
Ms Carol Thorogood, Midwife Educator

Tuesday, 14 September 1999 at 9.05 am, Coles Room, Level 11, State Library of New South Wales, Macquarie Street, Sydney

Australian Midwifery Action Project
Ms Sally Tracy, Senior Research Midwife
Ms Pat Brodie, Senior Research Midwife

Professor Marie Chamberlain
Clinical Chair in Midwifery, University of Sydney

The National Association of Childbirth Educators
Ms Karen Myors, National Vice President and NSW State President
Ms Pauline Green, Member and Trainer
Ms Lynne Clune, Member

National Health and Medical Research Council
Professor Lesley Barclay, Council Member
Professor David Henderson-Smart, Member, Health Advisory Committee

Midwifery Practice and Research Centre
Professor Lesley Barclay, Principal investigator
Ms Caroline Homer, Senior Research Midwife

Australian Society of Anaesthetists
Dr Rod Westhorpe, President

NSW Pregnancy & Newborn Services Network & Centre for Perinatal Health Services Research
Ms Chris Blatch, Director, Policy, Planning and Service Delivery
Ms Wendy Fischer, Health Services Manager, Research, Planning and Policy

Royal North Shore Hospital – Hospital Based Midwives
Mrs Lynn Evans, Clinical Midwife Consultant
Ms Catherine Maher, Midwife Educator
Ms Yvonne McCann, Director, Nurse Management, Women's and Children's Health

Westmead Hospital, Division of Women's Health and Newborn Care
Dr Andrew Pesce, Staff Specialist

Wednesday, 15 September 1999 at 9.10 am, Kevin Cronin Room, Ground Floor, Administration Building, Mater Misericordiae Hospital, South Brisbane, Qld

Queensland Council on Obstetric and Paediatric Morbidity and Mortality
Dr James King, Chairman

Dr Sarah Buckley (Private capacity)

Mater Misericordiae Mothers' Hospital
Mrs Jennifer Skinner, Executive Director
Professor Jeremy Oats, Director of Obstetrics and Gynaecology
Associate Professor David Tudehope, Director of Neonatology
Ms Jane Jacobs, Nurse Researcher
Ms Kathleen Ramsey, Project Officer, Women's Health Strategic Plan

Association for Improvement in the Maternity Services
Ms Christine Grose, Vice-President, South Queensland Branch
Ms Catherine Renkin, Secretary
Mrs Bronwyn Tocker, Treasurer
Ms Ulrike Weckes, Committee Member

Home Midwifery Association (Qld)
Ms Deidre Bowman, Committee Member
Ms Marion Begalo, Public Relations Officer

Dr Kathleen Fahy
Associate Professor & Master of Midwifery Coordinator,
University of Southern Queensland

Australian College of Midwives – Queensland Branch
Ms Patricia Schneider, President
Ms Carmel Dunne, Vice-President

Queensland Health
Dr John Youngman, General Manager, Health Services

Royal Women's Hospital Health Service District
Dr Don Cave, Director, Maternity Services
Ms Corelle Davies, Project Officer, Obstetric Services

APPENDIX 3

MATERNAL MORTALITY – INTERNATIONAL COMPARISONS

Numbers and rates of maternal mortality

Country	Year	Maternal deaths per 100,000 live births	Estimated number of maternal deaths, 1990	Lifetime risk of maternal death, 1990
Australia	**1994**	**7.0***	**25**	**1 in 4,900**
Canada	1994	3.6	25	1 in 7,700
Denmark	1993	7.4	5	1 in 5,800
France	1994	11.7	110	1 in 3,100
Germany	1994	5.2	190	1 in 2,700
Greece	1994	1.9	10	1 in 5,600
Hong Kong	1994	11.2	5	1 in 9,200
Ireland	1992	5.9	5	1 in 3,800
Israel	1994	5.2	5	1 in 4,000
Italy	1994	12.4	65	1 in 5,300
Japan	1994	6.1	230	1 in 2,900
Netherlands	1994	6.1	25	1 in 4,300
New Zealand	1993	20.4	15	1 in 1,600
Norway	1993	3.4	5	1 in 7,300
Singapore	1994	6.1	5	1 in 4,900
Spain	1993	6.2	30	1 in 9,200
Sweden	1993	5.1	10	1 in 6,000
Switzerland	1994	3.6	5	1 in 8,700
UK	1992	6.7	70	1 in 5,100
USA	1993	7.5	480	1 in 3,500
Asia			**323,000**	**I in 65**
North America			**500**	**1 in 3,700**
Europe			**3,200**	**1 in 1,400**
Oceania			**1,400**	**1 in 26**
World			**585,000**	**1 in 60**

