20th of July 2009

To the Inquiry into Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009.

Regarding
Proposed changes to Maternity Services that will remove independent homebirth midwives from the community.

I start this submission with dismay that I am even needing to write it.

I wonder why our government is expecting a mother to become lobbyist.

I ask why have I, and many other members of the general public spent so much time and energy writing into maternity reviews if the only result is to ignore us, then openly discriminate against us?

I wonder too, why a union, namely the AMA (Australian Medical Association) is controlling government policy and thus being allowed to dictate what care women will be able to access and how much our community will pay both on a physical and financial level?

I ask what government would want to make criminals of parents and midwives.

I attach my personal submission that I sent into the Maternity Services Review. I send it to your senate inquiry with the hope that it is read, which given the result of the Maternity Services Review Report, I doubt their members did.

This is how the proposed changes to the Maternity system has and will affect me.

I started a three year direct entry midwifery degree at the beginning of 2009, a week after the release of the Maternity Services Review Report. The report affected me deeply. As soon as I read it, I felt my future slip away.

I could see from the report that it had been written based on the information provided by the AMA, an organisation that wishes to have a complete monopoly over maternity care, the highest income section of health care in Australia.

I could see that I would never be able to practice independent midwifery within my rural community (East Gippsland) or in fact anywhere in Australia. That when I have my next child that I would have to do so illegally, underground or be in a country such as New Zealand.

I was concerned about the women birthing alone without professional support and the outcomes that would occur.

I also wondered how the maternity hospitals would be able to service the needs of an extra 700 women a year considering the majority of maternity hospitals are operating well over capacity. On the topic of operating, I also wondered why the government wanted to push healthy women who were taking financial and personal responsibility for their health and that of their child into a system that was failing all international standards IE extremely high intervention rates, high rates of admittance to special care nurseries, very low breastfeeding rates and the list goes on.

The stress and distress that the report and the proposed maternity service changes had on me was to leave, what had been a life long dream, my training to become a midwife.

It has put me in the position of investigating leaving my home country and going to New Zealand, a country that respects women and their babies by providing professional maternity service s to all women, regardless of where they might choose to birth.

I could also continue my dream of becoming a midwife, serving the community and a country that wants my skills.

I consider the planned changes to maternity services by removing the rights of a midwife to practice independently and of a mother being able to engage these services as a direct assault on my personal rights, my religious rights and the rights of my children.

If I, as an Australian woman do not have the right to engage a midwife in my hometown of Bruthen, East Gippsland from July 2010, to attend me at a place of my choosing, most likely at home, then I will leave this country forever.

I do not want to be within a country that thinks it is acceptable to impose medical treatment on myself or my daughters.

I pray that common sense will see through the proposed changes and that provision will be made for all Australia’s regardless of their location, their religion or their sex to access the professional health services that they require.

In Hope.
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Submission to the Maternity Services Review

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Submission to the Maternity Services Review

I answer the following questions from my own personal experience as a mother of two, a volunteer in numerous maternity organisations, and as a birth support person.

WHAT MODELS FOR MATERNAL SERVICES FOR RURAL AND REMOTE COMMUNITIES ARE WORKING WELL?

Currently the only services which are catering for the needs of women are those offered by independent midwives, but these services have restrictions as I will point out below.

I am aware that Mareeba Hospital in Queensland offers a midwifery-led rural maternity service. This service could be implemented in suitable communities. See Appendix A for the full details of this (Scherman 2008).

My Experience of Birthing in the Bush
I gave birth to my second child in rural Victoria in 2005.

The maternity system available to me was in no way suitable for my needs.

I had birthed my first child in a midwifery birth centre in Melbourne and I had attended many births in various Melbourne hospitals.

The services offered at my local hospital was far removed from anything remotely women centred. I could only be cared for by a GP/obstetrician, there was any one of a dozen midwives that might be present for my labour care, all of whom had varying perceptions of ‘normal’ birth, some openly disapproving of natural birth. The intervention rates for my local hospital were incredibly high, even though care was only provided to low risk women, with anyone considered high risk referred to other hospitals. I also had no access to deep water immersion for either labour or birth.