* The underlying rate was 5.3 per 100,000 births during the period 1990-1994.

Source: International Health – How Australia Compares (AIHW cat. No.HSE6) 1998.

This information relates to Paragraph 4.4 of the Report.

APPENDIX 4

INFANT MORTALITY – INTERNATIONAL COMPARISONS

Infant, neonatal and post-neonatal mortality rates (per 1,000 live births)

	Infant mortality rate							
Country	**1950**	**1960**	**1970**	**1980**	**1994**	**Year**	**Neonatal (<28 days)**	**Post-neonatal (28-364 days)**
Australia	**24.5**	**20.2**	**17.9**	**10.7**	**5.9**	**1994**	**3.91**	**1.95**
Canada	41.5	27.3	18.8	10.4	6.2	1993	4.15	2.15
Denmark	30.7	21.5	14.2	8.4	5.7	1993	3.57	1.83
France	52.0	27.4	18.2	10.0	5.8	1993	3.15	3.32
Germany (FRG)	57.2	33.8	23.6	12.6	5.6	1994	3.22	2.38
Greece	35.4	40.1	29.6	17.9	7.9	1994	5.60	2.33
Hong Kong	99.6	41.5	19.2	11.2	4.5	1994	2.68	1.81
Ireland	46.2	29.3	19.5	11.1	5.9	1994	3.96	1.96
Israel	47.3	31.0	25.3	15.6	7.5	1993	4.71	3.09
Italy	63.8	43.9	29.6	14.6	6.6	1992	5.85	2.06
Japan	60.1	30.4	13.1	7.5	4.2	1994	2.33	1.92
Netherlands	26.7	17.9	12.7	8.6	5.6	1994	4.02	1.63
New Zealand	27.6	22.6	16.7	12.9	7.1	1993	3.81	3.52
Norway	28.2	18.9	12.7	8.1	5.2	1993	3.45	1.66
Singapore	82.2	34.8	19.7	11.7	4.3	1994	2.40	1.85
Spain	69.8	43.7	26.5	11.1	6.0	1992	4.61	2.44
Sweden	21.0	16.6	11.0	6.9	4.4	1994	1.89	2.56
Switzerland	31.2	21.1	15.1	9.1	5.1	1994	3.27	1.84
UK	31.4	22.5	18.4	12.1	6.2	1994	4.12	2.07
USA	29.2	26.0	20.0	12.6	7.9	1993	5.29	3.07

Source: International Health – How Australia Compares (AIHW cat. No.HSE6) 1998.

This information relates to Paragraph 4.4 of the Report.

BIBLIOGRAPHY

Australian Bureau of Statistics and Australian Institute of Health and Welfare. (1999) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples.*

Australian Bureau of Statistics. (1999) *Causes of Death, Australia 1998.*

Australian Health Technology Advisory Committee. *Diagnostic Ultrasound. Discussion Paper – Forum on Ultrasound,* Sydney, 13-14 June 1998.

Australian Institute of Health and Welfare. (1999) *Indigenous mothers and their babies Australia 1994-1996,* Sydney.

Australian Institute of Health and Welfare. (1999) *Medical labour force 1997,* Canberra.

Australian Institute of Health and Welfare. (1999) *Nursing labour force 1998,* Canberra.