I instead turned to the assistance of a midwife who was currently working in the public system and requested that she offer me independent maternity care. I also requested a friend, who was a qualified midwife to be my second midwife. This friend had many years experience in midwifery but refused to work in the regional maternity services due to the state of the system.

I was more then satisfied with my two midwives, providing me pregnancy, birth and post natal care but …..

I was forced to attend a local GP/obstetrician to obtain referrals for blood tests and an ultrasound and to be assured of having a doctor that would be supportive of my choices and as such attend to me if I required assistance at our local hospital. Our community only had GP/ obstetricians with visiting rights, no hospital-based Obstetricians.

I found these visits completely unnecessary as they covered what my midwife had already performed and were an expense in regards to petrol and my time.

I ask,

- Why was my midwife refused the right to refer me for tests?

- Why was my visits to the doctor covered by Medicare but my midwife visit paid for by myself with no rebate available?

- I was a healthy woman who just wanted to have midwifery care, I didn't want to see a doctor or go near a hospital unless I needed help. Why did my care need to be fragmented?

I was also forced to book into the local hospital.

Here I was subjected to 'the system'. A hospital-employed midwife requesting information that I had already provided to my independent midwife.

I was also subjected to her personal shock and dismay when I disclosed that I was birthing at home. She was extremely uncomfortable and demanded to know "Did my doctor know what I was up to?"; and when I told her that my doctor did know, then demanded to know who was my midwife.

At this stage I was concerned about my midwife's professional welfare and I refused to disclose who she was, to which the hospital midwife ran through the names of who she suspected would be involved with homebirth, and again demanded to know which one was "doing a homebirth".

I ask,

- Why did I have to personally book into a hospital? Why weren't systems in place that would allow my midwife to just fax off a booking form, like Melbourne-based independent midwives do?

- Why do hospital staff believe they have the right to deter women from choosing their place of birth and care-giver?

I gave birth to my child at home with my partner, two midwives and a few friends. The midwives provided professional care and within hours of my birth I was tucked up into bed with my partner and new baby.

<u>Post-natal Issues</u>
A few issues occurred that effected my post natal period.

- My coccyx re-broke during birth from a pre-existing injury.
- My partner put his back out.
- Our planned post-natal support people were delayed in Melbourne

On waking with my new baby, I realised I was unable to move properly. It became clear very quickly that I had re-injured my coccyx. Even simple tasks such as getting out of bed and showering were very difficult.

My partner was unable to get out of bed as his back was injured. We needed help.

My midwives assisted us directly, well outside their scope of practice by cleaning, cooking and shopping, local friends stepped forward and brought over meals, chopped wood and lit our fire (our only heating).

My midwife and I requested help from the following local services:

- Council: I did not fit into any of their categories.

- Home Help: Only the elderly or people referred by the hospital would get assistance. They did refer me to a private agency but we did not have the money available to pay for their service. I did ask if we could be billed via account as we had a baby bonus arriving but they refused this arrangement.

- Hospital: Since I had not birthed in hospital, they said they could not verify I needed help. I would have to go into the hospital and be assessed, then I *might* be able to access their hospital-based funding for home assistance. I could not travel in a car and there was no medical services based in my town.

Why did the fact that I had birthed at home exclude me from help?

Why wasn't my midwife's professional opinion about my condition acceptable to the hospital, thus allowing referral for home assistance.

Why, when I needed help, did I, as a homebirth mother not fit into anyone's category?

WHAT ARE THE KEY ELEMENTS TO APPLYING SUCH MODELS MORE BROADLY?

All women should be able to access appropriate care and support regardless of where they live and who they choose as care providers.