Australian Medical Workforce Advisory Committee. (1999) *The Obstetrics and Gynaecology Work Force in Australia: Supply and Requirements 1997-2008,* Sydney.

Bastian H, Keirse JNC, Lancaster PAL. Perinatal deaths associated with planned home birth in Australia: population based study. *British Medical Journal,* vol. 317, 8 August 1998, pp. 384-387.

Brown S, Lumley J. Changing childbirth: lessons from a survey of 1336 women. *British Journal of Obstetrics and Gynaecology,* Feb 98, vol 105.

Brown S, Lumley J. Maternal health after childbirth: result of an Australian based survey. *British Journal of Obstetrics and Gynaecology*, February 1998, 105 (2), pp.156-161.

Brown S, Lumley J. Reasons to Stay, Reasons to Go: Results of an Australian Population-Based Survey. *Birth* 24: 3 September 1997, pp.148-158.

Buckley S. Epidurals – real risks for mother and baby. *Australia's Parents* Aug/Sept 1998.

Buckley S. Ultrasound – Reasons for Caution. First published in *Australia's Parents,* Summer 1999, as All about Ultrasound.

Chamberlain G, Steer P. Operative delivery. B*ritish Medical Journal,* vol. 318, May 1990, pp.1260-1264

Chapman M. Homebirth Control. *Australian Doctor,* 29 January 1999.

Commonwealth Department of Human Services and Health. (1995) *Compensation and Professional Indemnity in Health Care. A Final Report,* Canberra.

Cotzias C, Fisk N. Patient demand for Caesarean section. *Advances in Obstetrics and Gynaecology*, Issue 15.

Dangerfield J. *Birth Centre Evaluation 1995-1998.* Queensland Health, Royal Women's Hospital and District Health Service.

Day P, Sullivan EA, Lancaster P.(1999) *Australia's Mothers and Babies 1996.* Australian Institute of Health and Welfare National Perinatal Statistics Unit. Sydney.

de Costa C, Child A. Pregnancy outcomes in urban Aboriginal women. *Medical Journal of Australia*, Vol 164 (9), May 1996.

de Costa C. Caesarean section: a matter of choice*? Medical Journal of Australia* 23.5.99, 170, pp.572-573.

de Looper M, Kuldeep B. (1999) *International health – how Australia compares.* Australian Institute of Health and Welfare, Canberra.

Department of Health and Aged Care. (1999) *Clinical Profiles of Indigenous Status and Remoteness of Patients Usual Place of Residence, Australia, 1997-98.*

Department of Health and Aged Care. (1999) *Clinical Profiles of Selected Childbirth Interventions in Hospitals, Australia, 1997-98.*

Ewigman BG et al. The Effect of Prenatal Ultrasound Screening on Perinatal Outcome. *New England Journal of Medicine*, 16 September 1993: 329, pp.821-827

Fisher J et al. Private health insurance and a healthy personality: new risk factors for obstetric intervention? *Journal of Psychosomatic Obstetrics and Gynaecology*, 16, 1995.

Fitzpatrick J. Obstetric health services in Far North Queensland: is choice an option? *Australian Journal of Public Health*, Vol 19 (6), Dec 1995.

Giles W, Collins C, Ong F, MacDonald R. Antenatal care of low risk obstetric patients by midwives. *Medical Journal of Australia*, Vol 157, Aug 1992.

Gilkison A. Antenatal Education – Whose Purposes Does it Serve? *New Zealand College of Midwives Journal*, May 1991.

Haire D. *Medications used in Labour and their effects on Mother and Newborn.* Paper presented at UNICEF Birth without Boundaries conference, Chiang Mai, Thailand, 1 March 1997.

Hall MH. When a woman asks for a caesarean section. *British Medical Journal* 1987; 294.

Handa VL et al. Protecting the pelvic floor; obstetric management to prevent incontinence and pelvic floor prolapse. *Obstetrics and Gynaecology* 1996, September: 88 (3), pp.470-478.

Health Department of Victoria (1990), *Having a Baby in Victoria*. Final Report of the Ministerial Review of Birthing Services in Victoria, Melbourne.

Health Department of Western Australia. (1996) *Response to Report of the Select Committee on Intervention in Childbirth.*

Health Department of Western Australia. (1998) *Your Birth Choice. Planning Ahead for Birth.*

Hickey AR et al. Early discharge and risk for postnatal depression. *Medical Journal of Australia* 1997; 167.

Hilder L et al. Prolonged pregnancy: evaluating gestation specific risks of fetal and infant mortality. *British Journal of Obstetrics and Gynaecology,* 1998;105: pp.169-173.

Innes KM. Why are general practitioners ceasing obstetrics? *Medical Journal of Australia*, vol. 166, 3 March 1997.

Jacobsen B et al. Opiate addiction in adult offspring through possible imprinting after obstetrical treatment. *British Medical Journal*, 10 Nov 1990, vol.301, pp.1067-70

Jordens CFC et al. Use of systematic reviews of randomised trials by Australian neonatologists and obstetricians. *Medical Journal of Australia* 1998, 168, pp.267-270

King JE. No money , no pills. *New Doctor*, Vol 65, Winter 1996.

King JE. Obstetric intervention and the economic imperative. *British Journal of Obstetrics and Gynaecology,* April 1993, Vol. 100.

Lancaster PAL, Pedisich EL. *Caesarean births in Australia, 1985-1990,* Australian Institute of Health and Welfare National Perinatal Statistics Unit, Sydney 1993.

Markey PG, d'Espaigent ET, Condon JR & Woods M. (1998) *Trends in the health of mothers and babies Northern Territory 1986-95*. Northern Territory Health Services, Darwin.

Matthias G, Morgan G. Aboriginal and non-Aboriginal perinatal deaths in Darwin: a comparative view. *Medical Journal of Australia,* Vol 156, April 1992.

National Health and Medical Research Council. (1996) *Clinical Practice Guidelines - Care around Preterm Birth.* Canberra.

National Health and Medical Research Council. (1996) *Options for Effective Care in Childbirth*. Canberra.

National Health and Medical Research Council. (1998) *Report on Maternal Deaths in Australia, 1991-1993.* Canberra.

National Health and Medical Research Council. (1998) *Review of services offered by midwives.* Canberra.

National Health and Medical Research Council. (1999) *A guide to the development, implementation and evaluation of clinical practice guidelines.* Canberra.

Neilson JP. Ultrasound for fetal assessment in early pregnancy. *Cochrane Review.* In Cochrane Library, Issue 3, 1999, Oxford: Update Software

New South Wales Health Department. New South Wales Mothers and Babies 1997. *NSW Public Health Bulletin Supplement,* No 2, December 1998.

Nolan ML. Antenatal education – where next? *Journal of Advanced Nursing,* London, 1997, 25.

Northern Territory Department of Health and Community Services. (1993) *Review of Birthing Services in the Northern Territory of Australia 1992,* Darwin.

Olsen Ole. Meta-analysis of the Safety of Home Birth. *Birth,* 24: 1 March 1997.

Olubusola Amu et al. Maternal choice alone should not determine method of delivery. *British Medical Journal,* vol. 317, 15 August 1998, pp. 462-463

Olufemi A et al. Physicians' attitude toward evidence based obstetric practice: a questionnaire survey. *British Medical Journal,* January 31 1998, vol. 316.

Parratt J. Practising Midwifery Independently: For the Majority of Midwives?, *Australian College of Midwives Incorporated Journal,* September 1996.

Paterson-Brown S. Are Clinicians Interested in Up to Date Reviews of Effective Care? *British Medical Journal,* vol. 307, 4 December 1993.

Paterson-Brown S. Should doctors perform an elective caesarean section on request? *British Medical Journal,* vol. 317, 15 August 1998.