I suggest the following models:

- A Mother Help service such as Australian Mothercarer Program based in South Australia be available to every mother. Other countries have a long history of providing extensive post-natal support service to new mothers. The Dutch based post-natal care workers called, *kraamverzorgende*, are a wonderful example of home-based help. Whilst establishing these home-based support systems, existing local government home-help networks could be extended to cover all new mothers who wish to use the service (Zadoroznyi 2007).

- Midwives are provided universal referral and visiting rights.

- Case Load or KYM (Know Your Midwife) or Group Midwifery Programs[1] are started within every community.

- All midwives regardless of where they work and provide care are immediately provided with insurance.

- All midwifery care should be rebated or covered by the government.

- All communities are practically and financially supported in setting up groups such as, BaBs, (Birthing and Babies Support Groups). This is a volunteer-based program that brings together pregnant and parenting women and their families with the supportive presence of a midwife to encourage information, education and support (Babs 2008).

WHAT ASPECTS OF THE AUSTRALIAN CONTEXT ARE DRIVING HIGH INTERVENTION RATES?

The whole system is based around a medical model designed for treating sickness and injury. Pregnancy, labour, birth, and all the changes that occur to a woman at this time are a normal physiological process – it is not an illness!

Almost all women attend a GP to confirm pregnancy or to find out what they should do. Women are asked if they have private health cover; these women are then referred to private obstetricians. Women without private health cover are referred to a public maternity hospitals. Most of these services are not within a woman's own community; in fact she is usually required to travel great distances to access this care – this refers to both rural and urban women.

Women are automatically referred into medical models of care. Once this occurs, medical management of pregnancy, birth and the post-natal period is the norm, rather than being reserved for women and babies with actual medical need.

There is no local-based systems in place that supports pregnancy, birth, breastfeeding and early parenting as normal life events within a community.

[1] *Group Midwifery
Small teams of midwives that share the care of women. Usually involving 3 to 5 EFT (Effective Full Time) positions. Group Midwifery Programs allow midwives interested in women centred care to offer their services whilst sharing the work load with the other midwives in the program. Group Midwifery Programs can allow midwives to work in a part time capacity whilst still working in a 'with women' model of care.
Any more then 3 to 5 EFT positions create confusion and excess fragmentation of care to women and should be referred to Team Midwifery. Team Midwifery is more suitable for the management of rosters then for the quality care of women.

WHAT ACTIONS ARE REQUIRED TO ADDRESS THIS?

Maternity Hubs
These are centres that act as maternity hubs within the community and opened for the sole purpose of providing maternity care.

These centres could offer services from:
- Pregnancy testing, antenatal and post-natal care;
- Pregnancy, birth, breastfeeding and early parenting education;
- Breastfeeding support clinics;
- Post natal in house mothering support services;
- Birthing services;
- Community pregnancy and parenting services and supports meeting space;
- Maternal and Child Health Centres;
- A referral hub for other services.

The aim of Maternity Hubs is to bring maternity back to the local communities in a sustainable manner.

Maternity Hubs can be converted houses in low-demand suburbs or towns to larger purpose-built centres in areas of high maternity service demands. The centres would cater for all women and utilise/refer to specialist services as and when required.

Establishing Maternity Hubs will immediately remove the pressure from our over-burdened hospitals, and by providing care within local communities we would be reducing the carbon footprint of maternity care (*e.g.*, the pollution caused by extensive travel).

Who would provide Maternity Hub services?
Services could be provided by a combination of directly-employed, sub-contracted, or independent professionals provided with visiting rights:
- Case Load or KYM (Know Your Midwife) Programs
- Group Practice Midwifery,
- Independent Midwives
- Team Midwifery[2]

Who would manage the Maternity Hubs?
Maternity Hubs would be managed by the community, for the community with support and guidance from maternity professionals.

Who would fund Maternity Hubs?
Multi-layered funding approaches have not worked effectively in the past; it has resulted in a system in crisis. Our community is being deeply affected by our current services. A one-stop funding source is required to create a sustainable, effective maternity service.

[2] Team Midwifery: roster-based staffing systems of usually 5-10 midwives reporting to a unit manager.