Pelly J et al. Clinical practice guidelines before the law: sword or shield? *Medical Journal of Australia* 1998, 169, pp. 330-333.

Powell J, Dugdale AE. Obstetric outcomes in an Aboriginal community: A comparison with the surrounding rural area, *Australian Journal of Rural Health,* Vol 7(1), Feb 1999.

Quinlivan J, Peterson R, Nichols C. Patient Preference the Leading Indication for Elective Caesarean Section in Public Patients – Results of a 2-year prospective audit in a teaching hospital. *Australian and New Zealand Journal of Obstetric Gynaecology,* 1999, 392, pp. 207-214.

Read A, Waddell V, Prenidiville W, Stanley F. Trends in caesarean section in Western Australia, 1980 -1987. *Medical Journal of Australia,* Vol 153, Sept 1990.

Review of Professional Indemnity Arrangements for Health Care Professionals. (1995) *Compensation and Professional Indemnity in Health Care, A final report.* Canberra.

Roder D, Nguyen A, Chan A. Trends in perinatal characteristics in South Australia, 1998 to 1994, by place of residence of mother. *Australian & New Zealand Journal of Public Health*, 1997, Vol. 21, No.5.

Sachs BP et al. *The Risk of Lowering the Caesarean-Delivery Rate.* New England Journal of Medicine, 7 Jan 1999, vol. 340 pp.54-57.

Sayers S, Powers J. Risk factors for Aboriginal low birthweight, intrauterine growth retardation and preterm birth in the Darwin Health Region. *Australian and New Zealand Journal of Public Health,* Vol 21(5), 1997.

Schiff et al. Maternal and Neonatal Outcomes of 846 Singleton Breech Deliveries. *American Journal of Obstetrics and Gynaecology* 1996, 175, pp.18-23

Shearman R. (1989) *Final Report of the Ministerial Task Force on Obstetric Services in New South Wales,* New South Wales Health Department.

Shorten A, Shorten B. Episiotomy in NSW hospitals 1993-1996: Towards understanding variations between public and private hospitals. *Australian Health Review*, Vol.22, No. 11.

South Australian Health Commission. (1995) *Report of the South Australian Models of Maternity Care Working Party*.

Sparling JW et al. The relationship of obstetrical ultrasound to parent and infant behaviour. *Obstetrical Gynaecology* 1988, vol. 72, no. 6, pp.902-7

Territory Health Services. *Alternative Birthing Services Program, Midwifery Project, Report February 1994-January 1995*, Darwin.

Territory Health Services. Women's Health Strategy Unit. *And the women said…Reporting on birthing services for Aboriginal women from remote top end communities*, Darwin.

Territory Health Services. Women's Health Unit. (1997) *Evaluation of the Alternative Birthing Services Program in the Northern Territory*, Darwin.

Thornton JG. Active management of labour. *Current Opinion in Obstetrics and Gynaecology*, vol. 9, no. 6, December 1997.

Tito F, Newby L. (1998) *Medico-legal implications of clinical practice guidelines.* Sydney, National Health and Medical Research Council National Breast Cancer Centre.

Turnbull DA et al. Women's role and satisfaction in the decision to have a caesarean section. *Medical Journal of Australia 1999;* 170.

Turnbull Dr H, MLA. (1995) *Select Committee on Intervention in Childbirth*, Perth.

Wagner M. Ultrasound: More Harm than Good? *ACE Graphics*, 2 November 1998.

Wilkinson C et al. Is a rising caesarean section rate inevitable? *British Journal of Obstetrics and Gynaecology* 1998, vol. 105, pp.45-52.

Women's and Children's Hospital, Adelaide. (1996) *Perinatal Protocols and Guidelines for Management.*

World Health Organisation. Appropriate Technology for Birth. *Lancet,* Aug 24 1985.

Zhang Jun et al. Epidural analgesia in association with duration of labour and mode of delivery. A quantitative review. *American Journal of Obstetrics and Gynaecology,* vol.18 (4) April 1999.