WHAT, IF ANY, ARE KEY SUPPORT SERVICES, INCLUDING PEER SUPPORT WHICH WARRANT NATIONAL COVERAGE?

BaBs
Birthing and Babies Support Inc is a community based volunteer program that encourages women to come together and share their experiences of pregnancy, birth, breastfeeding, parenting and life in general. BaBs assists in recreating community networks and support which are lacking in our contemporary society (Babs 2008).

Australian Breastfeeding Association (ABA)
All services offered by ABA should be fully funded and supported. Access to all health systems by ABA counsellors should be guaranteed. Every women should be provided with information regarding her local group and the national help line. Breastfeeding education sessions by the ABA should be fully funded and available to every Australia women.

WHAT IS REQUIRED TO ENSURE THE QUALITY AND CONSISTENCY OF KEY SUPPORT SERVICES?

Services should remain independent of the government, but funded to enable these groups to offer their services nationally.

Assistance in creating guidelines and implementation strategies should be offered to existing and new community-based organisations.

The creation of new ideas could be encourage by offering annual seed grants to enable the trial of concepts and locally created programs to expand nation-wide; this would enable new approaches to always be evolving.

Like any independent program receiving financial support from the government, standard accountability and reporting should be in place.

HOW ARE MATERNITY SERVICES CURRENTLY ORGANISED AND FUNDED?

In a very complicated fashion…

Please look towards New Zealand for how they have funded their maternity services.

Maternity care should be directed by the women not by the services.

HOW IS CURRENT COMMONWEALTH FUNDING TARGETED?

Funding currently appears to support hospitals and obstetric (*i.e.*, surgical) specialists to provide *all* birthing services.

Funding should be targeted to provide the pregnant woman with the means to access the type of care she chooses. Funding should be woman-centred, not system-centred.

WHAT ARE THE KEY PROFESSIONAL DEVELOPMENT NEEDS FOR THE MATERNITY WORKFORCE?

All maternity professionals should be well educated in normal, physiological, undisturbed, non-medicalised birth!

Apart from a number of births required by students to become qualified, there should be a requirement that a percentage of these births be 'natural births', without any interventions.

Clinical placement with independent midwives would ensure the continuity of practical skills and expertise. Professionals would experience community-based midwifery care and homebirth. Professionals with a broad range of pregnancy and birthing experiences (obstetricians, midwives, GP's, etc.) would have a wider scope of practice, and an understanding and appreciation for the diversity of cases that exist within the community, and be able to provide care that is appropriate for (and wanted by) the individual woman.

Breastfeeding education should be dramatically improved. The WHO Breastfeeding code should be taught to every maternity professional and implemented within every maternity service.

HOW WILL MODELS OF WORKFORCE SUPPORT VARY IN RURAL AND URBAN SETTINGS? WHAT ARE THE POTENTIAL AREAS FOR CHANGE TO EXPAND MIDWIFE-LED CARE ACROSS ANTENATAL, BIRTHING AND POSTNATAL SERVICES?

Utilise independent midwives
There are independent midwives currently working within the urban and rural settings. This workforce has the ability to expand their current services to more women, once insurance is provided, and referral and visiting rights are granted.

These same midwives can be utilised to mentor current hospital-based midwives in providing case-load and midwifery group practice, in setting up of Maternity Hubs, and training of the next generation of maternity professionals.

Once insurance, referral and visiting rights are provided, midwives who have been forced out of our system as either independent midwives, or due to their inability to work within a medical-based system will return, increasing the amount of professionals available for maternity care.

Create satellite clinics
To cater for populations with very low birth rates, offering satellite clinics or home-based visits by a midwife will enable quality care within a women's own community. These services can be provided by a community-based midwife, working within a case-load program or an independent midwife, depending on what service the women is wishing to access.

Maternity Hubs
As mentioned before, Maternity Hubs could be created in most areas, including rural and remote. These services would be flexible enough to cater for the employment needs of the local maternity professionals.

Turn Level 1 Hospitals into Midwifery-led Care Units
To increase job satisfaction and to operate more user friendly services, Level 1 maternity services could be turned into Midwifery-led care units. This has been shown to have reduced

levels of intervention and would allow medical professional to be better utilised in other much needed areas (Scherman 2008).

Create Level 3 Hospitals within large regional centres.
This would prevent women and their families needing to travel to city centres; assist in the prevention of unnecessary separation between mothers, babies, family and support circles in times of need; create job opportunities for maternity professionals; and create high level training facilities within regional area, in turn encouraging students to accept positions within regional areas, and generally reduce the burden on urban-based systems. When urban services are overburdened these regional centres can then be utilised to handle the excess demand.

WHAT ARE THE EXISTING EFFECTIVE MODELS FOR MIDWIFE-LED MATERNITY SERVICES?

I would request that the Maternity Services Review obtain and view a copy of the documentary BirthRites, produced by Jag1 Films PTY LTD, PO Box 53 Margaret River, WA, (08) 9758 7404.

This documentary demonstrates a model that would be suitable not only for women and their families within remote rural location, but equally for women based in regional and urban settings.

Birth Rites draws powerful comparisons between birth in outback Australia and the icy regions of Canada. These two indigenous cultures have a shared history of dispossession as well as social and health problems.

Both countries have routinely evacuated women from their hometowns to birth alone in far away hospitals.

The Inuit midwives have made a breakthrough with the first Inuit controlled Birth Centre in remote Puvirnituq (Canada). In Australia, the women's stories expose for the first time the devastating personal and cultural repercussions of this "separation policy" (Gherardi 2001)

WHAT ARE THE KEY WORKFORCE BARRIERS TO INTEGRATED MODELS OF CARE?

WHAT KEY INFRASTRUCTURE IS NEEDED?

Maternity Programs should be community owned and operated.

Funding could be made available by using the example of funding systems for Neighbourhood and Community House programs. This would then enable local solutions to local maternity needs, provide community based direction.

Support and guidance would be offered from a central-based department that would assist with the implementation and operation of such programs.

ARE THERE OTHER ISSUES THE REVIEW SHOULD CONSIDER?

The Cost to a Rural Community.
Apart from the social, emotional, physical and financial costs to the community with a dysfunctional maternity service, there is also the medical services costs for the general community.

From what I have witnessed in just one area of Australia, the issue with Maternity Services in the bush is more of an under-utilisation of the existing professionals, than a true shortfall of skilled personnel.

Example: 300 births in one country town, population 20,000.
Every birth is under the exclusive care of a GP/obstetrician who has visiting rights to the local hospital.

Each women has approximately 14 clinic visits to her GP/obstetrician, plus attendance at her birth.

Based on NZ statistics, if these births occurred in NZ, 80% of births would be under midwifery care.

Based on these numbers, if women had access to midwifery care, then 240 women in this country town would have no need to tie up local doctor services.

This would free up 3,360 doctor visits to the community, not to mention relieve the already overworked GP's from the pressure of being on call to such a large number of people.

This town would only require 6 EFT midwives to directly care for 240 women.

There could be a combination of 2 EFT case-load midwives and a midwifery group practice of 4 EFT midwives working on a roster basis, allowing these midwives the flexibility that comes with roster-based employment, but also the enjoyment of working in a 'with woman' model of care. This would free up the local doctors to take care of the medical needs of the local community and to provide care to women requiring medical assistance with their pregnancy (*i.e.*, high risk cases).

There are midwives ready to provide services within many areas around Australia.

There are women wanting to have true choice of care provider across Australia.

Currently, access to doctor services in country towns is of great concern. It is common for people in rural/remote areas to be unable to access necessary medical attention due to the doctor clinics appointments being full; in cases I have been aware of, they have needed to wait for a week or more to access care.

Simple solutions are available – the women have been saying what they want, and the midwives have been attempting to offer it.

We just need to be heard and our wishes enabled.

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Appendix A

Mareeba Model Shows That Consultation, Cooperation and Flexibility May Keep Rural Maternity Units Operating

A detailed study of the first year of operation of a midwifery-led rural maternity service in Mareeba, North Queensland, provides hope that more rural maternity units can remain viable if there is optimum cooperation and coordination of local health workforce and resources.

The study is published in the latest edition of the *Medical Journal of Australia*.

The authors – Dr Samantha Scherman (obstetrician gynaecologist), Jan Smith (clinical nurse consultant), and Megan Davidson (registered midwife) – advise, however, that it should not be assumed that the Mareeba model of care would be effective in other regions.

Mareeba is a country town of 8000 people 64 kilometres south-west of Cairns. In May 2005, the local hospital's maternity service, which handled an average of 196 births per year between 2000 and 2004, was closed due to medical workforce shortages.

Six weeks later, the service re-opened as a midwifery-led model of care for low-risk women, with higher-risk patients being referred to Cairns Base Hospital (CBH).

Under the Mareeba model, all women booked with the local maternity unit have a case conference with a Cairns-based obstetrician on a monthly basis, with outpatient antenatal care and inpatient intrapartum and postpartum care provided by the local midwives on a 24-hour basis.

The Cairns obstetrician oversees all emergency care and pregnancy complications. Medical officers from Mareeba District Hospital (MDH) are available to give basic medical assistance in an emergency, and there are four appropriately qualified GPs in the town who can be called upon when urgent medical intervention – including caesarean section – is required.

Dr Scherman says that the model of care available in Mareeba is fully explained to women when they are booked in.

"In general, women appear to have been supportive of this model of care, with very few deciding to change to a different model after their booking visit," she said.

Of the 203 women who were booked for antenatal care at MDH and gave birth in the first year of operation (June 2005–June 2006) of the new model, 170 were categorised as low risk and suitable to give birth at MDH. Of these, 147 did give birth at MDH, with another 17 transferred to Cairns prior to birth, and six transferred during labour.

Of the 33 women categorised as high risk, 22 gave birth at CBH as planned, seven had elective caesarean sections performed by a GP at MDH, and four presented to MDH in labour and gave birth there with no complications. Of the 158 women who gave birth at MDH, 146 (92 per cent) had normal deliveries.

Dr Scherman says that outcomes for the first year of operation of Mareeba's midwifery-led model of care are consistent with a viable maternity unit, but due consideration must be given

to the characteristics of each individual rural institution before such a model is implemented elsewhere.

“Mareeba has a favourable combination of characteristics,” she says.

“There is a dedicated and experienced midwifery team, a supportive community, a group of women willing to accept the potential limitations of this model of care, a cooperative Cairns Base Hospital to act as the referral centre, supportive and experienced local GPs, and overarching supervision by a Cairns-based obstetrician.

“A similar set of circumstances would need to be in place for this model to be successful in other rural areas,” Dr Scherman says.

In an accompanying editorial, the Chairman of the National Association of Specialist Obstetricians and Gynaecologists, Dr Andrew Pesce, says the search for models of maternity care best suited to women in rural areas will continue to challenge health service planners.

Dr Pesce notes that it is estimated that more than 130 Australian rural maternity units have closed since 1995.

“It seems likely that continuing provision of maternity services in rural areas will depend on optimum use of the local workforce and health facility infrastructure,” he says.

“Individual regional areas will need to come up with arrangements based on consultation with the local community and health workforce.

“This will require a flexible approach and should recognise that transfer of women may sometimes be required, because of temporary unavailability of a core of necessary staff.

“It is unlikely that a ‘one size fits all’ approach will deliver solutions to all areas at all times.

“It remains to be seen which elements of the Mareeba model of care are most appropriate to consider replicating elsewhere without compromising safety and quality of maternity care,” Dr Pesce says.

The *Medical Journal of Australia* is a publication of the Australian Medical Association.

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